

# CONCERN WORLDWIDE

## USAID Child Survival & Health Grants Program EXPANDED IMPACT CHILD SURVIVAL PROGRAM

*USAID/M/FM/CMP GHS-A-00-06-00018-00*

*October 2006 – September 2011*

## DETAILED IMPLEMENTATION PLAN

### KABEHO MWANA

### “Life for a Child”

**Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke,  
and Nyaraguru Districts, Rwanda**

*A Partnership of Concern Worldwide, the International  
Rescue Committee, and World Relief*

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## **ACRONYM LIST**

ACT	Artesunate Combined Treatment (Coartem)
ANC	Antenatal Care
ARI	Acute Respiratory Infections
CCM	Community Case Management
CDC	Community Development Committee
CHW	Community Health Worker
C-IMCI	Community- IMCI
CSHGP	Child Survival Health Grants Program
CSP	Child Survival Program
CTC	Community Based Therapeutic Care
CW	Concern Worldwide
DHMT	District Health Management Team
EICV2	National Integrated Living Conditions Survey 2
EIP	Expanded Impact Program
ENA	Essential Nutrition Actions
GESIS {HMIS}	Rwanda's Health Management Information System
GoR	Government of Rwanda
HC	Health Center
HDDS	Household Dietary Diversity Score
HFA	Health Facility Assessment
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Prevention Treatment
IRC	The International Rescue Committee
LLN	Insecticide Treated Bed Nets
LQAS	Lot Quality Assurance Sampling
LRA	Local Rapid Assessments
MDG	Millennium Development Goals
MINISANTE	Rwandan Ministry of Health
MMS	Management Monitoring System
MUAC	Mid-Upper Arm Circumference
NICRA	Negotiated Indirect Cost Recovery Agreement
ORS	Oral Rehydration Salts Solution
PDA	Personal Digital System or handheld computer
PMI	Presidents Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PNILP	National Integrated Malaria Control Program
PPA	Periodic Performance Assessments
PRSP	National Poverty Reduction Strategic Plan, 2005
PSI	Population Services International
PVO	US Private Voluntary Organization (refers to CW, IRC and WR)
QA	Quality Assurance

RDHS	Rwanda Demographic & Health Survey, 2005
Rwf	Rwandan francs
SP/AQ	Sulfadoxine/pyrimethamine and amodiaquine
TBA	Traditional Birth Attendants
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WR	World Relief
WRA	Women of Reproductive Age

## A. Executive Summary

Rwanda is a small, land-locked country in Central Africa. With a population of approximately 9 million people inhabiting some 26,338 square kilometres it is the most densely populated country in Africa (340 persons per square km). Half the population is under 15 and the annual population growth rate is 2.8%. The population is projected to double to 16 million by 2020. Rwanda currently has a Human Development Index score of 422, thus ranking 158 out of 175 or 17<sup>th</sup> from the bottom. It is estimated that one-third of families live in extreme poverty with less than a dollar per day.<sup>1</sup> The child mortality rate, 152, has declined by 20% over the last five years,<sup>2</sup> but remains unacceptably high. Heavy burdens of serious yet preventable childhood illness from endemic malaria, diarrhea and acute respiratory infections place a huge burden on families that are already struggling. Lack of financial access to primary health care for the poor, frequent co-morbidity, and underlying chronic malnutrition result in the devastating statistic of one in seven children dying before their first birthday.

In the face of so much challenge for Child Survival, **Concern Worldwide (CW)**, the **International Rescue Committee (IRC)** and **World Relief (WR)** have demonstrated that through effective strategies, including inter-agency collaboration and partnership with the local health departments and the community, improved coverage of child survival interventions is achievable in Rwanda. Building on sound performance record, the three agencies under the leadership of Concern, the prime agency, USAID awarded this five-year **Child Survival Expanded Impact Category Grant** to extend the reach of interventions to districts that need them most.

**The Kabeho Mwana Program**, meaning “Life for a Child”, covers six underserved districts in Southern and Eastern Rwanda: Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke, and Nyaruguru (see Map in Annex A). The area has a total population of 1,588,479 including 437,462 women of reproductive age and 309,426 children under-five (*67,576 infants under 12 months; 62,241 children 12-23 months; 179,609 children 24-59 months*).<sup>3</sup>

The program’s goal is to **reduce child mortality in six underserved districts reaching over 300,000 children under five years of age**. The technical interventions address the three leading direct causes of child mortality in Rwanda: malaria, diarrhea, and pneumonia. The program will provide leadership in the field application of the national community integrated management of childhood illness (C-IMCI) strategy, prioritizing social mobilization and community case management through skilled, equipped and supervised Community Health Workers (CHWs). Key approaches are built around enhancing family health practices at the household level, increasing quality of child health care services at the community level and enhancing community and local health services partnerships. Mechanisms to ensure that newborns also receive appropriate care are included to reach this special need population.

The purpose of this program is to mobilize communities as part of local health systems in order to protect and treat children so as to avoid unnecessary deaths and reduce costs of illness and treatment. The program will harness a network of over 8,200 community health workers (CHWs) building on best practices from the World Relief Care Group methodology. It is the intention of the three PVOs

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<sup>1</sup> UNICEF, State of the World’s Children 2005

<sup>2</sup> Demographic Health Survey, Rwanda 2000 and Preliminary Report November, 2005

<sup>3</sup> Population figures based on Rwanda National Census 2002 with 2.5% annual growth estimate for 2007. Sub-population distributions based on 2005 Rwanda Demographic and Health Survey findings.

for this program to become a leader for national replication and scale-up of C-IMCI throughout Rwanda.

Program objectives and targets include:

Prevention and treatment of malaria with a 35% level of effort:

- Increase the proportion of children under five with fever in the past two weeks who received anti-malarial treatment according to NMCP policy within 24 hours of onset of fever from 20% to 60%
- Increase proportion of mothers with infants 0-11 months who received two observed IPTs during last pregnancy from 31% to 80%
- Increase the proportion of children under five sleeping under a treated mosquito net the previous night from 74% to 85%

Control of diarrheal disease with a 35% level of effort:

- Increase use of oral rehydration therapy among children with diarrhea with from 19% to 50%
- Increase use of zinc treatment among children with diarrhea with from 5% to 50%
- Increase hand-washing with soap at critical times (after defecation, after handling children's feces, before preparing food, and before feeding children/eating) from 2% to 25%
- Increase the proportion of children provided continued feeding during diarrhea from 22% to 50%.
- Increase the proportion of children given increased fluids during diarrhea from 36% to 60%.

Pneumonia case management with a 30% level of effort:

- Increase the proportion of children with pneumonia who receive appropriate treatment from 13% to 50%
- Increase by 50% the number of sick infants under-two months seen at health facilities in the program area
- Increase the proportion of children 6-59 months who receive vitamin A from 66% to 90%

The primary partners include the District Authorities of the six districts who are responsible for selection, motivation, supervision and capacity building of the CHWs and ensuring quality referral services at the Health Center and District level as well as our subgrantee technical partners: the IRC (charged with monitoring and evaluation) and World Relief (charged with community mobilization and social behavior change). Key institutional partners at the national level who will contribute to the fortification of the national C-IMCI strategy and supporting tools and documents are the MOH, UNICEF, IntraHealth's Twubakane Project and BASICS. Management Sciences for Health Rationale Pharmaceutical Management (MSH/RPM *plus*) will provide technical support in the management of community drug supplies and sustainability of supply through appropriate cost sharing and fund management.

As an expanded impact program operating at sub-regional scale, program documentation and focused, quality operations research are critical elements of the monitoring and reporting plan described here within. Progress reports by objective will be produced quarterly and annually by the Program Team. Special assessment and operations research reports are planned regarding key factors influencing sick child care, the application of hand held computers in district information system operations, effectiveness of Care Group vs. standard CHW model for community health

mobilization, ability of CHWs to reach newborns within a day of birth, financing of community drugs, as well as the management of co-morbidity by CHWs.

The USAID Mission's Health, Population & Nutrition Team has been involved in the design of the DIP, John Dunlop, Randolph Augustin, and Eric Kagame. Principle authors are Michelle Kouletio (CW), Emmanuel d'Harcourt (IRC), Anna West (WR) along with the EIP Team Leader, Dr. Rose Luz and her project staff. Inquiries regarding this expanded impact application should be directed to Siobhan Walsh, Executive Director, Concern Worldwide US, Inc., whose contact information is on the cover.

This five-year proposal, from October 2006 through September 2011, has a total budget of \$6.9 million, including \$4 million from USAID/Washington and the local mission, and \$2.8 million matching funds from the three PVOs. In addition, the program will be supported by additional USAID funds through the Presidents Malaria Initiative (PMI) which provides Coartem to qualified CHWs and the Twubakane Program's District Incentives Funds.

## **B. CSTS Data Form**

## C. DIP Preparation Process

From its inception up through this detailed implementation plan, the CW/IRC/WR Expanded Kabehe Mwana Program has maximized the contributions of the Ministry of Health (MoH), the USAID Mission and its partners in the design and planning for this program. Processes have included consultative meetings, document sharing, planning workshops and joint assessments.

This section outlines the key steps taken to prepare for the DIP from the moment of award recommendation to the date of submission of this five year workplan (May 2006 – April 2007) in the below table.

**Table 1: Key events leading to development of the detailed implementation plan**

Event	Dates	Purpose and Methods	Who Participated
Last Year's Mini-University (Observer status)	June 2006 (5 days)	Familiarization with baseline studies & DIP process and familiarization with Expanded Impact grants and USAID scale vision	Concern's Rwanda Country Director, Eddie Rogers
HQ Start-Up Meeting in New York	June 2006 (1 day)	Review key elements of design and strengths and weaknesses identified by reviewers Discuss financial reporting and money transfers Update collaboration opportunities with other national initiatives	IRC: Backstops, Regional Finance and Management Personnel ; WR: Backstops CW: Backstop and Finance; MSH/RPM <i>plus</i> Jane Briggs; BASICS – Diana (by phone)
Final Evaluation of CW Kibilizi CS Project	August 2006 (20 days)	Externally led participatory summative evaluation based on household survey and health facility assessment data as well as qualitative information collection from community member, community health actors, health center staff and district counterparts.	Jean Capps (Int'l Evaluator), Dr. Jean Kagubare (Nat'l Co-Evaluator); Michelle Kouletio (CW/US Backstop); Glenn Cummings (CW/US Finance); Eddie Rogers, CWR CD, Francois Nyitegeka NMCP, Gisagara District Health Director and Kibilizi Hospital Medical Director and the Concern Rwanda CS team
In country start up meeting	August 28 <sup>th</sup> 2006 (1 day)	To introduce the Team Leader. To discuss draft workplan for year one. To plan the recruitment process for EIP staff. To discuss details of sub agreements and reporting mechanisms. To discuss potential name and logo for the project.	Country Directors, Assistant CDs, Finance Managers from CW, IRC and WR. Technical and Finance backstops from CW. Team Leader for EIP.
Final Evaluation of WR Kibogora CS Project	September 2006	Externally led participatory summative evaluation based on household survey.... data as well as qualitative information collection from community member, community health actors, health center	Jean Capps (Int'l Evaluator), Melanie Morrow, Rachel Hower and Anna West (WR/US Backstop); Francois Nyitegeka NMCP, Cathy Mugeni, MoH, Nyamasheke District Health Team, Kibogora Hospital staff and the CS team.

Event	Dates	Purpose and Methods	Who Participated
Project HR Recruitment committee established	Started in September and met on average every 2 weeks	To finalize job descriptions for all project posts. To agree and implement the recruitment process – advertisement, interview and selection process Consistency on salaries and benefits for all posts agreed.	Committee chaired by the Team Leader and composed of HR staff from CW, IRC and WR.
Establish Subagreements with IRC & WR	Oct-Dec 2006	Official documentation of cooperative subagreements with prime agency that specify roles and responsibilities, narrative and financial reporting requirements, reimbursement procedures and workplan deliverables.	Backstops, CDs and Finance Depts
DIP Writers Meeting in DC	October 2006 (2 days)	Review CSHGP Strategic Results MAMAN frameworks Updates on Rapid Catch Indicators and Health Facility Assessment Review best practices in DIP development planning Discuss USAID finance requirements	Michelle Kouletio, CW/US Backstop  Katie Haxall, IRC Backstop
In country coordination meetings	October and November 2006	To start the process of designing the systems (admin, finance and logistics) that would be required for each of the six district level project offices.	CDs, Assistant directors and finance managers from IRC, CW and WR.
Start-up Planning	November 2006 (4 days)	Recruitment of Managers, reviewing partnership agreements; Planning for KPC survey (respondents, sampling methodology, identifying supervisors and interviewers) and Health Facility Assessment (HFA). Establish calendar for assessments, partnership meetings, and DIP development. Exchange visits to all three agencies former working areas.	EIP Team Leader, IRC, WR and CW staff  Health Backstops: Michelle Kouletio (CW), Emmanuel d'Harcourt (IRC), Anna West (WR)
Pneumonia case management at the community level	December 2006	Briefing meeting for MOH by BASICS and other Child Survival partners.  A technical working group was formed that will now write the protocol for C-IMCI, including the community case management of pneumonia	Dr Claude, MOH community health, MOH PCIME, MOH MCH Task Force, All child survival partners.
Mayor's EIP Orientation Workshop	Dec 2006	Program goal, objectives and strategy Selection of districts Partnership, roles and responsibilities Discussions on MOU with districts Baseline plans	Mayors Country and Assistant Country Directors, EIP Senior Team
Skill Building: M&E in DC	Dec 2006 (10 days)	KPC 2000+ New Rapid Catch Indicators Health Facility Assessment Tool Qualitative Data M&E Plans	EIP M&E Manager, Bosco  WR Backstop, Anna West  CW Backstop, Michelle Kouletio (2 days)
Introductory PMI planning meetings	December	To brief on the PMI proposed workplan. To discuss individual partner workplans	PMI, USAID, PNILP and all PMI partners

<b>Event</b>	<b>Dates</b>	<b>Purpose and Methods</b>	<b>Who Participated</b>
	2006	To discuss the transition from AQ/SP to ACT in relation to HBMM and the selection of pilot districts for ACT	
EIP planning meeting schedule	January 2007 (1 day)	Establishment of a clear schedule of monthly meetings for Directors and also finance staff to ensure that all PVOs are kept up to date on key issues with the baseline surveys, staffing and also finance reporting issues	EIP Team Leader Directors and Assistant Directors from IRC, WR and CW Finance Managers from IRC, WR and CW
BEHAVE Training in Bamako	Jan 2007 (5 days)	Orient to BEHAVE framework Develop priorities for formative research and monitoring work Initiate BEHAVE frameworks for EIP	EIP Mobilization Manager, Melene Kabadege
Technical working group on C-IMCI meeting	15-19 January 2007, Musanze	Tools (including CHW kit contents, training modules), algorithms and reporting formats were drafted	IMCI Task Force
KPC Survey	January – March 2007 (5 weeks)	Pre-test questionnaire Training team Bosco & Katie KPC in six districts	M&E Mgr, IRC Backstop, M&E Officers, District reps
Child Health Service Provision Assessment (HFA)	January – February 2007 (5 weeks)	Review and adaptation of standard tool Translation HFA at 30 Health Centers and 150 CHWs in six districts	EIP Quality Assurance (QA) Manager
Community Institution Capacity Assessments	January – February 2007 (5 weeks)	Qualitative assessment of leadership and management of key community institutions (30 COSAs and 30 Community Development Committees [CDCs])	EIP Mobilization Manager
Systems for admin, finance and logistics at District office level	February 2007	All three PVOs adopt a document that outlines systems for finance, logistics and general administration at the district office level. This will be used as a trial for six months	Directors from WR, IRC and CW.
DIP Partnership Workshop	March 13-16 (4 days)	Review preliminary baseline findings Strategies and key activities Roles and coordination MOU with Districts HIV&AIDS mainstreaming	EIP Team, District representatives, Francois/PNILP, Georges MOH, Venestre from Twubakane, Mathias/BASICS, Three backstops
Technical PNILP/PMI meetings	Monthly	The role out of HBMM using ACT in new pilot districts. To clarify the role of distributors as community health workers within the new imidugudu structure. To discuss the integration of HBM with C-ICMI.	PNILP, PMI and their partners.
Consultation with Technical Partners (MoH, NMCP, USAID, BASICS, Twubakane )	March 19- April 10	Office based meetings in Kigali to discuss priorities, area for collaboration, etc.	Denise, IMCI MoH Corine, PNILP Augustin/Kagame at USAID Mathias/Diana/Naomi at BASICS Jane Briggs, MSH/RPM

<b>Event</b>	<b>Dates</b>	<b>Purpose and Methods</b>	<b>Who Participated</b>
Workplan Meetings with Implementing Partners	March 19 – April 10	Detailed activity plans by intervention Training Plan Roles and responsibilities of staff Management Budget review Discussion on critical issues	WR, CW, IRC
Technical working group on C-IMCI meeting	23-27 April 2007	Tools (including CHW kit contents, training modules), algorithms and reporting formats will be finalized.	IMCI Task Force

The implementing partners also took part in two major national assessments included the WHO/BASICS/UNICEF National Child Health Assessment in 2005 and the National Home Based Management of Malaria Evaluation in September 2006. Recommendations from these assessments have shaped many of the strategies selected in this DIP.

In addition to specific decisions made about program strategies and the workplan, the following is a list of key follow-up action points that emerged from the events above:

- Decision about forum for partner collaboration and advice into the implementation of the EIP will be made at the next MoH Health Cluster meeting on April 20<sup>th</sup>. There are concerns about too many coordinating bodies and an expressed desire that a sub-committee is formed form within the existing national IMCI Task Force (see Management section for further details)
- Continued collaboration with BASICS and PMI on workplan
- Performance incentives agreements with Districts regarding CHW Supervisors and outreach support by September 2007

## D. Revisions (from original application)

There were very few changes made in the program design from the original application following the DIP preparation process with the exception of changes in the official names of the selected intervention districts and in the budget which are described here within. There are no changes in key personnel since those proposed in the original application and subsequently approved by USAID.

**Program Name:** As part of staff team building and building relationships with national stakeholders, a new name was established for the program to better reflect the essence of its aims and objectives. In April 2007 at the National IMCI Task Force meeting, the title **Kabeho Mwana**, meaning “life for a child” was established. This replaces the previous name indicated in the branding strategy stated in the preaward.

**District Names:** In January 2006, the Government of Rwanda official redefined and enlarged the administrative districts from 106 to 30 districts. At the time of the original application development we were aware of the ongoing decentralization policy and anticipated changes in district areas; however there was an element of uncertainty regarding actual names of districts. The table below summarizes names of districts in the original application compared to official names given effective January 1, 2006. It should be noted that these are the same geographic areas and populations targeted in the original application.

**Table 2: EIP District Name Changes and Lead Agencies**

District names in original application	Official name of district	Lead Agency
1. Gikongoro	Nyamagabe	WR
2. Gisagara	No change	CW
3. Kibungo	Ngoma	IRC
4. Kirehe	No change	IRC
5. Nyamasheke	No change	WR
6. Nyaruguru	No change	CW

**Budget increase:** As a result of these changes, some budget modifications were necessary resulting in an increased total program cost of \$610,807, all of which is borne by the increases in CW, IRC and WR match contributions.

**Table 3: Summary of budget adjustments by Major Category**

Category	September 2006 Preaward Budget			April 2007 DIP Revised Budget			Difference revised to original budget	Rational for Change
	USAID	Match	Total	USAID	Match	Total		
Personnel	612,516	334,874	947,390	613,847	455,378	1,069,224	<b>\$121,834</b>	<ul style="list-style-type: none"> <li>International Personnel: approx. \$8K increase per yr due to adjustments based on CWW salary grades</li> <li>Local Personnel: Approx. \$5K increase per yr due to addition of Lead Officer salary and increase in QA Manager's salary</li> <li>HQ Personnel: Reduction of Health Advisor's time from 50% to 30% and addition of Program Officer support (40%)</li> </ul>
Fringe Benefits	213,595	95,458	309,053	178,388	178,388	356,777	<b>\$47,723</b>	<ul style="list-style-type: none"> <li>Corresponds to salary changes in personnel</li> </ul>
Travel	15,704	60,103	75,807	27,005	77,410	104,415	<b>\$28,608</b>	<ul style="list-style-type: none"> <li>Other Travel: Per Diem for travel staff to and from districts for meetings and training increase of approx \$14K;</li> <li>HQ Travel: Two int'l flights added (Yr 2 &amp; Yr 5) for the Finance Director</li> <li>In-country per diems &amp; accommodations added-US, Kigali</li> </ul>
Equipment	0	44,000	44,000	0	77,300	77,300	<b>\$33,300</b>	<ul style="list-style-type: none"> <li>Three generators moved from Supplies to Equipment due to revised unit cost of \$12,000 each;</li> <li>3K reduction in photocopier cost</li> </ul>
Supplies	95,320	354,599	449,919	33,278	394,941	428,218	<b>(\$21,817)</b>	<ul style="list-style-type: none"> <li>Printing of Forms removed from budget (IRC will cover the cost of Printing forms);</li> <li>Even though there is a reduction, the cost of Respiratory Timers was added to the budget for Yr2 &amp; Yr5, which is funded by a private donor)</li> </ul>
Contractual	0	0	0	0	0	0	<b>0</b>	No change. Please see IRC Budget for the Mid-term and Final Evaluation Consultant contract.
Other - Training	215,753	71,918	287,671	171,376	125,487	296,863	<b>\$9,129</b>	Revised and streamlined the Training Plan and Training Budget. Please see the Training Budget for more details. This category is also higher due to the inclusion of Staff Development set at \$11,750 per partner organization.
- Subgrant IRC	1,304,154	437,487	1,741,641	1,304,153	485,170	1,789,323	<b>\$81,843</b>	<ul style="list-style-type: none"> <li>Personnel: Increase of approx. \$54K in Personnel costs due to salary changes for the M&amp;E Manager and the M&amp;E Lead Officers;</li> <li>Other Travel: Per Diem for travel staff to and from districts for meetings and training;</li> <li>HQ Travel: Technical assistance flights increased by two trips, \$10K</li> <li>Other: Increase due to the addition of Support for CHW Supervision and Training Costs</li> </ul>
- Subgrant WR	1,306,166	511,246	1,817,412	1,306,166	649,407	1,955,572	<b>\$138,115</b>	<ul style="list-style-type: none"> <li>Personnel: Increase in International Staff costs due to increase in Director of Programs salary of approx. \$57K and in increase in</li> </ul>

Category	September 2006 Preaward Budget			April 2007 DIP Revised Budget			Difference revised to original budget	Rational for Change
	USAID	Match	Total	USAID	Match	Total		
- Other direct costs	116,344	38,781	155,125	218,842	180,812	399,654	<b>\$244,529</b>	<p>the Mobilisation Manager and Lead Officers' salaries of approx K38K;</p> <ul style="list-style-type: none"> <li>• Other Travel: Per Diem for travel staff to and from districts for meetings and training led to minimal increase;</li> <li>• Other: Significant increase in costs of approx. \$28K due to revisions in the Training Plan</li> </ul>
Total Direct	1,269,231	999,733	2,268,964	1,241,119	1,523,101	2,764,219	<b>\$495,255</b>	See Budget line items above.
NICRA	120,450	94,875	215,325	148,562	182,315	330,877	<b>\$115,552</b>	Increase based on Direct Cost increase and current NICRA rate of 11.97% for CW
<b>Totals</b>	1,389,681	1,094,608	2,484,289	1,389,680	1,705,416	3,095,096	<b>\$610,807</b>	See budget line items in Annex J Revised Budget

## E. Detailed Implementation Plan

### 1. Program Site Information

#### a. Program Area

The program will cover six of the countries' thirty districts. **Maps of these areas are included in Annex C.** Operation areas were selected based on key factors of health need, economic profiles, and consistency with USAID strategic districts for the Twubakane Project, proximity to original program areas of the CW/IRC and WR previous USAID funded Child Survival projects, and absence of other actors implementing child health activities.

#### b. Total population

The population statistics for Rwanda are staggering. Approximately nine million people (UNICEF Rwanda Country Program, 2006) inhabit some 26,338 square kilometres, giving a population density of up to 340 persons per square km. There are an estimated 1,550,000 children under the age of five (PMI –Malaria Operating Plan [MOP], 2007). It is the least urbanised country on the continent and has only one city, Kigali the capital, with a population greater than 35,000. Half the population is under 15 and the annual population growth rate is 2.8% that would result in a projected population of 16 million by 2020.

The program area population is estimated to cover 1,588,479 with a total of 276,395 children under-five and 390,766 women of reproductive age. Population estimates are based on the 2002 national census and subpopulation distributions on the break-out of the 2005 Rwandan Demographic Health Survey (RDHS). Specific breakdowns by District are shown in table 4 below.

**Table 4: Estimated population for program, 2007**

District	0-11 Months (3.8%)	12-23 Months (3.5%)	24-59 Months (10.1%)	Total <5 yrs (17.6%)	WRA 15-49 yrs (24.6%)	Total Population 2007
Gisagara	11,454	10,550	30,445	52,449	74,153	261,262
Kirehe	9,866	9,087	26,222	45,175	63,867	230,833
Ngoma	9,982	9,194	26,530	45,706	64,618	<b>257,669</b>
Nyamagabe	12,247	11,280	32,551	56,078	79,282	290,565
Nyamasheke	13,974	12,871	37,142	63,987	90,465	311,734
Nyaraguru	10,053	9,259	26,719	46,031	65,077	236,416
<b>Total 2007 Estimates</b>	<b>67,576</b>	<b>62,241</b>	<b>179,609</b>	<b>309,426</b>	<b>437,462</b>	<b>1,588,479</b>

Sources: Population based on 2001 Census with estimated 2.5% annual growth. Sub-population calculations based on 2005 DHS distributions, Institut National de la Statistique du Rwanda (INSR) and ORC Macro, 2006. Rwanda Demographic and Health Survey 2005. Calverton, Maryland, U.S.A.: INSR and ORC Macro.

The program area includes all of the PVOs former child survival working areas. CW had worked in Kibilizi District now a part of the larger Gisagara District. WR worked in Kibagora now part of the larger Nyamasheke District. IRC worked in all of the current Kirehe and Ngoma Districts. The program will start operations in these former working areas, covering of the population of the expanded district areas in year one and then move to the new districts of Nyamagabe and Nyaraguru in year two.

### c. Health status of the population

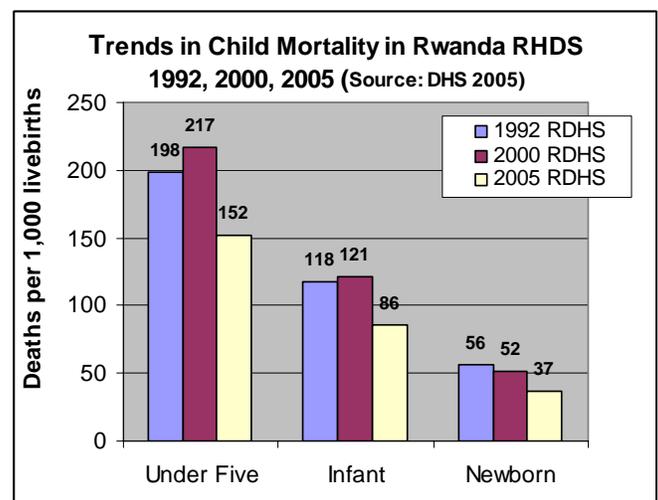
For much of the 20<sup>th</sup> century, Rwanda has been characterized by social tensions, poor governance and cyclical episodes of communal violence that resulted in successive waves of population displacement within the country and also to neighbouring countries. At various times there have been movements of displaced populations back into Rwanda. The 2006 EICV2 Survey stated that nearly 20% of adults over 15 years of age have changed their district of residence in the last five years.

Although considerable progress has been undertaken in many areas following the 1994 genocide, the health status of women and children remains behind target vis-à-vis the Millennium Development Goals. Newborn, infant and under-five mortality rates all proportionately declined by approximately 20% over the last five years,<sup>4</sup> in part due to the contribution of the CSHGP. However, the results from the 2005 Demographic and Health Survey (DHS) revealed that for every 1,000 live births, 86 children die before their first birthday (37 between birth and one month and 49 between 1 and 12 months). For every 1,000 children who survive to age one, 72 do not reach their fifth birthday. Rural areas have a 57% higher under-five mortality rate (192 per 1,000 live births) than the urban areas (122 per 1,000 live births). The Eastern province has the highest childhood mortality rates; infant (125 per 1,000 live births), post-neonatal (76 per 1,000) under-five (233 per 1,000) with the West and South provinces closely behind. While rates remain high, childhood mortality rates have been declining since 1992.

Figure 1 : Trends in Child Mortality in Rwanda 1992-2005

The leading direct causes of child death are malaria, anemia, pneumonia and diarrhea; malnutrition is a contributing factor in over half of all child deaths. Child morbidity is very high throughout the country. During the 2005 RDHS, within the two-weeks preceding the survey, 26% of children under-five had fever, 17% had acute respiratory infections, and 14% had diarrhea.

Nutritional status of children is poor with nearly half of the children stunted (45%), one in five underweight (19%) and 4% wasted according to the 2005 RDHS. While exclusive breastfeeding



<sup>4</sup> Demographic Health Survey, Rwanda 2000 and 2005  
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practices are nearly universal, poor weaning and sick child feeding practices as well as poverty and food scarcity are major culprits. The EIP 2007 baseline of children under-two revealed that 20% were underweight (6% severely underweight) and 8% were wasted (6% moderate, 2% severe) according to MUAC measures<sup>5</sup>.

**Malaria is a major burden** throughout Rwanda, and is the principal cause of morbidity and mortality, causing 40% of health facility visits and 43% of all deaths. Transmission has increased over the years, due to mounting drug resistance, increasing population density and population movements, human and economic activities, and increasing farming in low laying valleys (infamous) breeding place for mosquitoes. Approximately one-third of all cases of malaria were among children under age of five and 34.5% of facility deaths among children under five (RDHS 2005).

The 2007 EIP KPC survey found that 50% of sick children under-five suffered from fever in the past two-weeks. The January to December 2006 health management information system reports (GESIS) from the Program Area Districts mirrored the national findings, with 43% of all child health facility visits due to malaria. While Nyamagabe and Nyaraguru are considered to be hypo-endemic and not PMI priority areas; GESIS reports for the same period in these respective areas showed that 16% and 30% of all child consultations were due to malaria. Despite somewhat lower prevalence in the two non-prioritized districts at 34% in Nyamagabe and 44% in Nyaraguru, the burden of fever is still excessive.

Malaria is also a health risk for pregnant women and their unborn children. Since April 2006, two intermittent presumptive treatments (IPT) with fansidar for malaria has been policy for pregnant women. The EIP KPC 2007 survey found 31% of mothers with children under 23 months to have received two IPTs during their last pregnancy.

Coverage and use of treated mosquito nets has dramatically increased in the EIP area following the recent September 2006 free net distribution campaign coupled by the subsidization of nets to antenatal clients. The effect of the campaign is clearly seen when comparing the nationwide the 2005 RDHS results showing that only 13% of children slept under a treated net. However, the EIP KPC revealed substantial increases following the September 2006 net campaign with 74% of children under-two sleeping under nets by the 2007 EIP KPC period.

**Diarrhea is a leading public health risk to families.** Nationally the RDHS 2005 found that 14% of children under five<sup>6</sup> suffer from diarrhea during two-week recall surveys, with highest prevalence among children aged 6 – 23 months (24%). Weaning practices and poor hygiene are primary direct causes to diarrhea and largely attributable to reliance on open water sources that are distant from homes reducing the quantity of water available in households, and consumption of untreated water. Hand washing with soap practice is also low.

The burden of diarrhea among children is a chief complaint from mothers. However, careseeking at the health facility is generally low as indicated by low sick child consultations for diarrhea. The 2006 annual GESIS reports from the EIP program area reported that only 7% of the health facility visits among under-five children were due to diarrhea. Zinc has only recently become incorporated in national treatment guidelines. Feeding practices for sick

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<sup>5</sup> Acute malnutrition measured among children 6-23 months

<sup>6</sup> DHS 2005

children recommend that during diarrhea episodes, children should consume more food and fluids than usual but 40% of mothers gave less fluids than usual. This problem was highlighted during the final evaluations of all three PVOs original programs.

**Pneumonia is also a leading cause of under-five mortality and morbidity and new opportunities exist to expand access to prompt treatment.** Acute respiratory infections (ARIs) accounted for 26.8% of outpatient consultations for children under five years of age in the six District EIP area in 2006 according to GESIS records – second only to malaria– and 10% of deaths, according to national health information statistics. Up until recently, children could only be assessed and treated at a formal health facility; however, the MoH now interested in field-testing community case management. The relatively high immunization coverage in Rwanda effectively prevents some pneumonia cases, but poor nutritional status leaves and high use of wood as a cooking fuel resulting in indoor air pollution leave many children exposed. RDHS 2005 survey showed a higher prevalence of ARI in the East and South provinces.

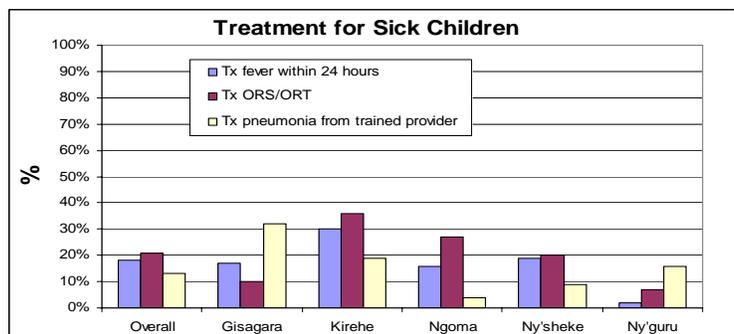
**Vaccination levels** are fairly high coverage, with a national full coverage of 75%; varying between expanded impact provincial levels range from 67% in the East to 84% in the South Provinces.<sup>7</sup> Improvements have been measured over the past five years in all districts supported under the CSPs, whether or not there was a specific intervention. For example, in Nyamasheke District (former Kibogora), full vaccination coverage increased from 47% to 85%<sup>8</sup>. The program will work with district health authorities and MOH to continue to ensure prompt identification, confirmation, and an effective response to epidemics as appropriate.

Child Vitamin A coverage had typically been maintained through district campaigns but shifting towards integration into routine vaccination schedules. Comparing data from the 2005 RDHS where 84% of children 6-23 months versus 68% in the 2007 EIP KPC survey, coverage may be slipping.

**Access to treatment and care-seeking for malaria, pneumonia and diarrhea** is poor. Results from the 1997 EIP KPC showed that caregivers of children who reported having a child with fever in the past two weeks before the survey, only 20% of children received treatment within 24 hours. The survey also found that only 21% of children under 59 months with diarrhea received any ORS or other rehydration therapy. Rates were lower in areas that had not been exposed to the Home Based Malaria initiative. Only 13% of mothers with child under 59 months with fast, difficult breathing and cough being seen by a health provider within two-weeks of the illness in the Program area.

Access to care is limited by the following factors: a) fees for consultation, lab work and treatments; b) poor geographic access, while distances are relatively short for African standards, due to the mountainous terrain strenuous

Figure 3: Treatment of sick children by District.

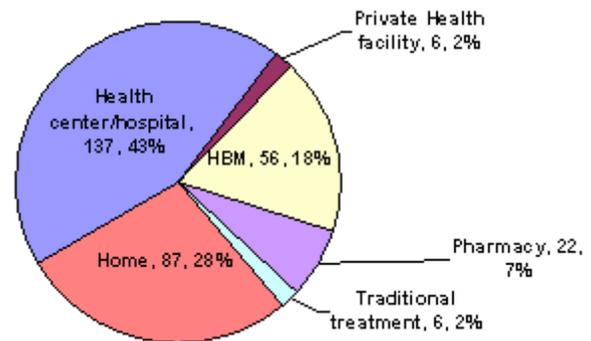


<sup>7</sup> DHS 2005

<sup>8</sup> World Relief, KPC

hikes of an hour or more are required ; c) opportunity cost – the walk to plus the wait at the health facility for most households takes away a days work, stripping the family of production gain. The client satisfaction ratings during exit interviews in the 2007 HFA found that most caretakers were only fairly satisfied with the waiting time, explanation of child illness and treatment received ; and d) culture, families increasingly turning to “scratching” of the throat by traditional healers, a highly unsafe practice usually reserved for “gapfura,” a disease described as being similar to tonsillitis or upper respiratory infection, but that may be invoked when lower respiratory symptoms are present.

The figure to the left indicates the place of treatment among the 2007 EIP KPC sick child survey respondents aged 0-59 months for with fever, diarrhea and/or respiratory illness in the two weeks preceding the interview. Variations in source of care indicate that 43% of all sick children under-five are seen at the formal health services while 28% sought no care outside the home. Careseeking outside the home was lowest among those suffering from diarrhea. CHWs were sought for 18% of the cases. Alternative sources of care including traditional healers, pharmacies and shops and other private providers is very low.



#### **d. Other factors that influence child health**

Economic characteristics of the population. Agriculture accounts for some 40% of GDP and involves some 90% of the population. Poor rural households, who are highly dependent on agriculture, face three main problems - landlessness and diminished access to land, low agricultural productivity and lack of crop diversification. The average landholding is 0.7 hectares (ha) which is less than the minimum of 0.9 ha necessary to sustain an average sized family. Across the country thirty percent of rural households have less than 0.2 ha of land (PRSP 2005).

The pressure on land has intensified as a result of population growth and previous land inheritance practices that have resulted in land plot sizes getting smaller. The mountainous slopes covering most of the country further limit access to arable land and contribute to soil erosion. Overexploitation of the land is increasingly depleting soil fertility, severely affecting productivity over the past two decades. The 2000 staple crop yields of bananas and beans were approximately seventy percent of 1984 levels. Other crops such as peanut, sorghum, soya and maize yields had also declined by 20 to 40% over the past 15 years. Poor quality seeds, limited use of composting and the price of chemical fertilizers are also contributing factors.

Gender. Nationally 34% of households are female headed. CWR’s 2002 Gender & Health Study in the former Kibilizi District (now part of Gisagara) concluded that women are responsible for health promotion in the home but that the husband has the authoritative voice when it comes to seeking care outside the home.

Rural women have been increasingly forced to care for the sick suffering from chronic illnesses, such as HIV&AIDS, in addition to caring for families, a triple burden that further affects the loss of livelihood opportunities, food security, the time and quality of childcare, and basic maternal health.

Education Attainment. Over 2/3 of all girls have attained primary school level education according to the 2005 RDHS.

Social & Cultural Factors. A bounty of household data regarding perceptions, beliefs and practices exists and has been studied and incorporated in behavior change interventions. For example:

- In Rwanda, as in most countries with high mortality levels, over 70% of child deaths occur at home. The WHO/BASICS/UNICEF Rapid Child Health Assessment in 2005 concluded that home herbal remedies, purchasing drugs from pharmacies and the informal sector, and prayer were the most common frontline treatments for sick children. When care is sought a large number go to the public hospitals (36%), pharmacies (29%), health centers (12%), and traditional healers (11%).<sup>9</sup> There is still a high level of trust in the traditional practitioners, particularly in the more remote, rural areas.
- Access to newborn and postnatal care is restricted because women are traditionally not allowed out of the house until the naming ceremony which occurs a week after the delivery.

Potential geographic, economic, political, educational, cultural constraints. There are several constraints that were taken into consideration in developing this detailed workplan:

**1. Gacaca** - a quasi-traditional system of justice was revived by the government in October 2001. Evidence gathering, documentation and pre-trial hearings have taken place across the country since 2002 with trials getting underway since March 2005. Judgments started being handed down by gacaca courts as from July 2006. This ongoing process has impacted public life in a number of ways. While aimed at bringing justice and reconciliation in the medium-to-long term, in the short term these trials have, in cases, led to new accusations, renewal of communal tensions, and even threats against potential witnesses. The gacaca process is most likely to affect project activities in the following ways: i) hearings taking place on different days in different sectors, working in several sectors at once introduces scope for misunderstandings with the local authorities and accusations that the PVO is not respecting Gacaca; ii) work days lost when staff attend the weekly gacaca sessions; iii) training activities when community members, CHWs, other health staff are not available; iv) general increase of tensions within communities; and v) potential for population movements out of program areas resulting from rumors or possible fears about gacaca. The Gacaca trials are scheduled for completion by mid-2008, although there are an estimated caseload of 760,000 suspects to be tried by 12,103 courts and 170,000 judges.

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<sup>9</sup> Rapid Child Health Assessment, 2005

**2. HIV & AIDS:** The 2005 RDHS survey results showed that HIV prevalence nationally was 3.6% among women and 2.3% among men. There are over 210,000 HIV related orphans in Rwanda. Fortunately, significant resources and programs are available and effectively coordinated through PEPFAR, World Bank's MAPS II, and the Global Fund for the prevention, care, support, and impact mitigation of HIV&AIDS, including the national roll-out of antiretroviral treatments and establishment of Prevention of Mother-to-Child Transmission (PMTCT) services at all health centers. While the RHDS 2005 survey showed that 76% of the women and 78% of the men surveyed had never been tested and only a quarter of those tested received the results, coverage and participation was much higher in CSP-supported districts. This demonstrates the added-value the EIP can play in mainstreaming a response to HIV within its program scope.

Recognizing that challenge posed by HIV&AIDS the Program will use mainstreaming to ensure that it responds appropriately. The three PVOs all have varied experience of HIV&AIDS activities, either mainstreaming or direct interventions, in Rwanda. A detailed AIDS Competence Self Assessment Framework will be conducted by the project team to fully assess the situation and where possible adaptations may be needed. The project team will firstly look at internal mainstreaming to assess the level of awareness that the staff possess as well as the workplace policies that are in place. Issues that could be addressed are training and awareness sessions for staff and their partners, and also an analysis of workshop training venues based on the risk for participants.

The next step would be external mainstreaming in order to ensure that all the program components take into account the issues and challenges posed by HIV&AIDS. Consultations and local rapid assessments by the staff will be held in the next few months with each of the six districts to more fully analyze the local situation. Modifications or additions to certain activities will be discussed and implemented as necessary. For example, certain BCC messages would need to be sensitive to HIV&AIDS, including the importance of PMTCT and special care needs for sick children. Where appropriate, aspects concerning HIV&AIDS could be included in the training sessions for CHWS. Identification and referral mechanisms will be established as available by district for special support services such as exemptions from mutuelles, associations for those infected and affected by HIV, and other support to orphans and vulnerable children.

**3. Decentralization process and changes of staff at district level:** A number of large decentralization reforms were implemented in early 2006. This resulted in a complete change of administrative structures (12 provinces to 5 regions, 130 to 30 sectors) and a complete change of local-authority staff. While this process seeks to ensure that more power and a greater proportion of the budget are transferred from national to local level, it has also carried forward something of a trend of frequent personnel shuffles and replacements. Undertaken as they may be to ensure that low performers are quickly moved out, these changes can often undermine/delay/hinder work undertaken with local authorities. New staff may not be apprised of previous agreements or programs, and may not share the priorities of the previous incumbent. One must also calculate the value lost in building local-authority capacity with training and awareness-raising, when within a relatively short time span the beneficiaries will no longer be exercising the same duties.

During 2006 the district mayors have been required to draw up formal performance contracts to be signed with the President of the Republic, known as *imihigo*. Because the officials' jobs may be on the line in the case of underperformance, the obvious temptation is to see NGOs as an alternative provider of promised services, pushing them to exceed their own planned and agreed-upon activities. PVOs can spend considerable time and energy in clarifying roles and responsibilities with local officials.

**3. Land law:** Land distribution is one of the primary future sources of potential conflict in a country with notoriously high population density and limited availability of arable land. The various population displacements going back to 1959 have created competing, politically charged claims to land (and residences) countrywide. The Government of Rwanda recently passed a new land law designed to increase average plot size through consolidation of land holdings, and facilitate profitable exploitation of available land. Overall the law does give the state ultimate authority over land ownership and usage, via new land commissions, which will become operational during the course of 2007, and the government will be allowed to expropriate land in the 'public interest'. Certain vulnerable groups will be in particular need of information regarding their rights and obligations under the new law. People already in conflicts over land ownership, whose land is claimed by others, or who are unable to exploit their plots "productively" should know the provisions of the new law.

**4. Clients pay for health services in Rwanda,** which presents a huge barrier for the 36% of families living in extreme poverty of less than \$1/day. In the DHS 2005 survey, some of the identified barriers to accessing health care are lack of money for treatment as the primary barrier, followed by distance to the health facility, and having to take public transport. National health accounts indicate that people paid for over 50% of health expenditure in 2003. The 2007 HFA found that on average payment made for sick child consultation was 132 Rwf (range 0-515Rwf) while non-members paid on average 563 Rwf (range 0 – 1890 Rwf).

Cost recovery is a reality in the Rwandan health system with about 1/3 of the population subscribing to social insurance schemes that entitle them to low co-payments for services at the health centers and hospitals. National expansion of "mutuelles," a community-based social insurance health program, is increasingly significant in reducing financial barriers to health care for a good portion of the population and includes exemptions for about 10% of the population. However, the system is still nascent with formal guidelines and the 2004-initiated training program is still underway. Nationally, household mutuelle coverage is estimated at 45% in 2007<sup>10</sup>. Family membership costs about \$6 annually and covers consultation, drugs, and some include emergency ambulance transport. A few districts are considering extending benefits for hospital and community services.

#### **e. Quality of health care services in the program area**

Starting in the mid-1990s, the Rwandan health system was decentralized to improve access and quality of basic health care services. The current health care system provides services at the following levels: community health worker, health center; first-level district hospital; second-level hospital; and third-level referral hospital. All HFs (public and private) are required to provide a minimum package of activities to cover basic health problems in an equitable,

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<sup>10</sup> Ministry of Health Community Health Desk report from GESIS, February 2007  
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effective and efficient manner and a complementary package at the hospitals of activities to provide curative care in an equitable, effective and efficient way using techniques unavailable at the primary level. As hospitals are designed to care for referrals from the health centers, they were excluded from the assessment.

The national IMCI task force has been functional since 2001 but it really took off in 2006 in terms of completion of the national standards, initiating national training of clinical IMCI facilitators, and moving forward in the development of the community IMCI strategy. Facility IMCI training in 2006 included 12 clinicians in Gisagara and in Kirehe Districts. Of the 30 nurses providing primary consultation to sick children at the HC level, only 10% had been trained in F-IMCI. Over 2/3 of the clinicians had received training on case management of malaria but training on other child health interventions was thin. The conception and roll-out of C-IMCI is expected to start later in 2007 in all of Kirehe District as a national pilot. By 2008, C-IMCI will be operational in all six EIP districts.

As shown in Table 5, all the program districts with the exception of Nyaraguru have at least one hospital. Plans are underway to upgrade the Nyaraguru HC to a hospital during the life of this program. Health centers per district range in number from 12 to 17, slightly more than half are government facilities while the majority of the others are faith-based operated. There is only one private HC which is located in Kirehe.

**Table 5: Summary of Formal Health Infrastructure in the Program Area by District**

Provinces/ District	Hospitals	All Health Centers	Gov't HCs	Mission/ Private HCs	HC personnel
Kirehe	1	12	11	1	81
Ngoma	1	12	8	4	62
Nyamagabe	2	13	7	6	89
Nyamasheke	2	17	6	11	155
Gisagara	2	12	5	7	96
Nyaruguru	0	13	7	6	112
<b>TOTAL</b>	<b>8</b>	<b>79</b>	<b>44</b>	<b>35</b>	<b>595</b>

*Table based on 2007 village (imidugudu) listings by CHWs in the 6 districts for the LQAS sampling. Proportion of target beneficiaries' source:*

As is described in the upcoming baseline assessments section, the program undertook a randomly sampled 30 health center Rapid Child Health Service Provision Assessment in 2007 (2007 EIP HFA) which included observation and exit interviews among 150 sick child consultations and interviews with 150 CHWs in the program area. Table 6 outlines the major indicators regarding access, inputs, processes and outputs (including performance) of from the formal health services component.

**Table 6: Findings from the 2007 EIP Health Facility Assessment**

Domain	Indicator	TOTAL	GAPS
<b>ACCESS</b>			
Service Availability	% HC that offer three basic child health services (growth monitoring, immunization, sick child care)	<b>87% (26/30)</b>	Most of the vaccination and growth monitoring is provided through weekly and monthly outreach services only. Sick child consultation is available every day at the HCs but less often during outreach – hence the preventive and curative aspects of child care are disconnected.
<b>INPUTS</b>			
Staffing	% staff who provide clinical services working in surveyed HC on the day of the survey	<b>89% (160/179)</b>	While overall the majority of clinical staff were present, absenteeism among other cadres, particularly nutritionists and pharmacy aides in Gisagara, Kirehe, Ngoma and Ny'sheke were observed.
Infrastructure	% essential infrastructure available in surveyed HC on day of the survey (power, improved water source, functional latrine for clients, communication equipment, emergency transport, overnight beds, setting allowing auditory and visual privacy)	<b>17% (5/30)</b>	Availability of electricity and/or alternative power sources and water from an improved source were found in about 2/3 of the HCs. Only 1/2 of the HCs had an ambulance available either on call at the District-level or based out the center – this is particularly a problem in Nyamagabe. Auditory and visual privacy was only observed in 2/3 of the HCs.
Supplies	% essential supplies to support child health in HC on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	<b>23% (7/30)</b>	While generally supplied with a functioning refrigerator as well as child and adult scales, only a ¼ of the facilities had a functioning timer for respiratory counts and a container, cup and spoon for ORS preparation.
Drugs	% first line medications for child health in surveyed HC on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line anti-malarial, vitamin A)	<b>63% (19/30)</b>	All HCs had Coartem and ORS packets available the day of the survey. Amoxicillin was available in all HCs but one. Supplies of Vitamin A, iron folate, LLNs and ciproflaxin were more sporadic in availability. Ngoma, Nyaraguru and Kirehe had lowest availability of all six essential drugs
Availability of Immunizations	% HC with all nationally-mandated vaccines in stock on day of survey	<b>83% (25/30)</b>	Ngoma, Nyaraguru and Nyamagabe were out of at least one vaccine the day of the assessment. All the HCs surveyed in the remaining districts had all vaccines available.
Availability of Guidelines	% HC with all nationally-mandated guidelines for care of children available and accessible on day of survey	<b>43% (13/30)</b>	Availability was highest in Nyamagabe and Nyaraguru and lower in the other districts. None of the HCs had guidelines that could be observed in Ngoma. The roll-out of facility IMCI should pay attention to filling this obvious gap.

Domain	Indicator	TOTAL	GAPS
Infection Control	% HC with all infection control supplies and equipment on day of survey	<b>40% (12/30)</b>	While most items were available among 2/3 to ¾ of the HCs, several HCs did not have all the items combined and hence the low aggregate score, particularly in Nyamagabe where sterilizers and protected infectious waste sites were less available.
<b>PROCESSES</b>			
Information System	% HC that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HC: have report in last 3 months and evidence of data use	<b>69% (20/29)</b>	Generally well maintained and most HCs who had a few incomplete entries. However, there were problems with diagnosis and treatment missing in Nyamagabe.
Training	% CHW in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	<b>73% (22/30)</b>	Availability of IMCI trained staff very low and only available in Kirehe & Gisagara Districts. Most providers have only received malaria training in past 12 months leaving gaps for vaccinations, ARIs/pneumonia, diarrhea and nutrition. In Nyamagabe, only one HC had a provider trained in child health topic in past 12 months.
Supervision	% HC that received <b>external</b> supervision at least once in the last 6 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	<b>93% (28/30)</b>	This is working very well at all HCs observed with 80% receiving supervision within past 3 months or less. Standard is monthly supervision. Quality of supervision also strong including observation, review of registers, coaching and praising.
HF-Community Coordination	% HC with routine community participation in management meetings (with evidence through notes) OR have a system for eliciting client opinion, and evidence that client feedback is reviewed	<b>90% (27/30)</b>	Generally very good in all districts with the exception of Nyamagabe where only 3 of the 5 HCs had some type of community participation. Most facilities have community members on their COSA (Health Management Committee) and/or through monthly meetings with CHWs/TBAs
Community Referral	% HC that received at least one referral from CHW in the last month	<b>13% (4/30)</b>	Written records of referrals were very low at the HCs in the registers with the exception of Kirehe. Difficult to account for CHW referrals even though they are happening particularly in HBM areas.
Quality Improvement Process	% HC that have documentation of routine quality assurance activities in last 3 months	<b>33% (10/30)</b>	While most facilities claimed to be using QA processes only 1/3 of them had any written evidence of such activities. Ngoma was the highest performer with 4/5 HCs having documentation.
<b>OUTPUTS</b>			

Domain	Indicator	TOTAL	GAPS
Utilization of Curative Services	# clinical encounters (CHW/HC / annualized) for sick children per U5 population	<b>0.6</b>	Generally pretty low and corresponds with findings from the KPC of poor careseeking of sick children. The rate was highest in Nyamasheke with 1.2 consultations per child per year. Ratios in the other districts were close to the program area average.
HW Performance (Assessment)	% key assessment tasks are made by HW (check presence of general danger signs, assess feeding practices, assess nutritional status, check vaccination status)	<b>16% (4/150)</b>	Inquiring about convulsions as well as weighing the child and checking vaccination status were quite low in all Districts except Kirehe. Most providers did inquire about ability to feed and presence of vomiting.
HW Performance (Treatment)	% clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Obs. for HC)	<b>71% (100/141)</b>	While most children diagnosed with fever/malaria received Coartem and children with diarrhea ORS, there were some problems with children with pneumonia either not receiving Amoxicillin despite its availability. Very few caretakers received counselling on administration of antibiotics received.
HW Performance (Counseling)	% clinical encounters in which the caretaker whose child was prescribed an antibiotic, antimalarial, or ORS, can correctly describe how to administer <b>all</b> drugs	<b>28% (42/149)</b>	Generally accurate information for Coartem (3 days and dose as per age of child) however caretakers were less aware of dose and number of days for antibiotics (particularly amoxicillin syrups) and had very vague information about administration of ORS.
	% clinical encounters in which the HW counseled the caretaker to continue feeding sick child	<b>19% (29/150)</b>	Despite obvious sub-optimal feeding of sick children, very few providers advised care taker on increasing fluids and maintaining feedings. Infant feeding counselling was nearly nil in Nyamagabe, Nyamasheke and Nyaraguru
Client Satisfaction / Perceived Quality	% clinical encounters in which the caretaker was very satisfied (4 on a 4 point scale) for all three of the following: wait time, explanation of illness, and treatment received	<b>10% (15/145)</b>	While few clients were <u>very</u> satisfied with all aspects most rated each service either fair or good. There was little variation across the six districts.

### Community-based services

At the community level, the Community Health Worker (CHW) plays an important role in the national strategy for primary health care, coordinating with and complementing the HC services. CHWs are trained to treat basic illnesses and to do health education and other preventive activities in their communities. The CHW is a volunteer and does not receive payment from the government, but is authorized small percentages of sales of commodities (such as bed nets and certain drugs). Many communities provide in-kind contributions to CHWs and some are employed on commercial farms.

**Table 7: Administrative areas and Community Health Workers**

Provinces/ District	Population	Sectors	Cellules	Villages (umudugudu)	CHWs (at 2 per imudgudu)	CHWs Anticipated*
<b>Eastern Province</b>						
Kirehe	230,833	12	58	582	1,164	1,212
Ngoma	257,669	14	64	475	950	1,226
<b>Western province</b>						
Nyamagabe	290,565	16	97	442	884	1,504
<b>Southern Province</b>						
Nyamasheke	311,734	15	79	553	1,106	1,716
Gisagara	261,262	12	59	515	1,030	1,406
Nyaruguru	236,416	15	93	322	644	1,235
<b>TOTAL</b>	<b>1,588,479</b>	<b>85</b>	<b>450</b>	<b>2,889</b>	<b>5,778</b>	<b>8,299</b>

The new Community Health Policy stipulates that there should be two CHWs per imudugudu, one male and one female. However, some of the umudugudu have more than one hundred households and distribution of housing can be very sparse so this program is anticipating (see above table with \*) somewhat higher numbers of CHWs based on achieving a ratio of 30 households with child under-five per CHW. (*Numbers are calculated based on the RDHS 2005 finding that 69.4% of rural households have at least one child under-five and an average household size of five persons*).

Additional community actors include Distributors who were introduced under the national home based malaria pilot in 2004-05 in Kirehe, Ngoma and parts of Gisagara and Nyamasheke Districts to identify and treat simple malaria and refer complicated cases to the Health Centers. The DIP Partnership Workshop revealed that a total of 1,052 Distributors are active in the working area. The Program will work with the MoH Community Health Director and District Health Directors to reassess specific requirements for each imudugudu based on its actual population and distribution of households and then with the respective communities in the selection process. We will encourage the inclusion of active and trusted Distributors where they are already available.

As part of the 2007 EIP HFA, 150 active CHWs were assessed in terms of record keeping, training, supervision, drugs and supplies.

Community assessments were limited in scope and methodology, but key findings include:

- **Utilization of clinical services is much higher at the community level** as compared to facility level, as noted above.
- **CHW functioning, as measured by supervision and drug availability, is higher in Kirehe and Ngoma**, not surprisingly given they have the largest community treatment programs.
- **Health committee and CDC functioning are highest in Nyamasheke and lowest in Kirehe and Ngoma**. This likely reflects a strategy, in Kirehe and Ngoma, of working directly with health centers rather than with surrounding administrative structures.
- **About one in three KPC respondents participate in community health insurance schemes**. Those who do participate are much more likely to seek care at health centers, with three in four health center attendees being members. Nyamagabe has the highest proportion of health insurance members.

Table 8 highlights key indicators and quality gaps.

**Table 8: Findings from the 2007 EIP Health Facility Assessment**

DOMAIN	INDICATOR	TOTAL	GAPS
Information System	% CHWs that maintain up-to-date records of sick U5 children (age, diagnosis, treatment)	<b>25% (37/150)</b>	While generally quite good in Kirehe and Ngoma completeness of registers by CHWs in Gisagara and Nyamasheke was weak.
Training	% CHW in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	<b>55% (82/150)</b>	Most trained in malaria but not nutrition, diarrhea, vaccinations nor ARIs.
Supervision	% CHW that received external supervision at least once in the last 6 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	<b>40% (61/150)</b>	Most supervision took place during monthly meetings at the HC not at the community level.
Drugs	% first line medications for child health among surveyed CHWs on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line anti-malarial, vitamin A)	<b>73% had ORS in 3 districts</b> <b>81% had AQ/SP in 3 districts</b> <b>96% had zinc in 2 districts</b>	Availability of drugs among CHWs in Kirehe and Ngoma was nearly 100% for ORS, zinc and AQ/SP. Few to none of the CHWs in Ny'gaba, Ny'guru and Gisagara had drugs. Oral antibiotics not permitted at time of survey.

Supervision of CHWs is generally the responsibility of the front-line HCs, although logistical challenges such as shortage of personnel and distances result in this rarely being done. The EIP HFA 2007 found only 7% of the HCs surveyed did any community level supervision. Most Districts have applied a CHW association strategy where CHWs are grouped by the HC and conduct monthly meetings with HC staff for community reporting, receipt of replacement drugs and supplies. Most supervision takes place during these visits, rather than in the community setting. NGOs providing rural health services work alongside the government to support training and supervision of CHWs.

#### **f. Vulnerable groups in the program site**

Selected areas are those among the worst off in terms of health and poverty. Most Rwandans living below the poverty line reside in the south and southwest areas of the country<sup>11</sup>. The vast majority of families are self-reliant farmers and day laborers. **Land**, a scarce and precious resource in Rwanda, is least available in the south. While nationally about 29% of households own less than 0.2 ha of land, the situation is much worse in the former Butare province, which includes Gisagara District. There, 62% own less than 0.2 ha, and in the area that now comprises Nyamagabe and Nyaruguru Districts, 59% of families have extremely limited

<sup>11</sup> PRSP 2002

landholdings or are completely landless (PRSP 2002). A plot size of 0.9 ha is recommended by FAO as the minimum sized land plot to sustain an average family.

Approximately 96% of food-insecure households live in the rural areas of the country. Poverty and food insecurity are most prevalent amongst **female-headed households** and smallholder farmers with insufficient and poor-quality land. The key factors that have contributed to this erosion of livelihoods are: low agricultural productivity, lack of crop diversification, landlessness and diminished access to land, poor access to markets, few off-farm employment opportunities, and the effects of HIV& AIDS. The proportion of **female and widow headed households** across the country remains high (24% and 18% respectively of the total population) with a predominance in rural locations (85%) with very little movement to any of the urban areas.

Although the number of **child-headed households** has diminished (1.3% of the population in 2001 down to 0.7% in 2006 – EICV 2006 report) the young adults who grew up in these especially vulnerable circumstances remain vulnerable. They are more likely to have dropped out of school, may well lack life skills after growing up without role models, and very likely do not possess sufficient land to satisfy their household food needs. They therefore most likely join the ranks of young, undereducated, unemployed youth in urban centers.

Four percent of the total population is considered “disabled” (synthesis of the 2002 national census) and they live predominantly in rural areas and can therefore be isolated from specialist services.

While mutuelles provide protection of families from illness burdened economic shocks, nearly ½ the population either chooses not to participate or cannot afford to participate. The CWR Kibilizi Child Survival final evaluation survey in 2006 clearly indicated that care-seeking for maternal and child health services is much lower among non-members.

There was no evidence of major gender bias present in child health consultations based on GESIS data for 2006 in the program area.

#### **g. Linkages and complementary activities**

Collaboration with national programs on child health includes:

- **MoH’s Maternal & Child Task Force** – Community Health IMCI, Nutrition and RH Officers
- **National IMCI task force** to update/refine IMCI intervention strategies, tools and facilitate training of trainers, coordination of IMCI implementing partners.
- The **National Malaria Control Program** (NMCP) with PMI and Global Fund funding, procure and provide long-lasting mosquito nets and home based treatment drugs, including training of trainers and the provision of working tools (kits) for CHWs ;
- **BASICS** provides technical support to the MoH in the development and roll-out of facility and community IMCI and implements the recommendations of the 2005 rapid child health assessment. The program is leading the inclusion of newborns into national protocols and supporting EIP with field-testing CCM of pneumonia. BASICS also has a large pediatric AIDS component.

- **Population Service International (PSI)**, which provides technical support in developing packaging designs for the National Malaria Control Program of the new Coartem anti-malarial drug, promotes social marketing of Sur Eau point of use water treatment, condoms, as well as deeply subsidized mosquito nets through ANC and EPI services across the country.
- **UNICEF's C-IMCI** in four districts (none overlap with program area), which financially support health facility IMCI training at the national and district level, provides Vitamin A, iron, and potentially zinc; UNICEF is also working in nutrition and maternal care.
- **USAID President's Malaria Initiative (PMI)**, is a 3-year national program closely linked to the PNILP focuses on increased coverage of long lasting nets, access to effective anti-malarials (Coartem) for community and health facility treatment, and indoor residual spraying. This program will provide Coartem for home based management of malaria in the Program area.
- **Management for Sciences and Health's RPM Plus**, focuses on strengthening national drug management systems from the central CAMERWA store to the district pharmacies. This program provides technical support to the child survival program in terms of a) strengthening drug management systems across the six districts for essential CCM commodities and b) establishing costing options for a viable longer term supply of community drugs.
- **Family Health International's IMPACT program is a major actor** in HIV & AIDS prevention, care including PMTCT services. They also support facility IMCI training in Nyamasheke.
- **National AIDS Commission**, which is active in national and zonal HIV & AIDS services and coordination. PEPFAR and MAPS are partners in VCT, PMTCT and care and support interventions throughout the country.

The following health and development actors operate in at least one of the EIP Districts and are henceforth identified as important stakeholders. EIP will work directly with each agency and through the district annual planning and regular coordination meetings to maximize leverage opportunities and avoid duplication to promote the health of children and providing special protection to the most vulnerable due to poverty, orphanage, and HIV & AIDS.

**Table 9: Health and Development Actors by District**

Health & Development Actors	Areas for Synergy with EIP	National	Districts					
			Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru
<b>Africare:</b> Case management of PLWHIV at the community, nutrition, PD Hearth for sick malnourished children, support for mutuelle membership of vulnerable children at community level	Identification of vulnerable families with young children including OVCs. Refer malnourished children to PD/Hearth and promotion of positive deviant feeding and caring practices					X		X
<b>BASICS:</b> National protocols and capacity building for IMCI	Pilot Pneumonia case management Pediatric HIV & AIDS	X		X				

Health & Development Actors	Areas for Synergy with EIP	National	Districts					
			Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru
and community and HF levels and improving care for pediatric AIDS	Strengthening IMCI for newborn care Strategies to roll out IMCI into HBM/PMI implementation							
<b>Cooperation Technique Belge (CTB):</b> Health Center Capacity Building	Training of health centre staff on IMCI			X				
<b>Cordaid:</b> performance based contracting with health services	Adopt best practices on performance based contractual services					X		
<b>Elisabeth Graser Pediatric AIDS Foundation (EGPAF):</b> HIV & AIDS services at Kibungo Hospital and prisons	Improved quality of referral services at the hospital for pediatric AIDS cases with opportunistic infections., causing dehydration and pneumonia				X			
<b>Family Health International (FHI):</b> HIV & AIDS programming including ARVs, VCT & PMTCT Start IMCI in Nyamasheke	Health facility training of IMCI in Nyamasheke	X			X	X	X	X
<b>Global Fund:</b> VCT & PMTCT services and support to indigent households and contractual approach	Integration of the Global Fund's supported activities in the district, the promotion of Key Family Practices Critical for Child Health and Nutrition	X		X				X
<b>GTZ:</b> District reproductive health strengthening and health system capacity building	Joint planning and resource support to District Improved integration of IPT in antenatal care		X					X
<b>Health Unlimited:</b> Radio health communications and community theatres for health messages' dissemination; rural women's associations' empowerment to poverty reduction through training	Use of their radio broadcasts time, community theatrical plays and their women's association to disseminate BCC messages on IMCI key family practices		X					X
<b>LWF:</b> Shelter construction and community development program	Integration of returnees to the Imudugudu CHWs and sensitizing them on C-IMCI services				X			
<b>Management Sciences for Health (MSH)/RPMPLUS:</b> Drug management, also provide full package of RPMPLUS support (pharmacist staffing, rehabilitation of district hospital pharmacy, provision of equipment and drug storage, training and supervision)	Technical advise in ensuring high quality of drugs – amoxicillin- and input in the design and packaging for easy dispensing by health workers; and training of trainers in drug management and rational use (especially for the community based pneumonia and malaria treatment).	X			X		X	
<b>PACFA:</b> Strengthening mutuelle capacity to support vulnerable populations (especially PLWHIV)	Identify orphans and OVCs and the support to insurance scheme facilitates children's access to first line community treatment for diarrhea, ARI and malaria					X		X

Health & Development Actors	Areas for Synergy with EIP	National	Districts					
			Gisagara	Kirehe	Ngoma	Ny'gaba	Ny'sheke	Ny'guru
<b>Partners for Health:</b> support to PLWHIV	Additional staff at HCs to support supervision of CHWs			X				
<b>President's Malaria Initiative (PMI)</b>	Home based management technical support and supply of Coartem  Linking vulnerable populations with additional LLNs		X	X	X		X	
<b>PSI:</b> Social marketing of sur'eau, LLNs, contraceptive pills, support VCT centers, including family planning services and Youth centers (community mobilization for behavior change)	Connecting CHWs to product social marketing, organizing campaigns  Promotion of appropriate use of LLNs and monitoring HH availability	X	X	X	X	X	X	X
<b>S.O.S.</b> Financial support to orphans	Identify orphans and financial support facilitates children's access to first line community treatment for diarrhea, ARI and malaria					X		
<b>Society of Women Against AIDS in Africa (SWAA)</b> – HIV & AIDS prevention and counselling	Integration into the group's activities the promotion of Key Family Practices Critical for Child Health and Nutrition				X			
<b>Twubakane :</b> Support technically and financially health facility IMCI training, functionalize health system infrastructure	District incentive funds linked to health planning; Facility IMCI training and linkage with community referrals in Kirehe, Ngoma, Nyamagabe and Nyaruguru			X	X	X		X
<b>UNFPA:</b> reproductive health	Integration into the agency's supported RH activities in the district, the promotion of Key Family Practices Critical for Child Health and Nutrition	X					X	
<b>UNICEF:</b> HIV & AIDS and IMCI	Financial support to health facility IMCI training; ORS supply	X					X	
<b>World Bank MAPS program:</b> HIV & AIDS programming and health services	Promote the integration of Key Family Practices Critical for Child Health and nutrition in home based care for PLWHIV		X				X	
<b>World Vision:</b> Supporting mutuelle membership at the community level especially for vulnerable children and their families	Identification of vulnerable families with young children, OVCs					X		X

#### Synergy with other CW/IRC/WR programs

All three EIP partner organizations implement complementary health and development programs that offer unique synergy opportunities:

**Concern Worldwide Rwanda** Concern Rwanda is implementing a Community Therapeutic care demonstration pilot in two sectors of Gisagara District with MINISANTE and UNICEF. Depending on results, this has the potential to scale up to other districts and to be incorporated into the national IMCI guidelines. Community-based Therapeutic Care (CTC) is a new approach to managing severe acute malnutrition with a focus on the decentralization of service delivery through an out-patient care program. The CTC approach treats cases of severe acute malnutrition without complications as out-patients, providing them with a weekly medical consultation and take-home therapeutic food, RUTF. For cases with any complications, these are treated in in-patient facilities using standard WHO treatment protocols and therapeutic milks. The CHWs will be trained on screening with mid-upper arm circumference tape (MUAC) and referral of sick children to the health centers for treatment of severe and moderate malnutrition

Nyaruguru District is also targeted by CWR's Livelihoods Security and HIV&AIDS Capacity Building Projects. In late 2007 there are plans to start up primary education support activities also in Nyaruguru District. The livelihood security project will work through national NGOs in order to increase food production and also off-farm income generation. The HIV&AIDS project (known as *Tubunganire*) will also work with national NGOs to minimize the socio-economic impact of HIV&AIDS and there will be an emphasis on tackling stigma and also on strengthening economic support mechanisms. The Primary Education project seeks to strengthen the role of Parent Teacher Committees in the management of primary school and increase the enrollment and retention of children from the poorest households.

Nyaruguru is one of the poorest districts in the country and the presence of Concern office with an integrated team of staff will give the opportunity for planned coordination with the child survival activities and ensure that linkages between the 4 projects are maximized. The particular emphasis will be on how to utilize the staff team for communicating a range of key messages, creating links between vulnerable households and income generation activities, and working with households to see how income is used on key services (health, education etc.)

**IRC** operates two other health programs, each emphasizing M&E system strengthening: a nutrition program in one sector of Ngoma and a reproductive health program in two health centers of Kirehe; both programs are community based interventions. The nutrition program targets children under five. It supports for CHWs to rehabilitate malnourished children. Working with child caretakers, educating them on ways to keep their children well-nourished using an approach derived from CTC. The second program is the reproductive health one which also uses the community approach. This program aims at increasing the use of health services, creating a link between the community and the health center. The reproductive health programs will use also community health workers to mobilize pregnant women to deliver at the health center. At the same time, IRC is in the process of hiring a midwife to work at the health center to improve the quality of antenatal and delivery care. Being community based interventions and targeting the same vulnerable groups, meaning children under five and pregnant women, the two programs will complement EIP efforts to reduce morbidity and mortality in these groups.

IRC is also implementing several USAID governance programs, including one that works with local civil society organizations, providing small grants for income generation and other

purposes. Program staff will work with civil society program staff to see how CHW associations might qualify for such small grants.

**WR** operates a microenterprise and HIV & AIDS prevention programs that offer potentials for synergy with the Program. These include:

**1. Microenterprise and Development (MED)** is active in 14 districts in Rwanda with a total of 280,808 clients. The average loan is now \$68.24 per beneficiary. The strategic MED objectives are the following: 1) expanding economic opportunities in rural areas; 2) strengthening the capacity of women in solidarity groups and villages' banks; 3) building the capacity of the 2 local partner microfinance service providers, CARE International and the Rwandan Microfinance Forum; 4) integrate HIV & AIDS community action and education within microfinance service infrastructure. This project is operational in Nyamasheke, Gisagara, Kirehe, Ngoma and Nyamagabe Districts. The program will connect with the MED solidarity groups at the village level for involvement in the EIP behaviour change strategy and community mobilization efforts.

**2. Mobilizing for Life operates in all 30 districts of Rwanda.** This HIV program is providing: i) family focused prevention based on faithfulness and beyond; ii) emergency food support and transportation to recovering PLWHIV & facilitate referrals to ARV treatment; training, capacity building and support income generating activities to recovering healthy PLWHIV; iii) strengthen Interfaith Committees in districts and build capacity of Volunteers; iv) Orphans and Vulnerable Children (OVC) support through the provision of a minimum of education materials (e.g. exercise books, pens, etc) package to high school OVCs in formal schools; income generating activities to OVCs; facilitate CD4 tests and ARV referrals. In the EIP Districts synergy areas include working with the Interfaith Committees as strategic channels for community mobilization and key health message transmission and linking for referrals for OVCs and PLWHIV needs.

## **2. *Summary of Baseline and Other Assessments***

### **a. Methodology of assessments**

Three baseline assessments were conducted to establish the baseline: 1) a Knowledge, Practice and Coverage household health survey, a child health service provision assessment of formal and community health services, and a Community Institutions Capacity Assessment. All the assessments were carried out in all each of the six program districts. In addition, 2006 health service statistics from malaria, diarrhea and respiratory illness were reviewed for the six district area.

The **KPC survey** was carried out from January 24 to March 30, 2007 (**2007 EIP KPC**), going sequentially in each of the six Districts, starting with Kirehe and ending with Nyamagabe. Its main purpose was to collect baseline data for the project's key indicators, and for as well as the CATCH indicators. **The full report is attached as Annex L.**

Questionnaire. The survey was constructed based on the recent (November 2006) version of the CATCH questionnaire as our starting point, adding a few questions needed to get data for

our baseline indicators. The questions were put into one of two questionnaires: one, the “**under-two**” questionnaire, was administered to mothers of children under two years of age, and included questions regarding care during pregnancy and delivery, immunization, hand-washing, bednets, and routine feeding. Another questionnaire, the “**sick-child**” questionnaire, was administered to mothers of children under five years of age who had been sick with fever, diarrhea, or respiratory difficulty in the last two weeks, and included questions about how the child had been treated and fed during the illness. The questionnaires were put into Personal Digital Device (PDA) forms using PocketPC Creations, and most data was collected using PDAs; in a few cases, survey questionnaires were administered from paper, re-transcribed within two days of collection.

Human resources. The survey was led by the M&E Manager, who attended the KPC training in Washington in November 2006, and carried out in each District by five teams of at least two people including an EIP program Officer and a District or health center staff member.

Sampling. Lot Quality Assurance Sampling (LQAS) with parallel sampling was utilized. Each of the Districts was divided into five sub-zones which comprised 2 or 3 contiguous health center catchment areas, grouped together to arrive at roughly even populations, to avoid over- or under-sampling some population. In each sub-zone we randomly selected 19 households as initial sampling points, using systematic random sampling and lists of individual households. From each sampling point, we chose one household which had a mother present with a child under two years of age, to whom we administered the “under-two” questionnaire, and also chose a household which had a mother present with a child under five years of age, to whom we administered the “sick-child” questionnaire. In some cases both questionnaires –under-two and sick-child– were asked in the same household, if the child happened to fit criteria for both (i.e. being under two and ill in the last two weeks); in others the questionnaires were administered in different households. Both questionnaires were administered to 569 households (in both bases one questionnaire was unusable because of error).

Analysis. The data was transferred from PDA to computer, the day of the survey or the following data, and analyzed using Excel and, for confidence intervals, Epi Info.

The **health facility assessment** was conducted from January 22 to March 2, 2007, sequentially in each District (**2007 EIP HFA**) Its main purpose was to assess quality of care at facilities and, in a more limited way, at community level. **The full report is attached as Annex E.**

Tool. We used the most recent (December 2006) draft of the Health Facility Assessment tool being developed by CSTS; we made minor adaptations to increase comparability with other assessments conducted in Rwanda, including the 2001 National Service Provision Assessment and the 2005 Health Facility Assessment conducted by Twubakane in its intervention districts. The instruments included five different questionnaires, corresponding to different data-gathering methods: observation of clinical care for sick children; exit interviews with caretakers of sick children; a checklist of equipment and supplies; interviews with health center staff; and interviews with community health workers.

Human resources: The survey was led by the Team Leader and Quality Assurance Manager. It was carried out in each District by four person teams comprised of two District health staff, two QA Officers with the QA Manager serving as team supervisor.

Sampling: One health facility was chosen at random from each of the LQAS sub-zones defined for the KPC survey, for a total of five facilities sampled in each of the six districts. In each facility, we observed five clinical encounters, interviewed five caretakers after the encounters, completed the health facility checklist, interviewed the health center manager, and interviewed five active CHWs. CHWs were purposively selected based on ease of communication by the HC personnel so that they could be called for a meeting at the HC the day following the HC assessment. Distributors were prioritized in areas covered by the Home Based Malaria Initiative.

Analysis: Some of the data, including the health facility checklist, was collected directly onto PDAs and transferred into Excel; other data was collected using paper questionnaires and manually entered into Excel. All quantitative analysis was done using Excel. Summary tables based on frequencies from the HFA database were prepared by the Concern Worldwide US office due to time constraints for the field teams who were involved in the DIP preparations. Detailed findings were documented by indicator. The survey team reviewed each indicator, identified issues regarding quality/limitations of the data, made general assessment of validity of the findings and identified key action points for the EIP based on the findings.

The **Community Institution Capacity Assessment** was conducted from January 22 to March 2, 2007. Its main purpose was to inform EIP capacity-building strategies related to leadership and management of two key community structures, the health committees (COSAs) and *comités de cellules* (CDC), as well as to community understanding of effective child survival programming. A total of 30 COSAs and 30 CDCs were assessed (five of each type in each of the six districts). **The full report is attached as Annex M.**

Methodology and sampling. The assessment team held separate focus group discussions with the health committee of each health center sampled for the health facility assessment, as well as the CDC closest to the health center. The team used a set of questions as a guide for the focus group discussions.

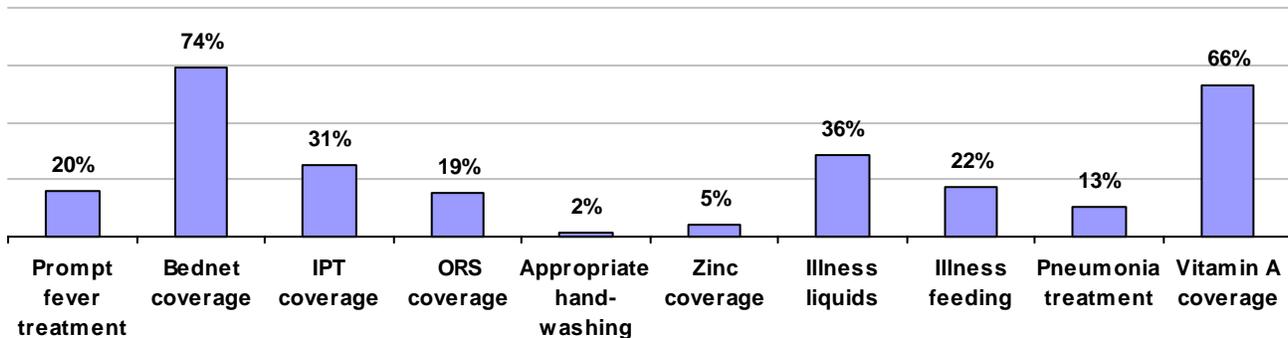
Human resources. The survey was led by the Mobilization Manager. It was carried out in each District with the Mobilization Officers. As available, members of the HFA team assisted as their schedules were contiguous.

Analysis. The Mobilization Manager and HQ World Relief technical advisor designed a scale that summarized each of the major elements in the assessment, as well as two summary performance scales, one for health committees and one for CDCs. The assessment team also did a qualitative analysis of the findings, which is summarized in the assessment report in the annex.

**b. KPC assessment findings highlights**

The following graphs summarize data for the project's key indicators, for each District.

1. All indicators



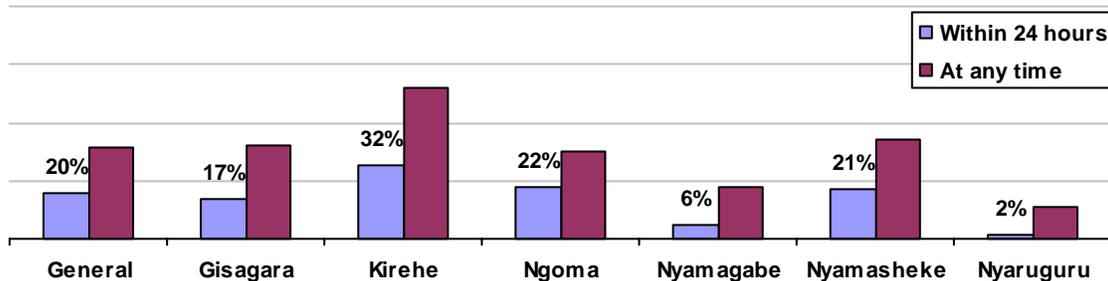
**Table 10: Difference between Districts**

	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaruguru
Prompt fever treatment	NS	+	NS	-	NS	-
Bednet coverage	NS	NS	NS	NS	NS	NS
IPT coverage	+	NS	NS	-	+	-
ORS coverage	NS	+	+	-	NS	-
Appropriate hand-washing	NS	NS	NS	+	NS	NS
Zinc coverage	NS	+	+	-	NS	-
Illness liquids	NS	NS	NS	NS	TBD	NS
Illness feeding	NS	TBD	TBD	-	NS	-
Pneumonia treatment	+	NS	-	-	NS	-
Vitamin A coverage	NS	NS	NS	NS	NS	NS

(Code: NS=not significant; + =significantly higher, - = significantly lower; TBD=to be determined)

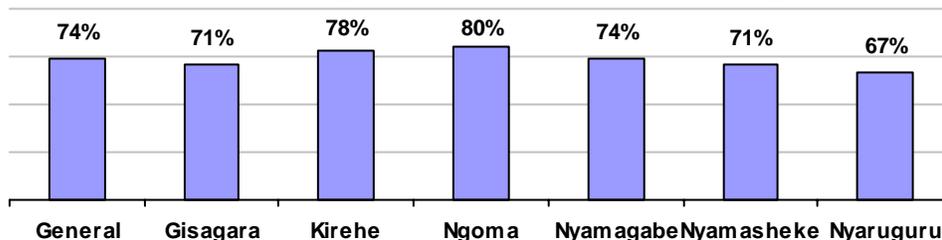
2. **Indicators by District.** Key indicators are given as bars; for some indicators, a relevant complementary indicator is added as a separate red bar

i. Appropriate presumptive treatment for childhood fever

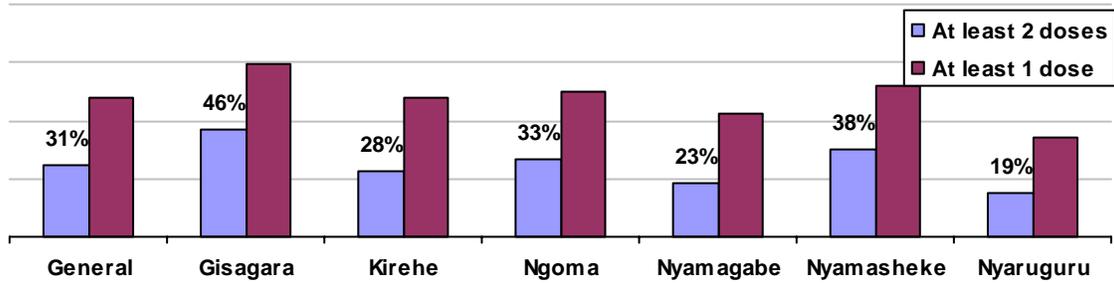


Major findings: Kirehe is highest while Nyaruguru and Nyamagabe are low or close to below the average.

ii. Bednet coverage (no statistical difference in coverage across districts)

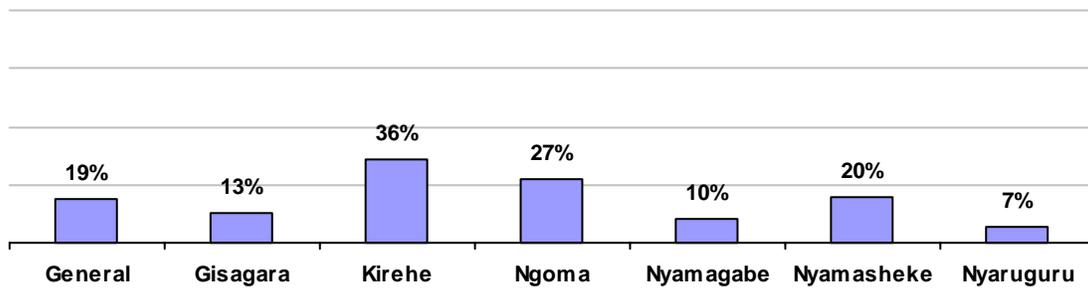


iii. IPT coverage



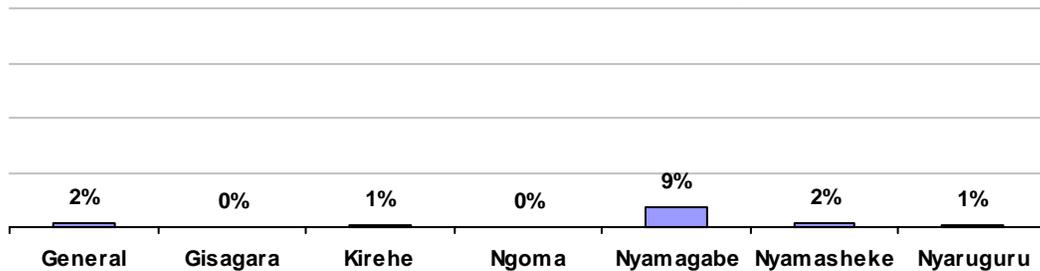
Finding: Gisagara significantly above the overall average while Nyamagabe and Nyamasheke are close. IPT coverage is lower in Nyaruguru district.

iv. ORS for childhood diarrhea



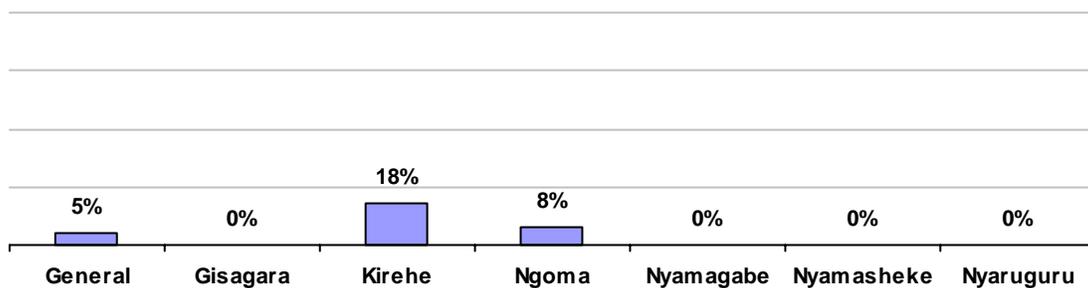
Kirehe significantly above, Ngoma close. Nyaruguru, Nyamagabe close to below

v. Appropriate hand-washing (regular place cited for hand-washing, soap observed, mother cites after toilet and at least one other key occasion for hand-washing)



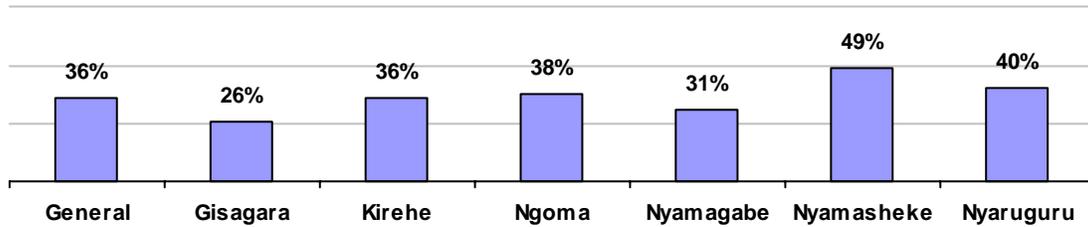
Nyamagabe is significantly above

vi. Zinc treatment for childhood diarrhea



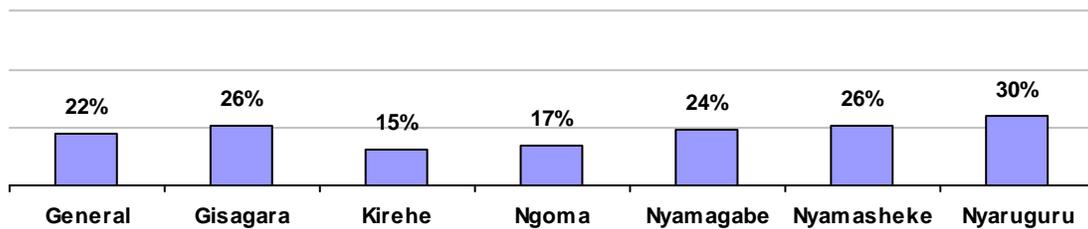
Kirehe and Ngoma significantly above.

vii. Increased liquids during illness, for children with diarrhea



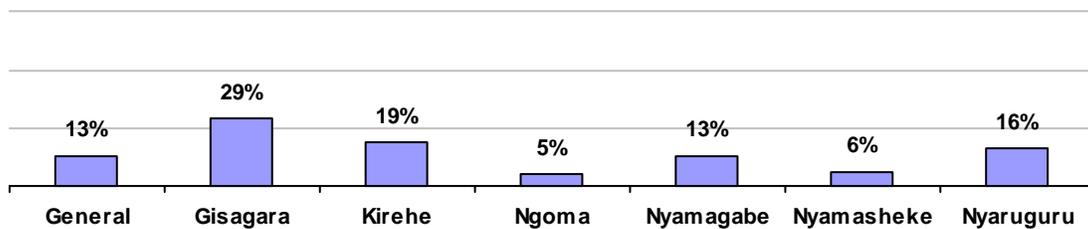
Despite the range in coverage, the sample is very small - not powered to tell differences between Districts.

viii. Continued feeding during illness, for children with diarrhea



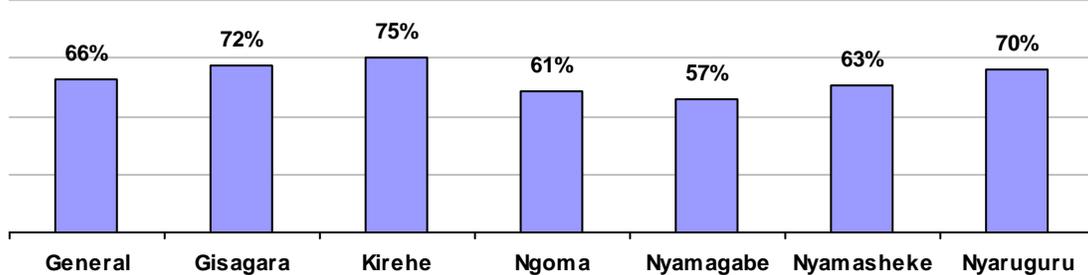
Very small sample, not powered to tell differences between Districts

ix. Appropriate treatment for presumed pneumonia



Gisagara higher, Ngoma may be lower

x. Vitamin A coverage



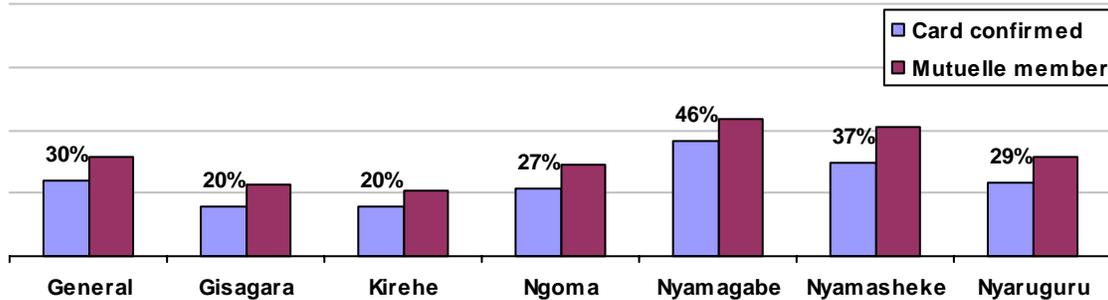
**3. Rapid catch, and additional key indicators for malaria and diarrhea intervention**

<b>Indicator</b>	<b>Program Area Result</b>
(1) Adequate Child Spacing	78%
(2) Maternal TT Vaccination	84%
(3) Skilled Delivery Assistance	39%
(4) Post-natal visit to check on newborn within the first 3 days after birth	13%
(5) Exclusive breastfeeding	88%
(6) Infant and Young Child Feeding	45%
(7) Vitamin A Supplementation in the last 6 months	66%
(8) Measles vaccination	92%
(9) Access to immunization services	69%
(10) Health System Performance regarding Immunization services	65%
(11) Child with fever receives appropriate antimalarial treatment	20%
(12) ORT use	19%
KI: Increased fluid intake during diarrheal episode	36%
KI: Continued feeding during a diarrheal episode	22%
KI: Zinc	5%
KI: Use of Medicine during diarrhea	9%
(13) Appropriate Care Seeking for Pneumonia	13%
(14) Point of Use (POU)	31%
(15) Appropriate Hand washing Practices	2%
KI: Safe Feces Disposal	n/a
(16) Child sleeps under an insecticide-treated bednet	74%
KI: Ownership of insecticide-treated bed net:	75%
KI: ITN use by mothers during pregnancy	74%
KI: IPT	59%
KI: Indoor Residual Spraying	0%
(17) Underweight	20%

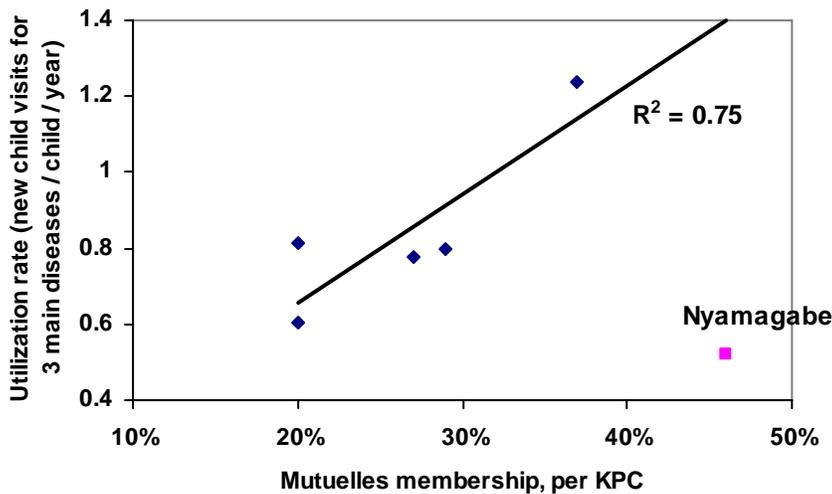
KI= Additional key indicator

#### 4. Mutuelles membership

*Mutuelles de santé* are community health insurance schemes which have been heavily promoted by the government, donor agencies, and implementing agencies. KPC respondents were asked if they were currently members of a *mutuelle*; if they said yes, interviewers asked to see their card.



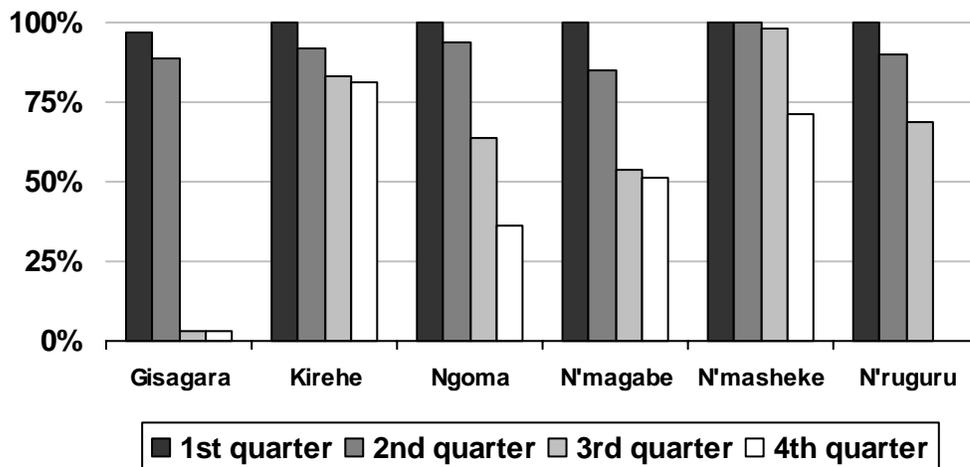
Not surprisingly, *mutuelles* membership in the general population is much lower than among health center clients (see health facility assessment), indicating that non-members are less likely to seek care at the health center, either because of the financial barrier or because they are less likely to be sick (and thus less likely to find the *mutuelle* worth the cost.) Nyamagabe has the highest *mutuelles* coverage according to both the KPC and health facility assessment. There is a strong association between *mutuelle* membership and utilization for child health services, with the notable exception of Nyamagabe—the correlation factor  $R^2$  is 0.75 without Nyamagabe, as shown in the graph below, but falls to zero when Nyamagabe is included. This may be due in part to much lower utilization for malaria in Nyamagabe.



#### c. Disease surveillance estimates

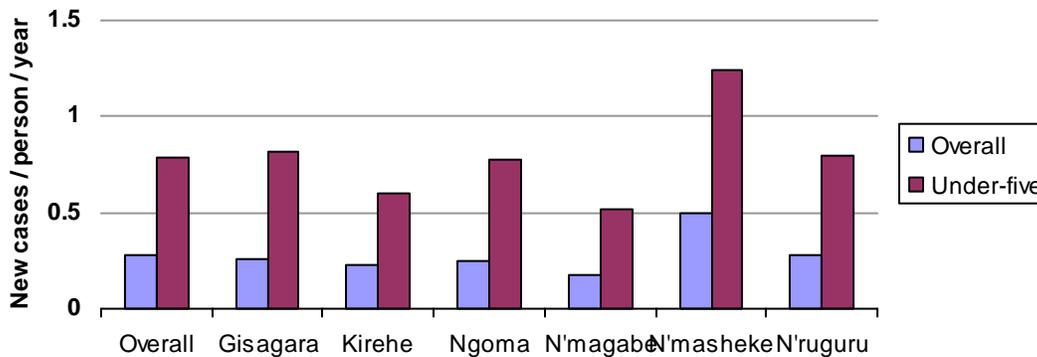
We analyzed 2006 data from the national health information system, GESIS, on utilization of curative clinical services for under-5 children with fever, diarrhea, and pneumonia. We looked at overall utilization of health services, seasonal patterns, differences in utilization between different diseases. For two of the districts, we also compared facility and community data.

##### 1. Report completeness



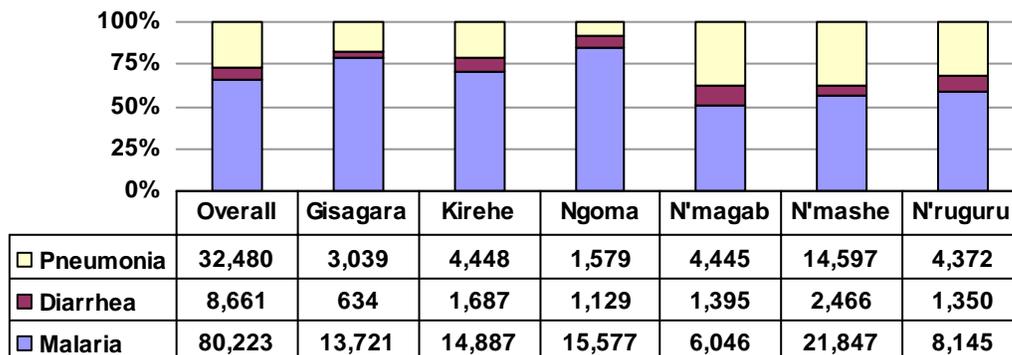
We first looked at report completeness. As the graph above shows, reporting rates fell off in the last two quarters of 2006, except in Kirehe and Nyamasheke.

2. Utilization for malaria, diarrhea, and pneumonia, first quarter of 2006

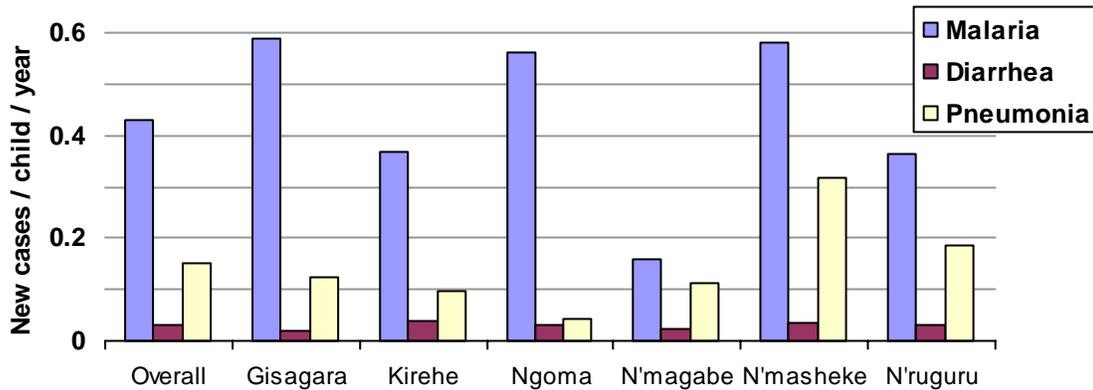


We only used first-quarter data to avoid a bias due to differing reporting rates. Utilization is highest in Nyamasheke –more than 50% higher than the average– and lowest in Kirehe and Nyamagabe, the two Districts that do not have hospitals.

3. Comparative utilization for children, by disease. The table shows the number of cases reported for 2006.

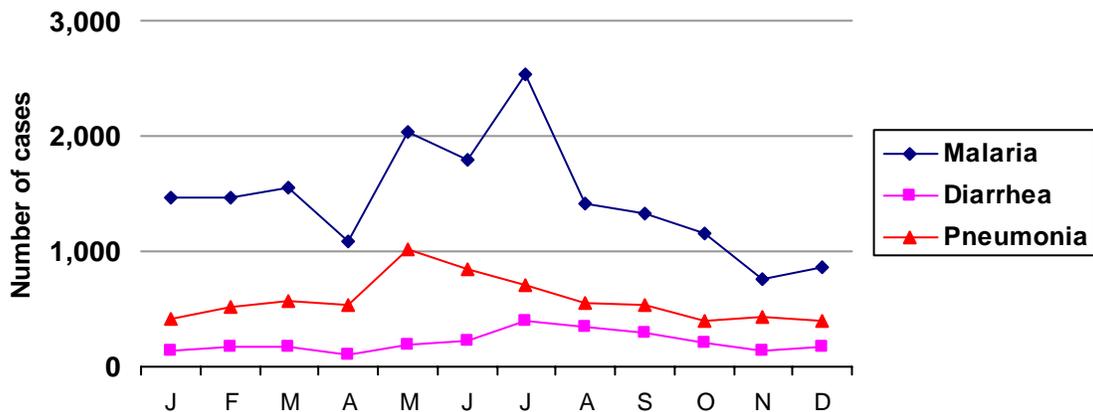


The data shows that malaria is the most commonly diagnosed of the three major lethal childhood diseases, by far. Malaria has a smaller burden proportionally in Nyamagabe, Nyamasheke, and Nyaruguru, as expected –these Districts are higher in altitude and have less intense transmission– but, even there, malaria cases represent more than half of the under-five diagnoses for 2006. Pneumonia (“lower respiratory tract infection”) is more commonly seen at health centers than diarrhea.



The graph shows similar information, displayed in terms of cases per child per year. This data is from the first quarter, to avoid reporting biases in comparing different Districts. In all three Districts, utilization for diarrhea is particularly low. This could be due to a low incidence of diarrhea, but evidence from the DHS and other surveys –including child survival KPCs– indicate that incidence is quite high, with about 14% of children having had diarrhea in the last two weeks. Low utilization means, then, that the vast majority of children with diarrhea are not taken to clinics for consultation. Utilization for pneumonia in Nyamasheke is double the average for the other Districts.

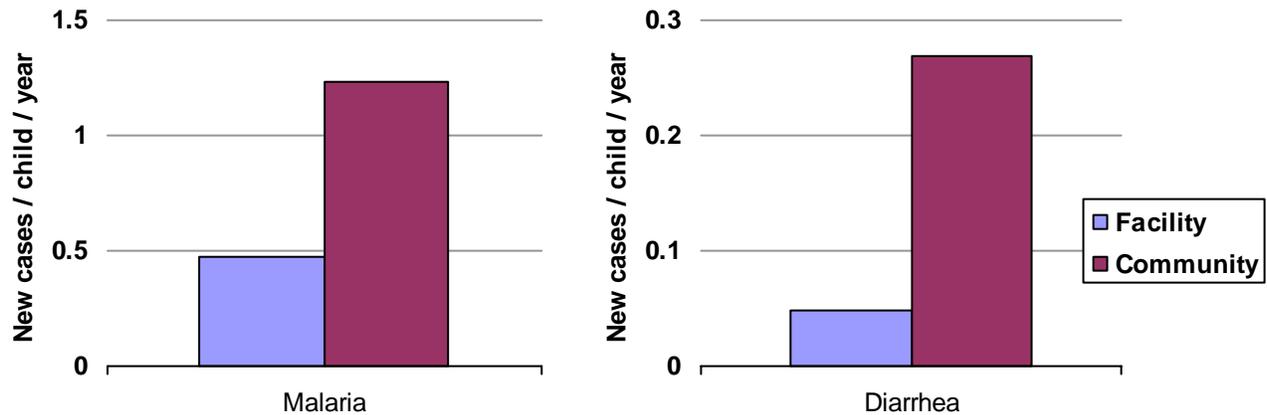
4. Utilization for children, for malaria, diarrhea, and pneumonia, for 2006 (for the 14 health centers that reported for every month of 2006)



This data confirms known seasonal patterns. There is a peak of malaria cases beginning one to two months after the start of the rainy season, in February, and continuing one to two months after it ends in June. Pneumonia peaks around the same time, possibly because of co-infection and co-diagnosis, given the similar clinical presentation of both diseases. Diarrhea, in contrast, peaks in the dry season, when water availability declines, leading to more use of poor-quality water, and less hand-washing. This data may also show the beginning of the impact of the Rwanda Expanded Impact Program – DIP July 2007

massive bednet distribution campaign carried out in September 2006, just before the start of the year's second rainy season. A stronger increase of malaria cases would have been expected in December.

5. Utilization for childhood diseases, facility vs. community, Kirehe and Ngoma Districts, for the first two quarters of 2006



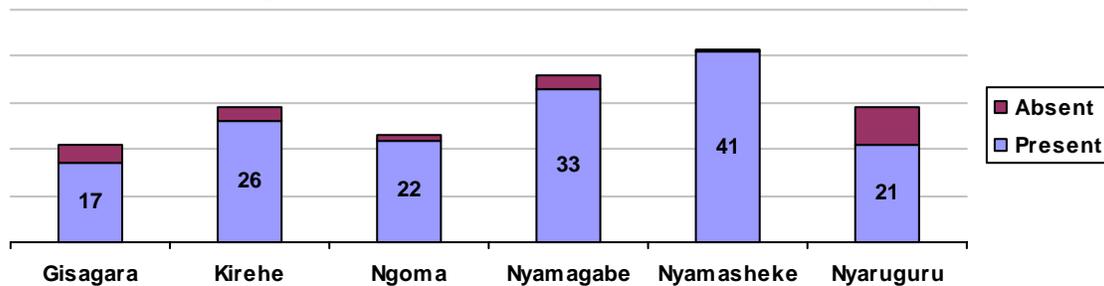
For both diseases, community providers see many more cases than health center staff. The relative difference is greater for diarrhea than for malaria: more than five and a half times more diarrhea treatments in the community than in facilities, versus two and a half times as many malaria treatments. This is consistent with data from other countries, and is most likely explained by the fact that caregivers perceive diarrhea as less dangerous, and less urgent, than malaria.

**d. Summary of health facility assessment**

The health facility assessment was organized around three key aspects of health center functioning: inputs, such as staffing, supplies, and infrastructure; processes, such as reporting, training, and supervision; and outputs, including utilization, performance, and satisfaction. The assessment focused mostly on facilities, but also extended to some community processes such as supervision of community health workers.

**1. Inputs**

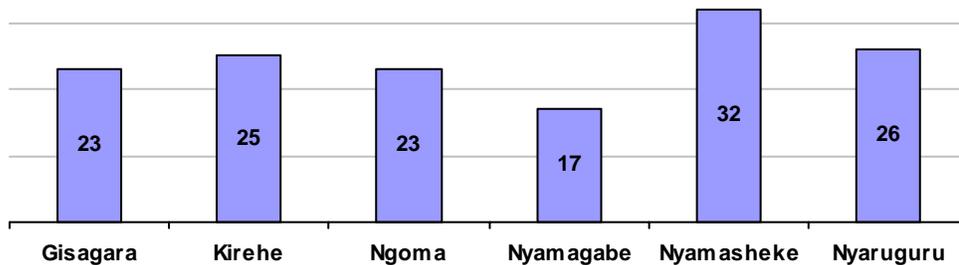
i. Staffing: number of clinical staff funded (for five facilities per District)



Clinical staff includes doctors, A1, A2, and A3 nurses, midwives, and other clinicians. Most of the clinicians –more than four in five– are A2 nurses. Nyamasheke has the most staff per health center, followed by Nyamagabe. Gisagara, Ngoma, and Nyaruguru have the least.

ii. Infrastructure and equipment: infrastructure score

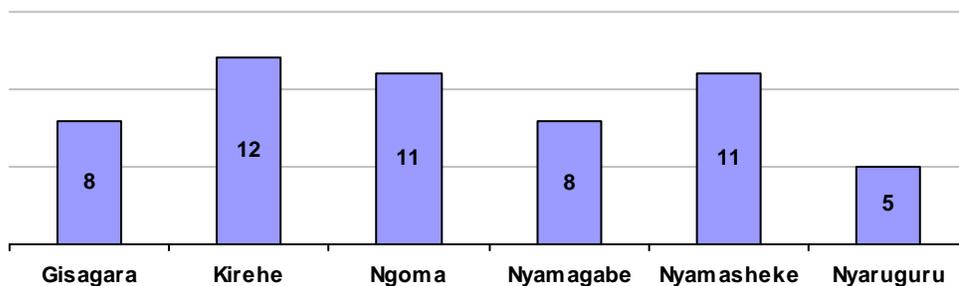
(1 point for each facility for each of the following: overnight beds; communication within 5 minutes' walk; ambulatory transport on site or on call; electricity on day of visit; useable latrine on day of visit; improved water source; consultation area with privacy. Maximum points for each District is 35.)



Nyamasheke is again the district with the best infrastructure, by this measure. Gisagara, Kirehe, Ngoma, and Nyaruguru are in an intermediate category, scoring between 66 and 74%; they all lost points on transportation, with other weaknesses varying by District. Nyamagabe – which was second best in terms of staffing– has the least infrastructure, getting less than half of all possible points. Its main weaknesses were transportation, communication, and water, with a total of 1 of 15 possible points in those areas.

iii. Supplies: essential supplies for child health services

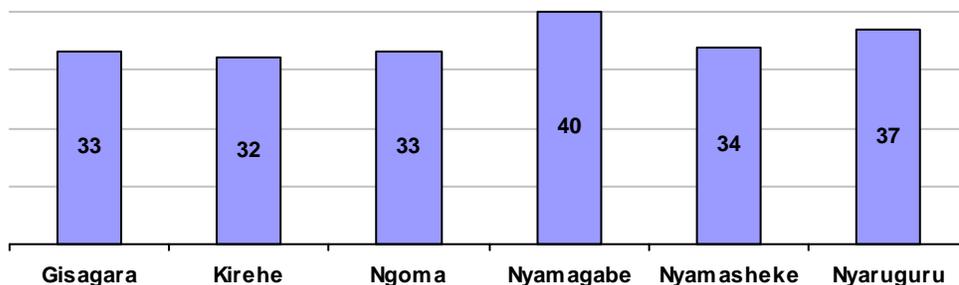
*One point for each facility for each of the following: functioning timer or watch; ORS equipment; hand-washing soap. Maximum points for each District is 15.*



None of the health centers register a high performance, primarily because of the lack of timers. All of the health facilities surveyed had hand-washing equipment. Most of the variety observed can be attributed to the presence or absence of spoons and cups for ORS preparation.

iv. Drugs: availability of eight key drugs and inputs for child health

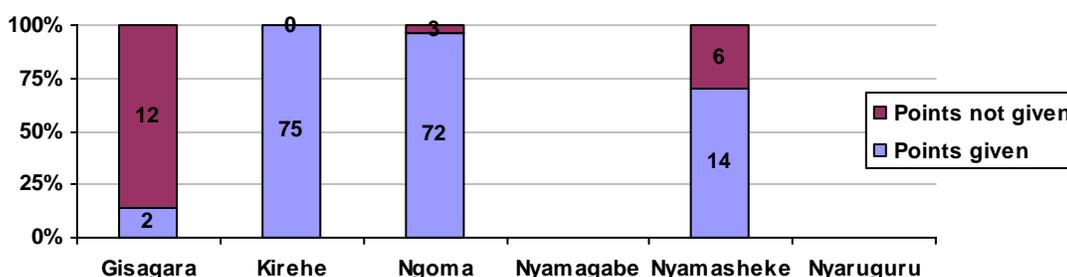
(1 point for each facility for each of the following: ORS packets; amoxicillin; ciproflaxin; Coartem; zinc; vitamin A; iron; treated nets. Maximum points for each District is 40.)



All Districts scored relatively high on this index, with Nyamasheke being highest, as with most other input indicators. Most of the variation between Districts is due to two inputs, zinc and treated bednets.

v. CHWs: availability of three child health drugs at community level

(1 point each for each of the three drugs for each CHW. Denominators varied, so results are reported as percentages. No results are reported for Nyamagabe and Nyaruguru, which do not yet have community treatment programs.)

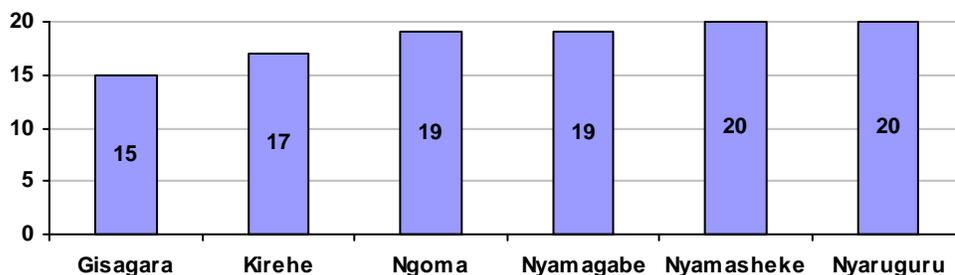


Kirehe and Ngoma had much higher drug availability, indicating the community distribution program has continued to thrive, despite decreased support from the Districts since decentralization. For Gisagara, only Amodiaquine/sulfadoxine/pyrimethamine was assessed, so the low result reflects the absence of an ORS intervention in that area. For Nyamasheke, 9 of 10 CHWs had antimalarials; most of the stock-outs were in ORS.

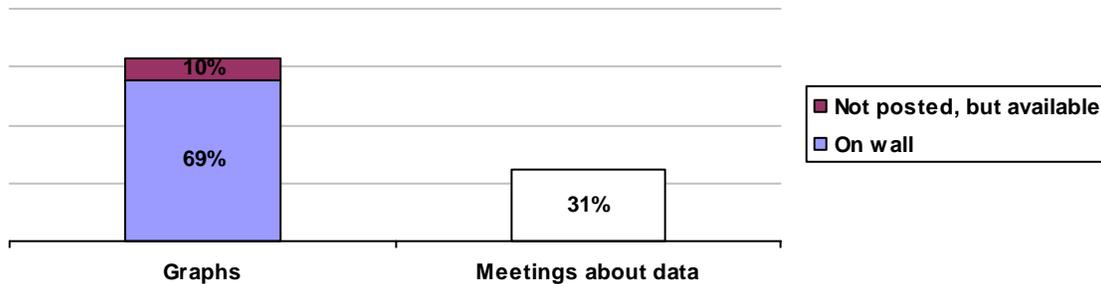
## 2. Processes

### i. Health information system

(1 point for each facility for each of the following: age, diagnosis, and treatment completely entered in registers; register entry in last 7 days; report written in last 3 months; evidence of data use. Maximum points for each District is 20.)

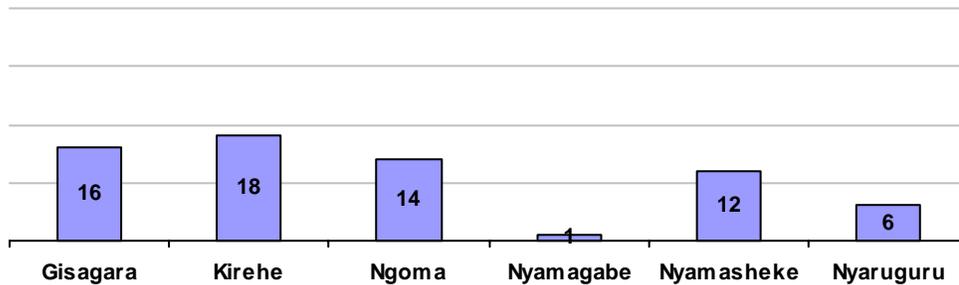


Nyamasheke and Nyaruguru are highest, with Gisagara lowest. All Districts are relatively high, in part because the criteria focused on the presence of data use, rather than the quality of that data use. The following graph details how data was used (graphs and meetings are not mutually exclusive, so the total is more than 100%).



ii. Training: trainings reported by health center staff

(1 point for each facility for every topic trained in over the last 12 months: vaccination; pneumonia treatment; diarrhea treatment; malaria treatment; malaria prevention; nutrition; breastfeeding; or IMCI. Maximum points for each District is 40.)



Health center staff in Nyamagabe and Nyaruguru reported many less trainings than in the other Districts. Kirehe may have had more trainings because it is a priority areas for several programs, in addition to the previous child survival program: the national malaria control program, facility IMCI, Twubakane, and Partners in Health.

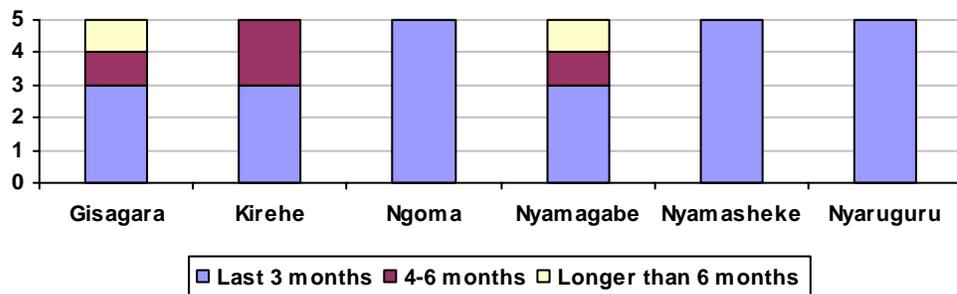
The following graph shows how frequently each topic was cited. Maximum is 30.



Of the project’s three intervention areas, malaria has had by far the most trainings; this may be due to the presence of an active, well-funded vertical program in the country.

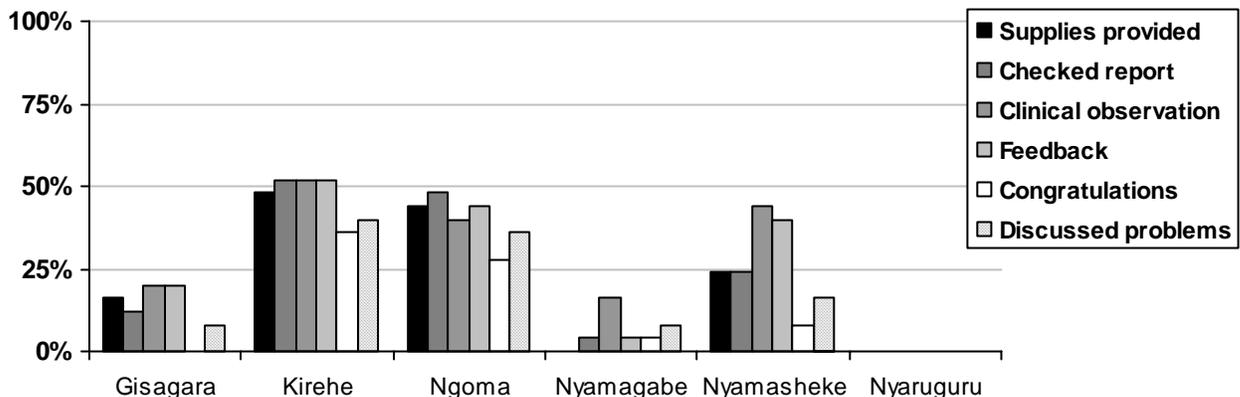
iii. Supervision

Most recent supervision from District to health center (out of 5 centers sampled in each District):



Most health centers sampled been visited recently, with Ngoma, Nyamasheke, and Nyaruguru having perfect records. Of note, the indicator does not correspond to the Rwandese Ministry of Health policy, which has a standard of one supervision per health center per month.

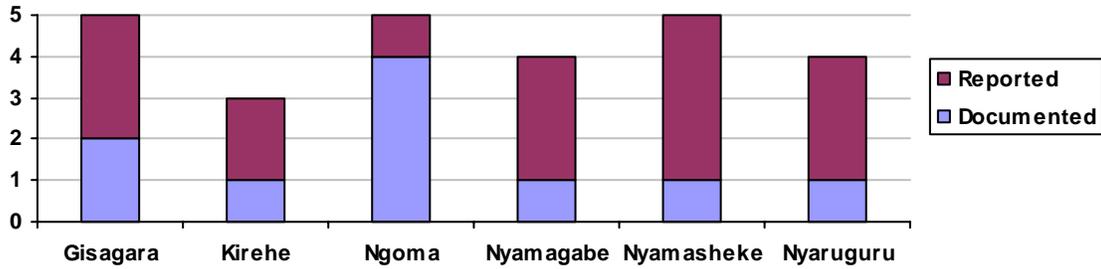
Supervisions done within the last six from health center to community workers. (Because this activity is at the heart of the project's activities, we present the results in more detail, indicating what was done in the supervision.)



As expected, Districts participating in the home-based distribution of malaria drugs program have more, and more thorough, supervision of community workers; Kirehe and Ngoma have higher supervision coverage because the program covers all of these Districts, in contrast to approximately half in Gisagara and Nyamagabe. There is room for progress, however, as only approximately half of CHWs involved in community distribution reported thorough supervision in the last six months.

#### iv. Quality assurance

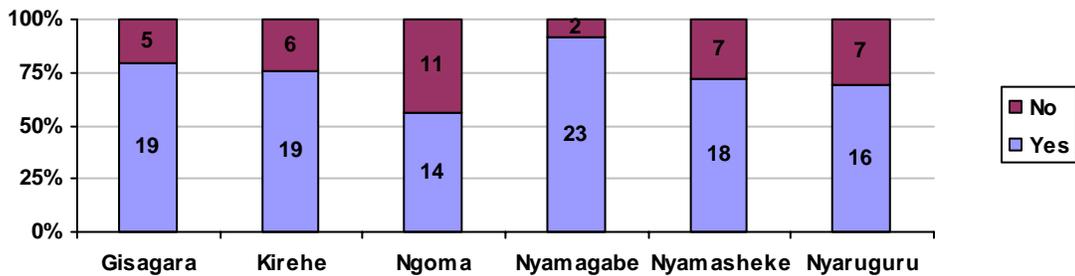
Health centers reporting quality assurance processes:



Over all, four in five health centers reported using quality assurance processes, but only a third could produce evidence of such processes, such as a report or tools in use.

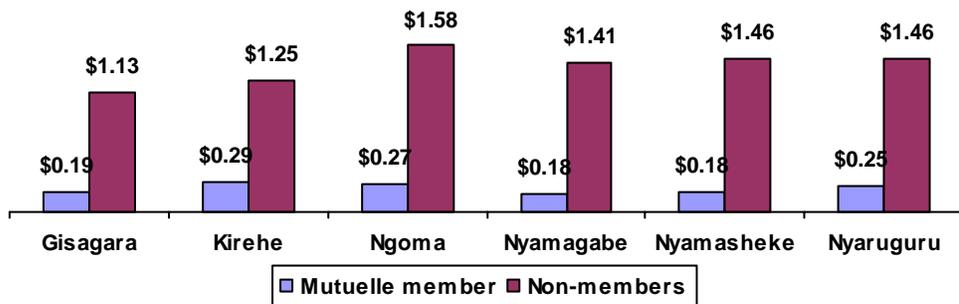
v. Cost accessibility

Membership in Mutuelles among client respondents to HFA



Membership among caretakers using Health Center services was quite high in all Districts. There may be a bias upwards because respondents were at health facilities—presumably people who are not members of Mutuelles are less likely to be at the health center.

Average price for a curative conversation for a child under five, for the five facilities in each District. All prices converted to US dollars.

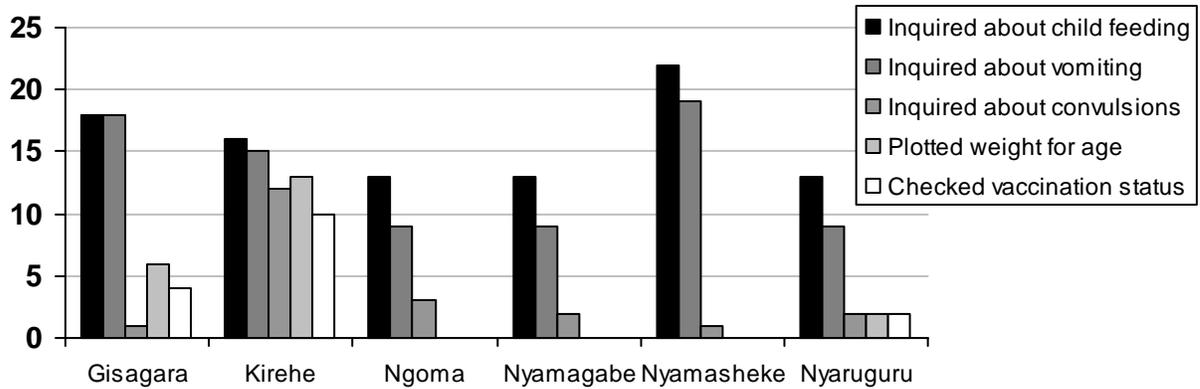


Prices for mutuelle members are more than six times lower than for non-members, an average of \$1.38 vs. \$0.23 for members. Prices are relatively uniform, with a maximum deviation from the average of 27% for mutuelle members and 18% for non-members.

3. Outputs

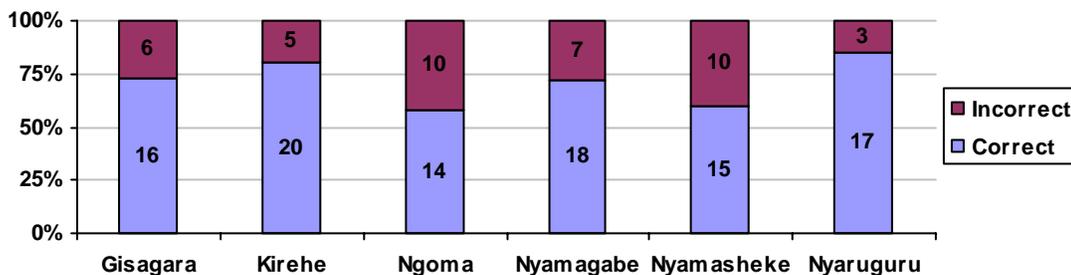
i. Health worker performance in the facility

Key elements of assessments completed (n=25 observations in each District)



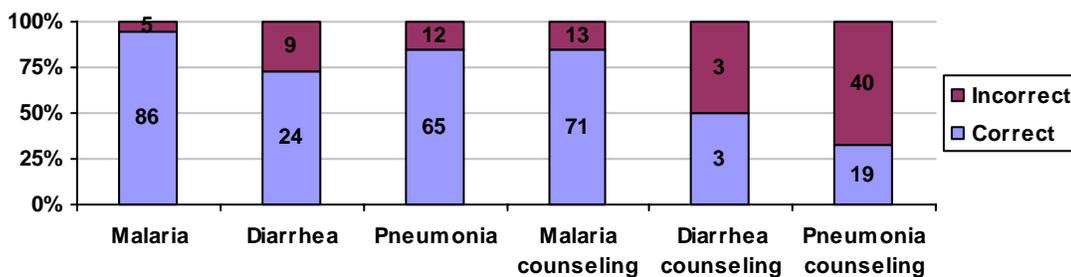
Assessment performance was concerning throughout. Kirehe has somewhat better results overall, even though it had the least quality assurance of all District. Feeding and child feeding were the most commonly completed assessment tasks; nutritional and immunization status were rarely checked.

Treatments for malaria, diarrhea, and/or pneumonia in under-fives done correctly



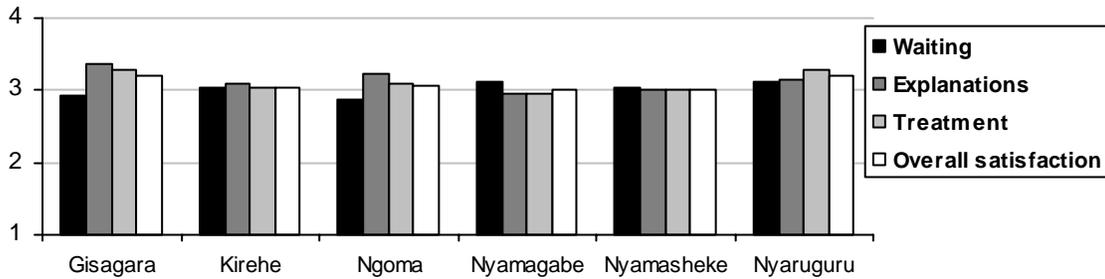
The proportion of treatments that were correct was highest in Nyaruguru and Kirehe, and lowest in Ngoma and Nyamasheke.

Correct and incorrect treatments, by disease. The graph also incorporates counseling.



The proportion of correct treatment and of correct counseling were higher for malaria than for diarrhea and pneumonia.

ii. Client satisfaction (1=poor, 2=fair, 3=good, 4=very good)



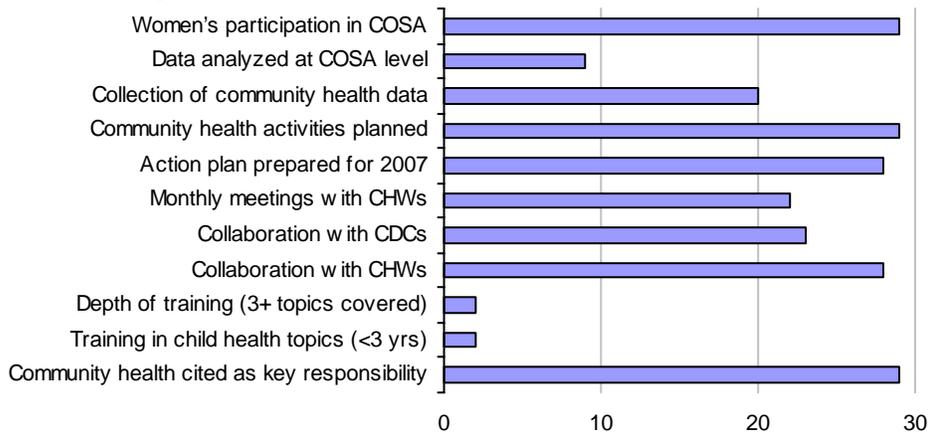
Satisfaction is relatively high, with average scores of “good”, but the remarkable lack of variation across Districts and in different elements of quality indicates that there may have been a bias in the measurement method.

**e. Community capacity assessment**

The community capacity assessment evaluated performance of health committees and CDCs (local governance institutions). Five health committees and five CDCs were evaluated in each District. The following graphs summarize the results.

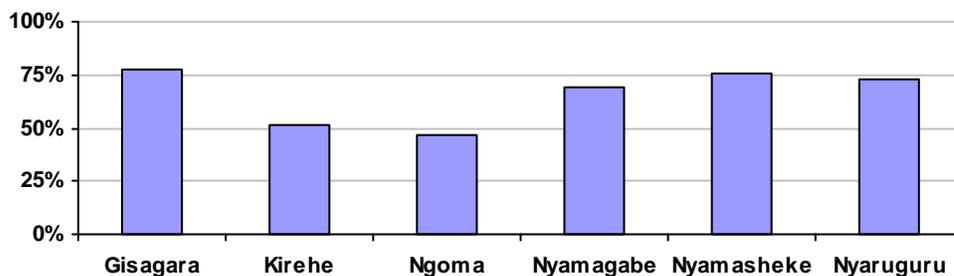
**1. Health committees**

Areas of strength and weakness (n=30)



Areas of lowest performance included data analysis and training.

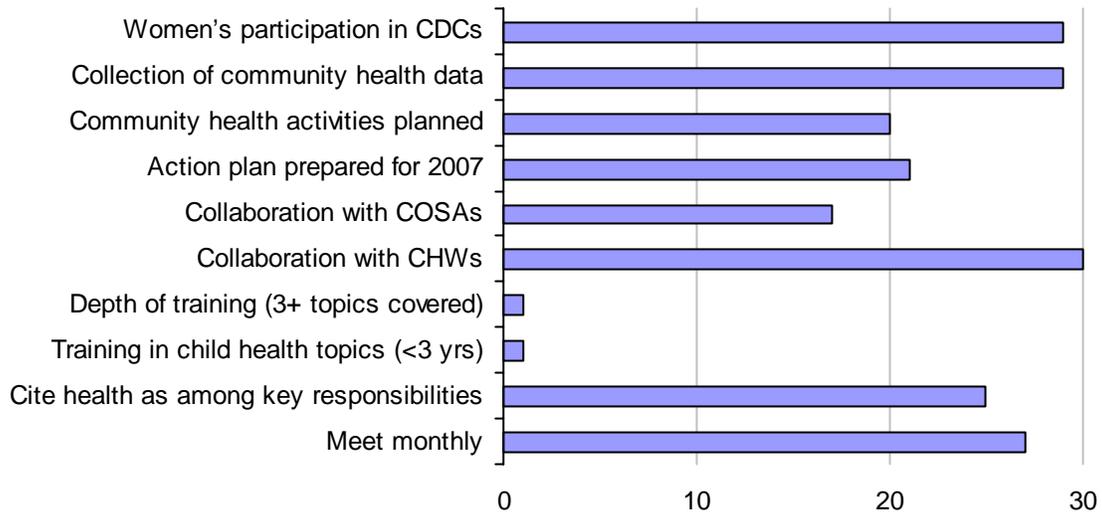
Relative performance for each District



Of note, there was no health committee interview in Gituku, in Ngoma District. Excluding Gituku from the analysis, overall performance for Ngoma is 68%

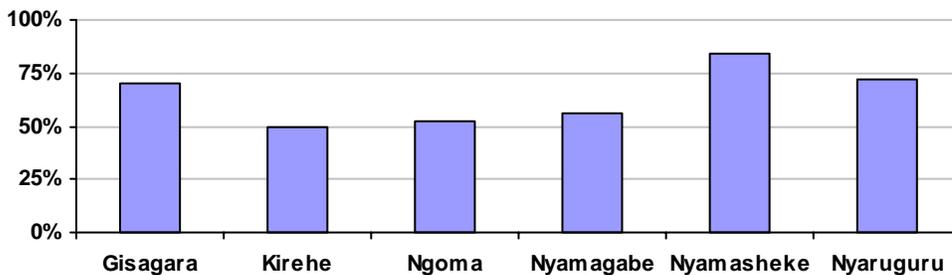
## 2. CDCs

Areas of strength and weakness (n=30)



As with COSAs, training was identified as a major priority. This may be related to the major financial incentives to individuals associated with training in the current aid system.

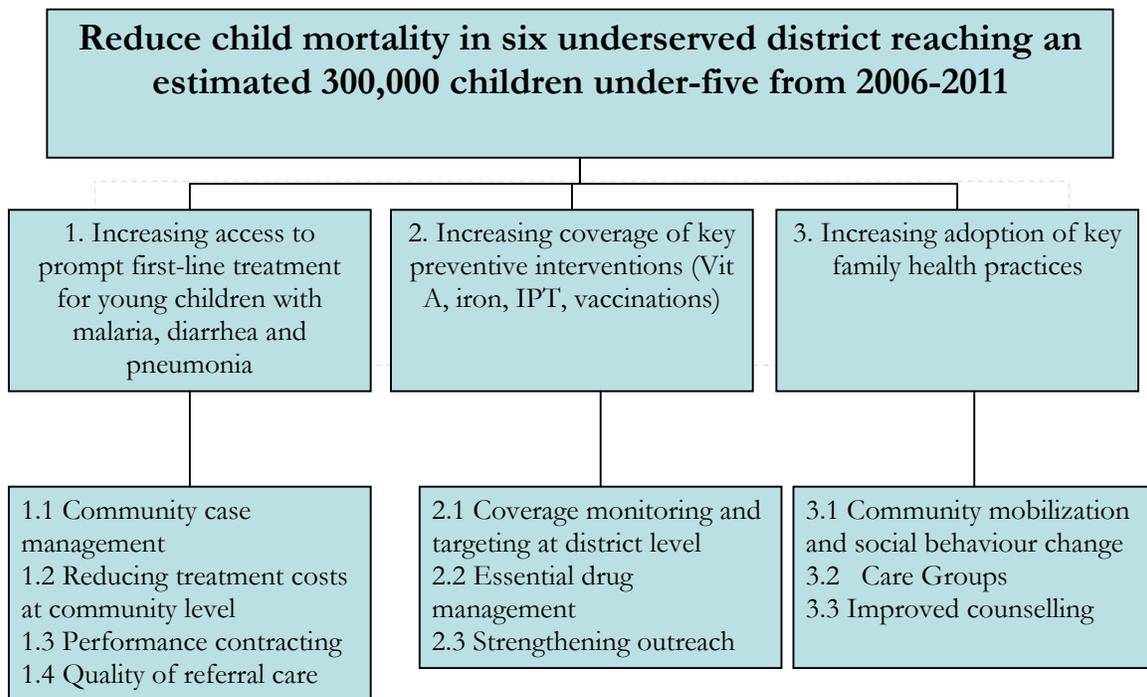
Relative performance for each District



As with health committees, Nyamasheke is the strongest performer; Kirehe and Ngoma are the weakest.

### 3. Program Description

#### a. Overall Program Strategy



The program will address the major direct causes of child mortality in Rwanda through a C-IMCI strategy for malaria prevention and treatment, pneumonia case management, and control of diarrheal disease. The program will expand access to quality treatment at the community and facility levels, promote C-IMCI key family practices through focused behavior change activities; and increase coverage of preventive interventions through an intensive community mobilization strategy. Strategies and activities were designed in close consultation with the Ministry of Health, including the IMCI, MCH, and Community Health Desks; PNILP; the USAID Mission to Rwanda; BASICS; Twubakane ; UNICEF, and WHO. Specific strategies will include:

#### 1. Increasing Access to Quality Treatment

The program will work on the major components of access and quality through expansion of community case management, reducing treatment costs at the community level, and continuous quality improvement at the facility level and through performance contracting for CHW supervision.

**1.1 Community case management.** The program will train and equip CHWs to provide community case management for fever, pneumonia (IMCI criteria), and diarrhoea. These activities will be complemented by a multi-faceted effort to increase recognition of danger signs and encourage prompt care-seeking from trained providers through a community mobilization and behaviour change strategy that engages district and community actors to

reach all households with children under five. The services will be made accessible geographically by using local CHWs, and financially through subsidies for drugs, particularly amoxicillin and zinc. All three PVOs are experienced with this methodology through implementation of the Home Based Management of Malaria (HBM) operated in the old Child Survival areas since 2005 that is now being extended nationwide. The IRC began community-based zinc treatment for diarrhea in two districts (Kirehe and Ngoma) in 2005. Based on these experiences, the program will expand community case management for malaria and diarrhea to all six districts.<sup>12</sup> Following more than two years of advocacy on the part of the IRC and others, the MOH has given approval for community case management of pneumonia. The program will pilot CCM for pneumonia in selected health center catchment areas in each district, and then draw on these health centers as resources for teaching and learning to rapidly scale up treatment throughout the project area. Detailed strategies for community case management of each disease are described in Section 4.

**1.2 Reducing treatment costs at community level.** The program will subsidize procurement of amoxicillin and zinc for community case management to reduce the cost of treatment at the community level below the cost of care at health facilities. The PNILP ensures the low cost of Coartem to treat simple malaria through CCM with financing from the Global Fund and increasingly from PMI. Program staff will advocate with districts and nationally for incorporation of community case management into *mutuelles de santé*, the national community health insurance system, to further reduce financial barriers to care, develop long-term strategies for cost recovery, and assure a continued supply of drugs for community case management. The program will also work with CDCs to link households affected by HIV, other chronic illness, loss of a parent, and/or severe financial hardship, to existing services for vulnerable households, such as support mutuelle membership and waivers for other user fees that may constitute barriers to care.

**1.3 Performance contracting for CHW supervision.** Supervision is an essential element of a community case management program. Supervision is an essential element of a community case management program. It serves a vital function in maintaining quality, motivating community workers, and ensuring the timely collection and use of data. EIP Managers will work with their counterparts at the District to establish a functioning, sustainable supervision system. The program will establish performance contracts with each district (described further in Section 3.f.) to ensure frequent and meaningful supervision of CHWs providing community case management. The QA and M&E teams will draw on data from CHW supervision monitoring tools to track service utilization and monitor the quality of care (e.g. age-appropriate treatment, counseling, referrals and follow-up) for rapid detection of quality assurance needs and continuous quality improvement.

**1.4 Quality referral care.** The Program will improve and maintain good standards through quality assurance (QA) methodologies, which are well implanted in Rwanda through the work of the USAID-supported QA Project. Details of the Quality Improvement Strategy are provided in this section 3.f. To promote improved quality of care for cases referred to health facilities, the program will also provide financial support for facility IMCI training for health center staff in Gisagara District. In other districts, facility IMCI training has or will be funded

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<sup>12</sup> N.B. Home based management of malaria will not be expanded into Nyaruguru District because the PNILP has classified this as a non-endemic area and presumptive treatment of fever with anti-malarials is not recommended.  
Rwanda Expanded Impact Program – DIP July 2007

by other health actors within the next year or two; however, the EIP QA and M&E teams will work support the Districts with supportive supervision and assessing performance improvement as well as monitoring case loads, outcomes and drug supply.

## **2. Increasing Coverage of Key Preventive Interventions**

The program will use three major strategies to extend the reach of preventive interventions.

**2.1 Coverage monitoring and targeting at district level.** The project will conduct semi-annual period performance assessments (PPAs) to monitor coverage and progress toward targets. In addition, the program's monitoring and evaluation manager, and the monitoring and evaluation officers in each district, will train and supervise health center staff to monitor coverage of key services in each health center catchment area (using service statistics and population estimates adjusted for population growth). This will take place through discussion of service statistics (HMIS) at monthly DHMT meetings, which bring together HC *titulaires* and NGOs active in health within the district, including EIP staff. Quarterly meetings will be more extensive and will focus on analysis of trends, identification of challenges, and joint problem solving. Data from the PPAs will be available on a semi-annual basis, offering a basis for triangulation and comparison with service statistics. This data and will also be shared and discussed during these meetings. This routine review and discussion of available data will allow district health staff to identify low-coverage areas and remedy problems proactively. It will also motivate health center staff to perform better, through peer acknowledgement of good performance, and by allowing them to rapidly identify and address problems.

**2.2 Essential drug management.** The program's quality assurance personnel will work with partners to insure that systems are in place in each district and each health center to procure, store and distribute key inputs of Coartem, amoxicillin, ORS, zinc, fansidar, ciproflaxin, vitamin A and iron folate with the aim of preventing stock-outs at the health center and CHW levels. The EIP QA team will work with the MSH RPMPLUS team to audit current systems, develop action plans with the Districts to address weaknesses in the system, and strengthen tools for monitoring stocks and forecasting procurement needs. A district drug situation report will be prepared by the QA Officer with the District Pharmacist (or Pharmacy Aide). The teams will apply local problem solving QA approaches to aim towards zero stock-outs at all levels. Problems with central stores availability will be aggressively pursued with the QA Manager in Kigali for resolution.

The program has resources to directly procure zinc, ORS and amoxicillin for CCM use through matching PVO funds for the first three years of the program. Community consultation fees will be established jointly with the IMCI task force; however at the time of establishing this workplan the plan is to maintain consultation fees at 50 Rwf regardless of diagnosis and treatment as is current practice under HBM. Proceeds are split 60% to the CHW association fund and 40% to the Health Center supervision and outreach funds. An ability and willingness to pay for community treatment will be studied by year two of the program in collaboration with the IMCI task force and UNICEF in particular to advocate for and establish longer term strategies to ensure resources for community drug supply.

The program will advocate for the inclusion of community services under social health insurance and exemption programs (e.g. *mutuelles*), or direct cost recovery for longer term

supply. Program staff will facilitate discussions at the district level regarding possible incorporation of community case management into the *mutuelles de sante*. Discussions will focus on the impact of this decision on access and on financial sustainability of the CCM programs, particularly in terms of ensuring continuous drug supply and supervision.

**2.3 Strengthening outreach.** While most households are within one to two hours walking distance of health centers and geographic distance is not the barrier that it would be in many other settings, bringing services into communities nevertheless increase the convenience of these services and is an effective means to improve uptake and coverage. Outreach services are a routine part of all health centers assessed but they focus predominantly on vaccinations only. A few also offer growth monitoring and antenatal care services. The program will work to broaden the range of services offered. Program staff will also review targeting and strategic planning for outreach with COSAs and health center staff to increase coverage and effectiveness of outreach activities.

The program will strengthen outreach through improved coordination between health centers, CHWs, and local authorities related to timing, location, and community mobilization for utilization of outreach clinics. Some CDCs and COSAs are already involved in identification and recovery of immunization defaulters through home visits to encourage participation in immunization campaigns and to reinforce normative messages about the importance of vaccines for protecting children's health. The IRC and Concern's experience in Rwanda demonstrates that these outreach sessions can serve to provide many services.

Program objectives include preventive child health service promotion including the maintenance of high coverage of bednets, child and postpartum vitamin A supplementation which are currently distributed through the formal health services. PSI under support of the Global Fund and PMI ensures supply of low cost nets for antenatal clients, mutuelle members, and children under-five throughout the country. The program will continue build demand and monitor availability and usage of nets in the six districts. Vitamin A supplementation has been traditionally depended on routine campaigns that engage CHWs twice per year. As the government shifts from a campaign centered strategy to a fixed vaccination service approach through the health services, there is a risk that child vitamin A coverage could decline. Strategies for protecting coverage will be established with each District that could focus on semi-annual community level distribution and tracking through CHWs. Reaching postpartum mothers with vitamin A supplementation, a relatively new intervention in Rwanda, through the formal health services along can be challenging given that 61% of women in the area deliver at home. The program will promote early home visits to check on the mother's situation (looking for signs of sepsis and post-partum hemorrhage), provide immediate breastfeeding counseling and other essential newborn care practices and mother within the first 24 hours of birth. The inclusion of postpartum vitamin A supplementation by the CHW during this visit will be studied.

### **3. Increasing Adoption of Key Family Practices**

Kabehe Mwana program will promote the adoption of key family practices for caring and care-seeking for the sick child, feeding and nutrition, and essential newborn care through social behavior change strategies at the household level. The Program is involved in the finalization of these key practices with the national IMCI task force in 2007. An emphasis is placed on

increasing equity for vulnerable households by prioritizing home visits and individualized problem solving for families with children under-two years of age, families affected by HIV & AIDS or other chronic illnesses, and households that have experienced a recent child death, and others identified through community processes.

Activities will include appropriate formative research to identify key obstacles and opportunities, testing of key messages, and the development of related written and illustrated materials, including job aids for CHWs. The behavior change strategy was developed using the CORE/AED BEHAVE Framework (See Section 3.d), and builds on proven approaches and materials from Concern, IRC, and WR CSP programs in Rwanda. The program will focus on passing key messages through formal and informal mechanisms, and through a variety of channels and people, including district, health center, and community health workers. Although nutrition is not designated as a technical intervention within EIP, the program will include activities to promote and strengthen key family practices to round out the complement of household-level Essential Nutrition Actions (ENA) that are critical to breaking the cycle of malnutrition and infection in children. This strategy and related messages will be elaborated during the process of refining the BC strategy towards the end of Year One and the beginning of Year Two.

**3.1 Community mobilization and social behaviour change.** Relationships at the community level are developed through informal meetings and by demonstrating respect through frequent visits, transparency, and involving community members to participatory processes to identify and address community problems. Mobilization officers and promoters will lead the community mobilization effort, engaging all stakeholders at project start up through sector-level meetings with Community Development Committees, Health Center Management Committees, and community opinion leaders (e.g. teachers and religious leaders). The project recruited experienced Mobilization Officers with excellent communication and facilitation skills. The district level project staff are all Rwandan nationals fluent in Kinyarwanda and with a solid understanding of the socio-cultural and political milieu in which they work.

The community mobilization strategy uses many of the approaches outlined in the 2007 National Community Health Policy, such as stimulating community dialogue related to needed improvements in child and maternal health. Through CHWs, promoters, nurses, and project officers, community members will be educated about the purpose of the new program, and the advantages it will bring to the community. Relationships will be developed and nurtured through open and transparent communication with all stakeholders and partners, and concerted effort will be given to building a strong sense of community among the CHWs and program staff. The program will also seek to strengthen CHW associations to improve impact and sustainability of program activities and leadership at the community level.

The program's behaviour change strategy is situated in this wider community mobilization approach. The program uses the BEHAVE Framework to guide planning for behaviour change activities and messaging. The current draft of the BEHAVE Framework, based on qualitative research from earlier CSPs as well as input from staff and partners, is provided below. This will be substantially refined during Year One and the first few months of Year Two through additional participatory qualitative work on key family practices and care-seeking behaviors. CHWs will be trained to counsel mothers and caregivers of sick children and to provide household level health promotion and problem solving through home visits to families with

young children, particularly those identified as vulnerable or at-risk of child death. CHWs will also model desired home behaviors with their own families and children, leading by example to effect community wide shifts in norms. The project will train CHWs to actively assist families to solve problems and overcome logistical as well as knowledge or attitudinal barriers to new practices and care-seeking.

Community opinion leaders and local authorities can reinforce CHW messages, enhance CHW credibility, and “facilitate space” for program activities, for example, by inviting CHWs to speak at community meetings. Throughout the district, EIP mobilization officers will work with COSAs, CDCs and other community entities, such as religious institutions and women’s committees, to build capacity for community mobilization and effective leadership in the project’s activities. Program staff will hold semi-annual meetings with sector-level CDCs to build leadership and technical understanding of child survival interventions, as well as coordinate program implementation in the context of other community mobilization and administration activities. Village leaders, e.g. CDC members, will be involved in such activities as CHW selection, planning meetings, regular monitoring and evaluation activities, and program implementation. These leaders will be consulted concerning program direction, and will receive verbal and follow-up written reports of the community health information data, highlighting the program’s progress and results, and overall impact on maternal and child health. The program’s M&E team will develop and institutionalize monitoring and reporting systems that enable prompt, meaningful feedback to the community level. The program will strengthen CDC and district capacity to monitor and report on key performance indicators, including LLNs, for district performance contracting and efforts to meet MDGs and Rwanda’s *Vision 2020* goals. Across all levels – CHW association or Care Group, CDC, COSA, health facility and districts – program staff will engage local partners in problem solving and increase the use of local data for decision making through data sharing, discussion and joint strategic planning.

### 3.2 Care Groups

The program will establish demonstration sites for World Relief’s Care Group strategy in each of the six districts. The program does not have the financial resources to implement the full Care Group model as described in *The Care Group Difference*, World Relief’s Care Group implementation manual published by CORE in 2005. Instead, the approach is one of testing a modified strategy, documenting processes and outcomes, and developing a streamlined community mobilization process that builds on successes and lessons learned from Care Groups but which can be implemented across a much larger geographic and administrative area with fewer external resources. At the midterm, the program and partners will review these demonstration experiences and distill critical elements of the strategy for a streamlined scale-up of community mobilization activities throughout the project area in the second half of the project’s lifespan.

**Strategy:** CHWs, TBAs (who have been “re-oriented” as maternal health animators), existing distributors, and other community-level health actors who are formally recognized by the health system will be invited to join Care Groups in the designated areas, forming a broader base of support for home visits, outreach, reinforcing BC messages, and problem solving at the household level. Members of the Care Groups will receive continuous bimonthly training and supportive supervision to strengthen the behavior change interventions in the context of a

broader community mobilization strategy. CHWs in Care Group areas will meet bimonthly with EIP staff (promoters) for participatory training and supportive supervision in small groups, resulting in a stronger emphasis on behavior change interventions. In contrast, CHWs in other project areas will meet monthly with CHW sector leaders in larger groups and will receive less frequent supervision related to BC activities. CHWs in both settings will receive quarterly supervision visits by HC-designated CHW supervisors under the project's performance contract with the district; these supervision visits will focus on the community case management component, whereas the promoters will provide supportive supervision focused on the BC strategy and wider range of community mobilization activities.

**Selection of CG areas:** Program staff will work with DHMTs to select two adjacent health centers as Care Group demonstration sites. These two health center catchment areas (roughly equivalent to two sectors) should form one LQAS supervision area in order to facilitate quantitative comparisons between Care Group and non-Care Group areas using baseline, midterm and final KPC surveys. Although lack of randomization in selecting CG areas limits comparability to some extent, transparency and District involvement in selecting sites was deemed important for buy-in and responding to locally-identified priority areas.

**Staffing:** The project will hire three paid promoters to provide integrated training and supervision in the two sectors. One promoter will be hired internally from the pool of promoters in World Relief's previous CSP in the former Kibogora District, and two promoters will be hired locally from the participating sectors.

**Formation of Care Groups:** The promoters will assist the sectors with the selection of CHWs according to the new national guidelines, as in other areas. In areas where the Care Group sites include distributors who were trained in the former CSPs, these individuals will also be recruited into the Care Groups. In addition, EIP promoters will coordinate with cellule-level CDCs and village (umudugudu) leaders to invite other community-level health actors that are recognized, such as TBAs, to participate in Care Groups. These other community actors will focus solely on reinforcing key family practices in the form of household level behavior change interventions, but will not participate in the training for community case management.

**Community health information system (C-HIS):** CHWs in Care Group areas will participate in all program-wide monitoring and reporting systems. In addition, Care Group volunteers (including formal CHWs and other community-level health actors) will gather information from the households they work with to build a C-HIS to provide local data for decision-making and rapid feedback, and as part of an ongoing effort to identify, monitor, and support households that are at elevated risks for child death or poor pregnancy outcomes. Care Group volunteers will also track pregnant women in the households for which they are responsible, to encourage early antenatal care, IPT, delivery in health facility, TT, post-partum Vitamin A supplementation, and targeted messaging about immediate and exclusive breastfeeding within one hour of delivery.

**Opinion Leaders Care Groups:** Community leaders, local administrators, teachers, religious leaders, and other opinion leaders will be invited to join Opinion Leaders Care Groups, which will meet monthly with a promoter. The meetings will focus on (a) sharing content of key messages and encouraging opinion leaders to reinforce key messages in their respective public venues; (b) increasing coordination between CHWs and community leaders for outreach

activities; (c) integration of health programming into ongoing community meetings and activities; and (d) helping local community leaders develop action plans for supporting program activities and improving child health in their communities.

**Assessment and scale strategy:** The program will use process documentation to carefully track the activities in the Care Group demonstration areas to facilitate identification of those elements that can be scaled up in other areas of the district using existing human resources, with support from the district-level program staff (e.g. Mobilization officers). At the midterm, the program will review the experiences in Care Group demonstration areas and develop a detailed implementation plan for scaling up lessons learned to expand aspects of the community mobilization strategy. Following the midterm evaluation, Promoters will turn their attention to the rest of the district and mentor CWH sector leaders, HC-based CHW supervisors, and others to strengthen community mobilization activities. District health supervisors and HC staff from other sectors will also be encouraged to visit the Care Group demonstration sites to learn first hand about best practices for participatory training and supportive supervision based on the Care Group strategy.

**3.3 Improved counselling by CHWs and Health Providers.** Good interpersonal communications between both health providers and caretakers can greatly improve the quality of follow-up care provided at home after the consultation, including adherence to prescriptions, feeding of the sick and recuperating child, awareness of danger signs to look for indicating child needs to return, as well as trials of new preventive family health practices. The multi-country midterm report of IMCI by WHO confirms that while there is tremendous opportunity, caretaking counselling is consistently one of the weakest components of IMCI practices. The 2007 EIP HFA identified confirmed this in the program area where few providers explained how to administer prescribed antibiotics and neglected to check the weight or vaccination status of the child and failed to provide any messages regarding the need to maintain food intake and increase fluids for the sick child. Further, when information was provided regarding administration of Coartem or preparation of ORS, very few caretakers included in the exit surveys were able to mention the name of the drug(s) received, frequency or duration of treatment indicating ineffective communication efforts.

The program will work with the DHMT to reinforce supervision systems and tools, such as exist interviews and clinical observation, to improve and monitor health worker performance, particularly following facility IMCI training. The QA team will review data from these supervision systems during the annual program review. The program will work with district supervisors to improve health worker skills through supportive supervision, including coaching and feedback. The program will work with the national IMCI Task Force throughout these processes. At the level of community case management, all CHW training will emphasize counselling skills. CHW Supervisors will provide supportive supervision, including interviews with mothers of children recently treated to assess patient counselling skills. CHWs will be supported to improve skills through feedback, coaching, and reinforcing key messages.

### ***b. Scale strategy***

The Kabeho Mwana Program is a collaborative effort of CW, IRC and WR, building on the successes and lessons learned from all three partners' previous child survival programs in Rwanda and expands the coverage area by 175% to six of the most underserved districts,

representing 20% of the districts nationally (there are 30 districts) as discussed in the section 1.b. The approach to scale leverages program implementation innovations developed in earlier CSPs and builds on PVO collaboration that dates to a pilot HBM project (2004-2006), funded by CORE and the USAID Mission.

The scale strategy emphasizes replicability in terms of building on standard community and government structures and resources, working with the national IMCI task force and its implementing partners, and finding long term solutions to supply of drug, training and supervision inputs as well as quality improvement processes. For example rather than placing program staff at the community level, the program mobilizes district personnel and community leaders and mothers themselves as facilitators, change agents and service providers while program staff serve as catalysts, quality monitors, and documenters to establish and strengthen the district IMCI system.

The program aims toward scale by broadening the role of CHWs in community case management by expanding their package of services from malaria to also include diarrhea, pneumonia, nutrition counseling, and essential newborn care, furthering the opportunities for lowering levels of child mortality. Program training curricula, health messages and materials, drug supply systems

Following two-years of advocacy effort by IRC and the 2006 National Child Health Assessment, the government has requested the project to pilot pneumonia case management with the aim of integrating it into the C-IMCI strategy. Rather than piloting it in a one-off manner in a few health center catchment areas in one district, four demonstration sites will be established across the early start EIP districts of Gisagara, Kirehe, Ngoma and Nyamasheke.

Working with the IMCI task force which harnesses expertise and operational efforts of multiple actors including BASICS, Twubakane as well as the MoH and the National Malaria Control Program (PNILP) will enable the development of common community case management algorithms, training strategies, health messages, financial strategies, as well as monitoring and evaluation systems that are informed by the expertise and experience of the PVOs. Not only does this improve the quality and practicality of working tools and strategies but it also ensures that approaches applied in the program area will be consistent with national strategy. This is key to ownership and replication nationally of the model developed in the program area.

**Streamlining community mobilization methodologies.** At the onset of the program, there are two different community health strategies at play as described in section 3.a – strategy three. The first being the standard CHW strategy where two CHWs per umudugudu are elected, trained, incorporated in a formal association, and supervised through monthly meetings at the health center. The latter strategy built around WR’s Care Group strategy which organizes greater numbers of mothers as health volunteers and stronger connections with community political, religious, and opinion leaders. Findings from the initial design indicated a formidable price tag of paying salaries for Promoters who are a key part of organizing the Care Groups. In each district, two demonstration sites will apply the wider Care Group strategy with some adaptation from the Kibogora approach transferring some of the community mobilization responsibilities to CHW Supervisors and sector leaders with the aim of developing a lower external human resource cost to establishing this model to facilitate nation-

wide replication. The program will use process documentation, quantitative process indicators, and qualitative inquiry at the midterm to identify essential elements of the Care Group strategy that can be taken to scale using existing human resources in the health system and in local government.

### *c. Behavior Change Strategy*

**Behavior change goals:** The program's broad behavior change goals for mothers and caregivers are as follows: (1) to increase adoption of key family practices for prevention of illness and appropriate home care for sick children; (2) to increase uptake and coverage of key prevention services; and (3) to increase prompt care-seeking from trained providers for children with symptoms of malaria, pneumonia and diarrhea.

The behavioral objectives of the strategies are to:

1. Increase the proportion of children under five with fever in the past two weeks who received anti-malarial treatment according to national policy within 24 hours of onset of fever from 20% to 60%
2. Increase proportion of mothers with infants 0-11 months who received two observed IPTs during last pregnancy from 31% to 80%
3. Increase the proportion of children under five sleeping under a treated mosquito net the previous night from 74% to 85%
4. Increase use of oral rehydration therapy among children with diarrhea with from 19% to 50%
5. Increase use of zinc treatment among children with diarrhea with from 5% to 50%
6. Increase hand-washing with soap at critical times (after defecation, after handling children's feces, before preparing food, and before feeding children/eating) from 2% to 25%
7. Increase the proportion of children provided continued feeding during diarrhea from 22% to 50%.
8. Increase the proportion of children given increased fluids during diarrhea from 36% to 60%.
9. Increase the proportion of children with pneumonia who receive appropriate treatment from 13% to 50%
10. Increase by 50% the number of sick infants under-two months seen at health facilities in the six districts.
11. Increase the proportion of children 6-59 months who receive vitamin A from 66% to 90%

The program uses the **BEHAVE Framework** to guide strategic planning for behavior change activities. Preliminary frameworks with monitoring plans used to develop this overall workplan are included as **Annex H** in this workplan.

**Caregiving and the household production of health:** Good health begins in the home, where caregivers of children make up the largest non-formal workforce in the health system. To influence what happens at home requires a comprehensive approach to behavior change communication, one that engages multiple levels of community organization and decision making for a common goal: healthy children and families. Thus, the behavior change strategy begins by recognizing of the central role of mothers and caregivers in the production of health at the household level. CHWs will be trained to share key behavior change messages and help

families to overcome barriers to adoption of new behaviors. By training and equipping CHWs to provide community case management for malaria, pneumonia, and diarrhea, the program will expand reduce geographic and financial barriers to appropriate care-seeking behavior for child illness as outlined in the specific technical interventions in section 4. The program will also engage in a broad community mobilization effort that will build capacity and leadership of local authorities and community opinion leaders to achieve and sustain improvements in child health and survival in the six participating districts.

While caregivers of children are most likely to be mothers, the toll of HIV & AIDS increases the likelihood that grandmothers and older siblings will also have significant childcare responsibilities. When a CHW visits the home, at least once each month (more often in homes with newborns and infants), she targets the primary caregiver but also welcomes others present in the household. This helps earn buy-in from grandmothers who may otherwise oppose new practices and from fathers who may act as gatekeepers to seeking care outside the home. Male support is also important so that husbands will value and encourage their wives to serve as CHWs. Additional strategies for reaching a cross section of the population are described below.

**Community Health Workers:** Central to the mobilization strategy for promotion of C-IMCI and key family practices is a vast network of volunteer CHWs, with a minimum of two per umudugudu, the smallest grouping of households in Rwanda's new system of civil organization. Each CHW is trained in all program interventions to promote key family practices for C-IMCI in addition to providing case management at community level per MoH guidelines and algorithms developed specifically for use by CHWs.

CHWs are trained and supervised in groups that meet monthly under the leadership of their sector representative. The CHW Supervisors convene the meetings serving as a technical resource, coaching CHWs based on findings from performance supervision, and overseeing monitoring and actions from community health reports. At each meeting they review health education lessons, using culturally appropriate adult education techniques including dialogue, pictures, stories, songs and dramas that are then replicated during home visits and group education. CHWs learn not just to repeat messages, but to respond to the individual situation of each family in their umudugudu, be it managing a present illness, following up on a sick child or helping families to address the problem of barriers to optimal practices.

CHWs do not act alone in the community. Their messages are reinforced and validated by opinion leaders such as teachers, religious and other community leaders who are trained by project promoters to spread consistent messages to a cross section of the community. Given that convulsions associated with malaria may be misperceived as a spiritual rather than medical condition and that many people in Rwanda call on their religious leaders to pray for the sick, equipping spiritual leaders to refer sick children for treatment is critical to community mobilization. Teachers are also widely recognized as opinion leaders and influence older children who are also frequent caregivers for their younger siblings. In addition to reinforcing messages, these opinion leaders create space for the program's activities and lend credibility to CHWs by inviting them to speak at community gatherings.

### ***Operationalization of Behavior Change Strategy***

**Materials and Messages:** Training materials and job aids for CHWs will be adapted from materials developed by the three PVO partners during previous CSPs but will require modification to ensure integration of messages and organization around the IMCI themes, e.g. general danger signs and sick child feeding. Content for respiratory illness will be developed, borrowing from IRC materials from South Sudan. The Mobilization Manager with the WR MCH Specialist based in Baltimore will lead the initial project team review and consultation with the IMCI Task Force for final content decisions.

Additional formative research will be conducted to identify barriers, facilitators, and key messages and to ensure that materials are appropriate for diversity of geographic and social contexts across the six districts which will be completed by Year Two. During the first half of Year Two, WR will manage a public health graduate student field internship to conduct a participatory qualitative inquiry into diarrhea classification and care-seeking to inform the behavior change strategy for expanding zinc treatment. This participatory process will focus on building staff capacity to conduct structured qualitative inquiries for behavior change planning and problem solving throughout the life of the project. During Year Two, World Relief plans a technical assistance visit to refine the behavior change strategy (see workplan). This process will involve local assessments to refine key messages and materials, which will then be disseminated and infused through the program's behaviour change and mobilization network during monthly CHW sector meetings, through supportive supervision visits, and refresher training (in Year Three).

**Communication channels:** The project will use multiple channels of communication to reinforce key behavior change messages and increase adoption of key prevention, home care, and care-seeking behaviors.

1. **Interpersonal communication:** CHWs will conduct home visits to share messages, solve problems, and directly assist families to successfully attempt and maintain key behaviors. Home visits will go beyond information sharing, and will incorporate skills development to enhance mothers' and families' self-efficacy to adopt new behaviors. In addition to home visits, CHWs will counsel families of sick children in key messages for prevention and optimal home care for sick children.
2. **Modeling key behaviors:** CHWs will be encouraged to set a good example by practicing the behaviors they teach about in their own homes. CHWs will also facilitate information sharing between "doers" and "non-doers" to help families overcome barriers to behavior change.
3. **Community gatherings:** Project staff will facilitate coordination between CHWs and CDCs at the cellule and sector levels to reinforce key intervention messages in community meetings. Local leaders have the authority needed to "create space" for project activities. For example, support from CDCs and other local authorities enhance CHW credibility and lend weight to their behavior change messages. CHWs will use culturally appropriate methodologies to share messages, including songs, drama, storytelling, role-playing, group discussions, and real life testimonies.
4. **Mobilizing community opinion leaders:** The project will build on existing community assets and social structures. Mobilization officers and promoters will mobilize community opinion leaders, including religious leaders, teachers, women's associations, chiefs of imidugudu and other traditional leaders, to share key intervention messages with faith communities, schools, and other community associations. Religious leaders will reinforce messages in sermons and through counseling and

referrals for families with sick children. Behavior change interventions will be introduced in coordination with COSAs, sector-level health and social affairs coordinators, and health center staff for maximum reinforcement of key messages.

**Non-communication activities to promote behavior change:** The project will also implement several non-communication activities to reduce barriers and facilitate behavior change. Examples of these activities include increasing access to treatment in the community to facilitate prompt care-seeking for child illness and increasing access to health-related products such as Sur'Eau (PSI point-of-use water treatment product) and ORS. The project will also mobilize families and communities to enroll in *mutuelles de santé*, Rwanda's community health insurance scheme. CDCs at cellule and sector levels maintain lists of indigent households who are eligible to receive targeted assistance when resources are available. The process of identifying and assisting these households has sometimes lacked transparency. To improve equity in the distribution of social welfare resources, project staff will facilitate CDCs and communities to engage in transparent, participatory processes to identify indigent households for targeted assistance with *mutuelle* fees.

The project values the participation and contributions of national, district, sector, and community-level stakeholders. At the **national** level, program staff participate in IMCI Task Force meetings and solicit input from Task Force members for aspects of program design and implementation, including the behavior change strategy. Representatives from the MOH Community Desk, BASICS, Twubakane, and PNILP participated in the DIP Partners' Workshop in March 2007, along with **District** Health Directors, Hospital Supervisors, and representatives from the Mayor's Offices. All participants were actively involved in developing the behavior change strategy and contributed to developing a comprehensive picture of household- and community-level barriers and facilitators that influence the behaviors for which EIP will set program targets. At the **sector** level, the community capacity assessments included a discussion with selected cellule-level CDCs were asked to give feedback on past experiences and recommendations for community mobilization activities. Finally, when the project begins implementation at the **community** level in April 2007, program staff and district counterparts will hold sector-level meetings to introduce EIP and the C-IMCI strategy. These meetings will also provide a forum for local authorities and community opinion leaders to provide feedback on the community mobilization component and behavior change strategy.

#### **d. Capacity Building & Sustainability Strategy**

**Capacity building:** The program will build the capacity of staff as well as community, district, and national level partners in technical and leadership areas. Capacity building is essential for reaching the program's objectives and for assuring sustained improvements in maternal and child health. The three PVO partners, MoH, CHWs, and communities must all work together to build institutional, community and individual capacity in order to effectively design, implement, monitor and evaluate its health-related interventions.

Specific objectives for capacity building include:

- To strengthen involvement of 5000 Community Development Committees (CDCs) in health activities and CHW support
- To ensure CHWs are supervised in their working areas at least four times per year

- To build capacity of 440 CHW associations to play a leadership role in community health
- To build technical knowledge and training skills of district health authorities, HC staff, and CHW Supervisors to train and supervise CHWs in effective behavior change activities.

Capacity building activities will involve:

- Establishing performance contracts with districts to enable health centers to hire CHW Supervisors to conduct frequent supportive supervision and monitoring visits;
- Assessing existing quality of care for selected health services
- Identifying means of increasing coverage and utilization of services
- Strengthening the link between the community and health services by reinforcing the COSAs role as an intermediary and information conduit between community members, CHWs, and health facilities.
- Promoting the efficient use of data collected for appropriate decision making through prompt and meaningful feedback to the health facility, sector administrators, CHWs, and community levels.

**CHW associations:** In addition to the peer and social support that comes from being part of a group, the CHWs have many sources of motivation to remain in their role. Benefits include social standing, public recognition from community leaders, regular training opportunities, small incentives that help to identify them as CHWs, copies of picture cards to be used in health education during home visits, and membership in CHW associations. CHW associations are very popular in Rwanda. Members share profits from community treatment activities, LLN sales and the like to fund member-determined income-generation activities. The regular review of community health information data also serves as a motivating factor, because it helps CHWs to see the impact of their efforts. WR has extensive experience with successful retention of large numbers of volunteer CHWs in Rwanda (94 percent of volunteers in CSP Umucyo remained active throughout the five years of the project). The midterm evaluation will include a CHW motivation assessment building on tools available from MSH/RPMPLUS to identify motivation factors and gaps to support the team in strengthening motivation strategies.

**Sustainability** The program will apply the Child Survival Sustainability Assessment framework to further develop a detailed strategy for sustainability. The sustainability vision and broad goals will be established during the first annual review and a measurement framework solidified during the second annual review.

Essential elements to be included in the framework were identified during the DIP and included:

1. Community level
  - a. Build capacity for local problem solving among CHWs, community leaders and households with young children at the umudugudu level
  - b. Establish routine reporting system on key child health data
2. Health Service Delivery
  - a. Build skill and enable HC staff to train and supervise CHWs
  - b. Build skill of CHWs to provide CCM and maintain accurate records

- c. Build COSA leadership for community-oriented health services
  - d. Ensure sound management of essential drugs and commodities
3. Local organizations
- a. Strengthen CHW associations
  - b. Develop CDC leadership in health
  - c. Develop church leadership in health
  - d. Reinforce mutuelles associations

### **e. Training Strategy**

The overall training plan will address four levels: community health workers, caretakers, district health personnel, and the EIP staff themselves. The strategy focus is to ensure the transfer of skills to the Community Health Workers and their supervisors at the Health Center level. Additional capacity building is focused on the District Health Units ability to manage child health from the community level up to the referral hospital level with emphasis on drug management system, health information system utilization, supervision and quality control on case management.

Planning for all trainings will include learning objectives based on a needs assessment, methods, core content as well as a training evaluation plan. Each training plan will be developed by the responsible EIP Manager with oversight of the Team Leader and will be reviewed and strengthened by the relevant US based technical backstop well in advance of the training event. EIP will collaborate with BASICS on community case management and MSH/RPMPLUS on drug supply management components of all training curricula related to each relevant training component.

#### Element One: Strengthening CHWs

The **core training strategy for community case management** consists of the following stages:

1. Refining training package and supporting CHW materials with the national IMCI Task Force
2. Training a set of master community trainers who will comprise of one District Supervisor and the QA Officers from each of the six districts
3. Training of Trainers for the selected District CHW Supervisors to establish local training strategy for CCM (led by the master trainers)
4. Orientation to the HC based CHW Supervisors will focus on core competencies of supportive supervision including interpersonal communications, quality assurance forms, and expectations and standards for performance incentives. Each CHW is expected to be supervised in his/her community every six months.
5. Roll-out of training of CHWs in small groups of 15-20 on community case management, including reporting and drug management as well as key health messages. While the CHW Supervisors will take a lead in organizing the training at the Health Center, at least one Master Trainer will be present to ensure the quality. Certification of CHWs to provide CCM will be based on a pass/fail performance test following the training.

CHW training will be rolled out in stages according to prior experience of the CHWs in CCM (e.g. in parts of Gisagara and Nyamasheke, CHWs already providing HBM services, in all of Kirehe and Ngoma CHWs providing malaria and diarrhea treatment, in the new

areas of Gisagara and Nyamasheke not included in the previous Child Survival efforts as well as all of Nyamagabe and Nyaraguru, CHWs have no experience with CCM. The plan is summarized in the table below:

**Table 11: Roll-out Plan of CCM training for CHWs**

<b>Districts</b>	<b>Malaria</b>	<b>Diarrhea</b>	<b>Pneumonia</b>
Gisagara (old Kibilizi)	Refresher with introduction of Coartem (1 day) (yr 1/qtr 4)	CHW Diarrhea with malaria refresher (3 days) (yr 2, qtr 1)	CHW Pneumonia (2 days) (Yr 2/qtr 2)
Nyamasheke (old Kibogora)	Refresher with introduction of Coartem (1 day) (yr 1/qtr 4)	CHW Diarrhea with malaria refresher (3 days) (yr 2, qtr 1)	CHW Pneumonia (2 days) (Year 2/qtr 2)
Kirehe	Refresher with introduction of Coartem (1 day) (yr 1/qtr 3)	CHW Refresher on diarrhea and malaria (2 days) (yr 2, qtr 1)	CHW Pneumonia (2 days) (pilot HCs yr 1/qtr 3; others yr 2 qtr 2)
Ngoma	Refresher with introduction of Coartem (1 day) (yr 1/qtr 4)	CHW Refresher on diarrhea and malaria (2 days) (yr 2, qtr 1)	CHW Pneumonia (2 days) (pilot HCs yr 1/qtr 4; others yr 2 qtr 2)
Gisagara (non-Kibilizi)	CHW Diarrhea with malaria (4 days) (yr 2, qtr 1)		CHW Pneumonia (2 days) (yr 2, qtr 3)
Nyamasheke (non-Kibogora)	CHW Diarrhea with malaria (4 days) (yr 2, qtr 1)		CHW Pneumonia (2 days) (yr 2, qtr 3)
Nyamagabe	CHW Diarrhea with malaria (4 days) (yr 2, qtr 2)		CHW Pneumonia (2 days) (yr 2, qtr 4)
Nyaraguru	CHW Diarrhea with malaria (4 days) (yr 2, qtr 2)		CHW Pneumonia (2 days) (yr 2, qtr 4)

- Annual CHW quality improvement reviews will be conducted by the EIP Officers and District Supervisors at each of the Health Centers to thoroughly review CCM performance, supervision and drug management situation, prioritize areas for improvement and develop a shared action plan. This event is also useful in recognizing highest performers (both among CHW Supervisors and CHWs themselves). It is noted that these areas are monitored and discussed on a monthly basis; however the annual review is conducted in a more evaluation type forum and feeds into the EIP internal annual reviews. Refresher training is included in these annual reviews, focusing on problematic areas.

The chief benefit of introducing several treatments at once is that it gives an opportunity to prepare community health workers for co-treatment—that is, knowing how to prioritize and co-treat when children present with more than one symptom. For example, it is clear that nearly every child presenting with rapid respiration will also present with fever; it is important that community workers understand that such a child needs to be treated with both an antibiotic and an anti-malarial; likewise, many children with malaria also have diarrhea, and need an anti-malarial as well as zinc and ORS. However, such integrated training may be more difficult for community workers to absorb. EIP staff will work with their counterparts to pilot integrated

training on a small scale, and determine if such a method can be used more widely, including in the two Districts to be added in the second year of the project.

#### Element Two: Health Education and Skill Building for Caretakers of Young Children

CHWs and Care Group members are the primary channels for influencing health awareness, attitudes and practices among caretakers for young children at the community level. The project works directly with these community actors to analyze the local situation develop and field-test health messages as well as delivery strategies.

While these issues are covered in the initial malaria, diarrhea and pneumonia training, a series of refresher and specialized orientations are covered during the CHW and Care Groups' routine meetings where they practice the messages and then develop plans to reach households with the information at more intensive levels through home visits and community dialogues.

#### Element Three: Strengthening Health Providers and District Health Managers

Messages are complemented by the providers at the Hospital and Health Center level particularly during counseling periods. While most of the District Health Unit (Health Director, Hospital Director, Supervisors, and Pharmacist) capacity strengthening will be conducted through on-the-job training through "peer" program implementation with the EIP Officers, some trainings are planned as outlined in the Training Plan in section 7 (M&E skills for HC, advanced data analysis skills for District personnel; practical applications in quality assurance, and advanced community mobilization skills).

EIP will collaborate with Twubakane and FHI with support systems following facility IMCI training for Health Center and Hospital personnel. This support includes strengthening quality of district supervision, improving management of district and HC management of essential drug supplies, and application of quality assurance processes. Due to an absence of partner agencies, EIP will organize and complete the facility IMCI training for Gisagara with the District's trainers by year two.

#### Element Four: Strengthening Skills of EIP Staff

Ensuring the capacity of project staff to fulfill their critical functions is essential function of the Team Leader, Managers along with the Technical Backstops. While overall performance reviews will identify skill gaps, the use of frequent field activity supervision with coaching as well as capitalizing on the quarterly staff meetings to review and discuss program strategies as well as technical interventions are key vehicles. Readers should refer to Section 6 as well as the content areas for staff training in the Training Plan in Section 7.

*The detailed training plan is presented in Section 7 indicating content, participants, duration, facilitators, and numbers and timing of training sessions by district.*

#### **f. Quality improvement strategy**

The main objectives for continuous quality assurance in the program are:

1. Improve the quality of community case management of uncomplicated malaria, pneumonia, and diarrhea performed by trained and supervised CHWs and ensure referral of complicated cases

2. Establish functional essential drug supply systems with the districts to efficiently manage preventive and curative child health commodities (vitamin A, anti-malarials, ORS, zinc, and essential antibiotics)
3. Improve targeting and increase breath of preventive child health services through outreach
4. Advocate for concise, effective, integrated protocols for community case management and long term drug supply
5. Strengthen review and action processes for community-based health information between CHWs, health facilities and community leadership to improve child health outcomes

The strategy functions at the community, health facility and district and program levels with linkages between each of them as outlined here:

At the community level, CHWs will be directly supervised in their working area by the CHW Supervisor who will review registers, drug supplies and follow-up with recent clients to assess quality of work and identify areas for improvement. A supervision checklist will be used for these purposes and maintained at the Health Center. All CHWs performing CCM are certified by the training team based on a standardized test demonstrating ability to identify very sick children requiring referral, to diagnose and classify, to provide correct medications (drug and dose), and to counsel the caretaker.

CHW performance will be reviewed and discussed during routine meetings with the CHW supervisor on a monthly basis. This is based on a review of reports of cases and referrals by the CHWs as well as findings from direct supervision. Problems regarding application of care guidelines, drug supply, and interpersonal communications will be identified early and addressed during these meetings. Minutes of the meetings including a monthly community report will be written and compiled by the EIP staff and District Supervisors. Issues beyond the control of the group will be raised to the District level by these persons.

At the district level, the QA team will strengthen District Health Supervisors and HC personnel skills in supportive supervision, problem identification and solution planning through joint supervision, coaching, and establishment of essential supervision checklists for performance monitoring. Every year the QA Manager will lead a case review with at least two CHW Supervisors to assess level of analysis, problem solving related to CCM by the CHWs. This will be further exploited during the more thorough annual CHW quality improvement reviews conducted at each Health Center bringing together all the CHWs. Here community and HC child health care reports will be consolidated and rigorously reviewed to highlight strong and weak areas, select key performance improvement areas to address, analyze barriers and opportunities, and establish a team action plan with targets and monitoring plan.

The QA Officer will work directly with the District Pharmacist (or Pharmacy Aide) to review the supply management chain for essential commodities required for the program interventions at community level as well as front-line drugs for IMCI and focused antenatal care at the Health Center level (Coartem, amoxicillin, cotrimoxazole, ORS, zinc, vitamin A, Long Lasting Nets, vaccines, fansidar and iron folate). The two will work together to strengthen store management, distribution of commodities to HCs, management of supply to CHWs, as well as procurement planning and monitoring. EIP is working with the MSH/RPMPLUS team in Kigali to standardize working tools for this process in year one.

At the policy level, EIP is fully engaged with the national IMCI task force in the establishment of simple and safe standard guidelines for assessing, diagnosing and treating the sick child

under five years of age as well as delivering effective counseling to the caretaker on treatment and feeding of the child. The Team Leader is the point person on the task force who works closely with her Managers and the HQ based backstops to promote global best practices into these standards and tools.

The availability of drugs at the community level is dependent on willingness of families to pay, provision of free and subsidized supply by donor programs, as well as good management by the CHW and the Health Center discussed previously. The QA Officers will study the costs, willingness to pay, and long term donor supply of these drugs under the leadership of the QA Manager and with technical support of the MSH/RPMPLUS team to lay out strategic options for long term supply at the community level. The findings from this assessment will lay the foundation of a likely advocacy push to include CCM services in the mutuelle benefits which currently only include services at the health center and hospital levels.

Supervision and performance contracting is an essential element of this community case management program. It serves a vital function in maintaining quality, motivating community workers, and ensuring the timely collection and use of data. The EIP Managers will work with their counterparts at the District to establish a functioning, sustainable supervision system, with the following standards and procedures:

- EIP will provide each District a monthly lump-sum contract payment for supervision, based on the number of health centers involved in community treatment.
- In return, Districts will be responsible for a number of deliverables outlined in a signed performance contract. These deliverables will include:
  - o Each health center has hired a CHW Supervisor. He/she should be someone already living in the health center area with a primary school education (based on IRC's experience, in other countries, that the motivation and attitude of a supervisor are more important for good performance than a clinical background).
  - o Every CHW attends at least one monthly meeting with peers; this meeting is facilitated by the CHW Supervisor or another health center staff. This meeting is used to collect data, re-supply community workers, and provide feedback on performance.
  - o Each supervision is recorded in an appropriate checklist, and that filled checklists are regularly entered into a database for analysis and feedback
  - o This data documents that each community health worker is supervised in her or his home at least once every quarter.
- A transportation allowance will be built into the amount for each health center. Districts and health centers will be responsible for determining the best mechanism for transport in any given area. For example, in some areas it may be possible to pool the transportation allowance over a year period and purchase bicycles; in others supervisors may prefer to receive the amount in cash and travel by their own means.
- Performance on the contract will be assessed by analysis of supervision data and by field visits by EIP Officers who will verify the accuracy of supervision checklists.

#### **g. Innovation, access and equity**

The real **innovation** of Kabeho Mwana is its effort to establish a replicable, effective community case management focused service to reach sick children that is supported by empowering community mobilization approaches that aim not only to increase access to Rwanda Expanded Impact Program – DIP July 2007

prompt care and treatment but also works towards enhancing prevention of child illness through key family health practices. Special components of the program include the demonstration of Care Group approach in each district; strategies to establish affordable drug supply at the community level; simplification of CHW working tools such as case management algorithms and reporting forms; as well streamlining essential newborn and HIV & AIDS interventions into the C-IMCI strategy.

**Access and equity strategy:** Emphasis on ensuring that all members of the population, particularly the poor and most vulnerable members have access to health services is central to program design. Vulnerable groups are outlined in section 1.f, comprising primarily of the landless, female and child headed households, orphans, and families affected by HIV and other chronic diseases or disabilities. CHWs will collaborate with the CDCs to map all households and classify their level of vulnerability, targeting them for existing social support such as free mutuelle membership, social funds and microcredit, and other social service subsidies. Future health surveys will include equity measures using the FANTA Household Dietary Diversity Score (HDDS) tool to determine the extent to which health service coverage and key family practices are reaching the poorest households.

#### **h. Collaboration with other actors**

Collaboration with national and district health and development actors is described in the section 1.g. “Linkages and complementary activities”. The process for managing collaboration is detailed in the Management section 6.d.

Kabeho Mwana operates in four of the USAID Rwanda’s priority districts for reproductive and child health. From the program’s inception, consultation with the local mission has been constant. Upon notification of recommendation for funding, CW, IRC and WR did a joint presentation to USAID and other child survival partners in early June 2006 This presentation outlined the program’s goal and the intervention areas. It also gave the chance to discuss issues of collaboration with other USAID partners in the six districts and also at national level.

Draft workplans were shared with the USAID mission for comment and suggestions. A more detailed presentation was made to the relevant mission staff (Health, Population, Nutrition Officer and the Maternal and Child Health Specialist). A specific meeting was held with USAID and Twubakane to clarify the roles of EIP and the Twubakane project at the various levels (National, District and community). This presentation was then shared with the MOH Maternal and Child Health Task Force. Meetings were held with Mission staff during visits from the three backstops (November and April) in order to provide updates on progress with the workplan for the first year and the design and implementation of the baseline surveys.

USAID mission staff attended the two main workshops that were held for the project – an orientation workshop in December 2006 attended by Mayors and Heads of Health and the March DIP partnership workshop for District representatives and other CS partners. The project contribution to USAID CSHGP’s program results in outlined in the M&E section.

As from December 2006 there have been numerous consultative meetings with the USAID Mission PMI Coordinator, and more recently with PNILP as well, to discuss how the project’s malaria activities fit with the PMI planned activities and to discuss workplans for year one. A copy of the preliminary workplan submitted earlier this year is included as Annex K .

Reviewers should note that this was created prior to the completion of baseline studies and development of DIP and thereby subject to change.

#### ***4. Intervention Specific Approach***

##### **a. Malaria Prevention and Case Management**

###### **i) Objectives and indicators**

Malaria prevention and case management represents a 35% level of effort in Kabehe Mwana. The specific objectives are to:

- Increase the proportion of children under five with fever in the past two weeks who received anti-malarial treatment according to NMCP policy within 24 hours of onset of fever from 20% to 60%
- Increase proportion of mothers with infants 0-11 months who received two observed IPTs during last pregnancy from 31% to 80%
- Increase the proportion of children under five sleeping under a treated mosquito net the previous night from 74% to 85%

###### **ii) Baseline situation recap**

The health system's current performance is highest overall for malaria interventions. Key findings include:

- **Malaria is by far the most commonly diagnosed of childhood illnesses;** this is true even in the three Districts with higher altitude and lower transmission. Most of the data used for analysis, however, are from before the large bed-net distribution campaign completed in September 2006, and which appears to have significantly reduced the number of malaria consultations at health centers.
- **Treatment coverage is lower,** with 20% of children under five getting appropriate presumptive treatment within 24 hours of the onset of fever. **However, several elements indicate a potential for substantial improvement.** First, coverage without a time limit is close to 40%, suggesting that focusing on speeding up treatment could bring improvements. Secondly, areas in which the community treatment approach has already been implemented have substantially higher coverage, with 65% of children in Kirehe, for example, reporting getting appropriate malaria treatment (including 32% within 24 hours). The project's strategy of extending this strategy is likely to yield substantial improvement.
- **Treatment quality is good,** with the vast majority of children treated for fever at health centers getting the right treatment, including appropriate counseling on taking Coartem.
- **Utilization rate for community treatment,** where it is available, **is several-fold higher than it is for facility treatment.** This provides further justification for the project's strategy of expanding access by providing treatment at the community level.
- **Bednet coverage is particularly high** at 74%, thanks mostly to a nationwide distribution campaign organized by the National Integrated Malaria Control Program; the child survival project's will to use the community health worker network, and a switch from a campaign to a routine approach, to maintain and further increase coverage for this highly effective intervention.

- **Intermittent presumptive treatment (2 doses) is relatively low** at 31%, but here again **there is potential for rapid, substantial improvement**. Three in five women get at least one IPT dose; it appears the main reason for the drop-off between one and two doses is that women come late for their first dose, and cannot complete a second visit. Thus results could increase substantially by having women come earlier for their first prenatal visit.

The MoH policy recommends three major strategies to lessen the burden of malaria: the use of LLNs for prevention, particularly among vulnerable groups including pregnant women and children under five; early diagnosis and treatment with combination therapy using Coartem; and, more recently, intermittent preventive treatment (IPT) during pregnancy with SP, which was incorporated into Ministry policy in February 2005. EIP's approach is consistent with all three MOH recommended strategies.

### **iii) Promotion of protective practices**

**Sleeping under insecticide treated bednets:** Awareness of the connection between mosquitoes and malaria, as well as LLN use for protection from malaria, is nearly universal among adults in Rwanda. In light of the very high rate of net ownership, the program will build on this high level of awareness and net ownership to promote LLN utilization by pregnant women and children under five through mobilization efforts by local leaders, CHWs and other community resource persons (refer to community mobilization section above). The project will also work with CHWs and health facilities to ensure that vulnerable groups, particularly pregnant women and new mothers who were not covered in the 2006 campaign, receive nets through routine service delivery points such as antenatal care and postpartum check-ups.

Behavior change messaging will emphasize the protection of vulnerable groups (children under five and pregnant women) and key messages will address barriers and reinforce positive factors identified through stakeholder input and previous qualitative research. CHWs will reinforce key messages in community meetings and home visits, and will provide direct assistance to families for installing nets in a variety of housing conditions.

**IPT:** Malaria is endemic in Rwanda, and pregnant women are at high risk of asymptomatic infections, which can have serious effects on newborns. The national policy is to provide two doses of IPT with Sulfadoxine-Pyrimethamine (SP/Fansidar) at the health center, during the first antenatal visit, and the second observed dose one month later to reduce the burden of parasite infection of the placenta and adverse fetal outcomes. CHWs will follow and encourage care-seeking for ANC among pregnant women in the households for which they are responsible. CHWs will counsel all pregnant women to attend antenatal care frequently and to start early. Mothers will learn that by receiving IPT early in pregnancy they can reduce the risk of perinatal death and low birth weight babies. At the health facility level, the program will include IPT in strategic planning and processes to improve quality, particularly with regard to ensuring that pregnant women receive two appropriately-timed doses of SP to ensure optimal effectiveness for the prevention of malaria during pregnancy.

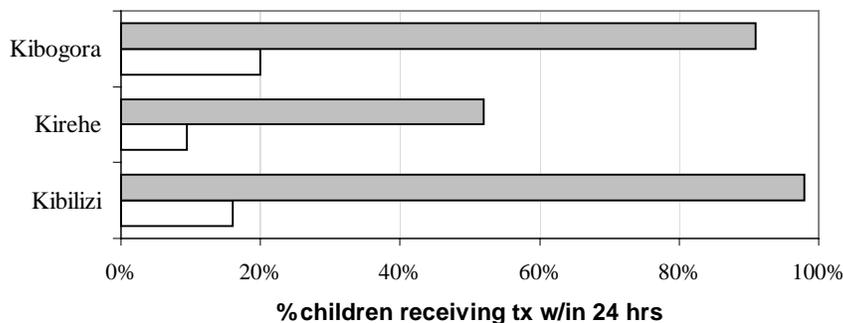
### **iv) Care-seeking and case management**

**Prompt care-seeking for fever:** There is a need to improve the timeliness of seeking care outside the home for children with fever, including newborns. Group talks and individual

interactions between CHWs and the families they serve are an effective means of raising awareness about the importance of immediate medical consultation. Experience from the home-based malaria treatment pilot demonstrated that a key factor in families seeking care from a trained provider in less than 24 hours of the onset of fever is the availability of trained and equipped CHWs who are able to manage simple, uncomplicated malaria near the home.

**Community case management of uncomplicated fever:** Community case management of malaria is a national health priority, and has been incorporated into the C-IMCI protocols following pilots in six districts. This effort was supported by CSPs with NMCP leadership, and financed by USAID, Belgian Technical Cooperation, and the CORE Group. The effort resulted in significant increases in prompt management of fever as shown in the below figure (white bars indicate baseline situation in 2003 and the grey bars for 2006).

*Impact of community treatment for fever*



This community based approach to case management for uncomplicated fevers in children will be scaled up and implemented through CHWs who will each serve a unit of 30 households grouped in an *umudugudu*). A three-day malaria training curriculum was developed under the previous program and will be reviewed with national stakeholders and adapted to include other major childhood diseases (see training plan). The curriculum includes basic facts about malaria transmission and prevention, the screening and treatment algorithm, counseling skills for CHWs, record-keeping and reporting and stock management. The curriculum will be adapted to accompany the introduction of Coartem for community case management of fever, which is described in further detail below. In addition to case management, CHWs will also emphasize optimal feeding practices for sick children, including continued feeding and increased fluids during illness, and increased recuperating feeding for at least two weeks following an acute illness.

Using quality assurance principles, the program will build the skills of district trainers to train, coach, and supervise CHWs in their working areas. The Program Managers will convene a national training of master CCM trainers who will conduct in liaison with PNILP and the IMCI task force TOTs for CHW Supervisors and District Supervisors in each of the EIP districts. Specific training of CHW plans will be set by the district trainers but will ensure standards of training CHWs in small batches of 15-20, certifying skills upon completion of training, and composition of training teams for each of the batched trainings. Supervision and quality assurance of training will be overseen by the EIP QA team with support of their district-based Officers.

The **case management algorithm** is for children aged 6 to 59 months; infants under six months with fever are referred to the health center for appropriate care. CHWs will screen sick children for danger signs of severe illness that require treatment at the health center, including convulsions; loss of consciousness; vomiting more than three times or vomiting everything; inability to drink, breastfeed, or eat; tiredness, inability to stand; cough with fast, rapid breathing; and/or severe anemia or pallor. Children will be referred to the health center due to young age and/or severe illness as well as non-responsive treatment to ACT. Health centers are equipped to treat with second line anti-malarials.

There is a significant overlap between the clinical presentation of malaria and that of pneumonia. A recommendation of the 2006 Rapid Child Health Assessment was to include community treatment for pneumonia in CSP programming, building on the fact that diarrhea and malaria treatment standards are already in place. However, CHWs will not be expected to distinguish between the two, but rather to treat both conditions if children present with symptoms that meet treatment criteria for both. The consortium is negotiating a special study with USAID IR 2 and CORE to assess the clinical overlap on community treatment, and to make recommendations for the treatment algorithm in 2007.

To improve the quality of prescribing practices of anti-malarials for children and caretaker compliance, NMCP/PNILP developed red blister packets of AQ/SP for children aged 6 to 36 months and yellow packets for 36 to 59 months. In November 2006, PNILP introduced Coartem as the standard first-line drug for treatment of simple malaria in health facilities, and preparations are underway to make Coartem available for HBM beginning in May 2007. New blister packs are currently being developed for Coartem. The first treatment is directly observed by the CHW. Drugs will be procured by CHWs from the health center pharmacy according to their registers of cases treated.

The CCM component will be closely monitored as described in the M&E section with the crux of the system based on CHWs will meet monthly with the health center manager and health district representative to provide a report on the number of cases seen, and the numbers treated, referred, and of deaths in the past month.

**CHW Supervisors** will conduct will include quarterly CHW community visits to review record keeping, prescription and follow-up practices, conduct follow-up home visits of recent clients, and review of drug availability and condition.

The national **drug supply strategy** for anti-malarials has improved considerably in the past year. PNILP, MSH, and PMI are working together with support from the Global Fund and USG to ensure continuous supplies of Coartem in health centers and for the expansion of CCM. The program is collaborating with PNILP in support of Rwanda's proposal for Global Fund Round Seven funding, which is essential to the continued availability of drugs, particularly in areas not covered by PMI. PNILP is developing blister packs for age-specific doses of Coartem for use in community case management. To enhance sustainability, all drugs used for HBM will be procured through CAMERWA with support from the national-level donors and distributed to CHWs from HC pharmacies/stores.

**Introduction of ACTs for community case management:** In November 2006 Coartem became available for management of fever/malaria in health facilities. In May 2007, PNILP

under PMI funding will pilot community case management of fever with Coartem in five districts, including one EIP district (Kirehe). An assessment of these pilot areas is planned for fall 2007 and will guide PMI's expansion of ACTs to HBM programs in other districts in Rwanda. Also in May 2007, PNILP will begin supplying ACTs to areas covered by existing HBM programs but still using AQ/SP. For EIP, these areas include: Ngoma District, the area formerly known as Kibogora District in the new Nyamasheke District, and the area formerly known as Kibilizi District in the new Gisagara District. As Coartem becomes available in these areas, EIP will train district and HC staff to conduct a three-day refresher training for CHWs who became HBM distributors under previous CSPs. CHWs in new parts of Nyamasheke and Gisagara Districts, which were not covered by previous CSPs, will be trained in a five-day course to provide home based management of fever using Coartem. PNILP plans to extend CCM for fever to Nyamagabe; EIP staff will conduct an integrated TOT and oversee training of CHWs in integrated management of fever, pneumonia, and diarrhea in Nyamagabe. Malaria is not endemic in Nyaruguru and as such, the area will not be included in national expansion of HBM for fever. CHW training for this area will focus on promotion of preventive practices (LLNs and IPT) and prompt care-seeking from trained providers for fever in children.

The cost of treatment at the community level was set by the National Home Based Malaria Technical Committee, which was determined to keep the price low and affordable so as to avoid barriers to drug access. To date, MoH has succeeded in finding donors to cover the pilot stage of this initiative. CHWs charge a fee of 50 Rwf (US\$0.08, modest even by the standards of rural Rwandese communities) per treatment, and 60% of the revenue is returned directly to the CHW association and 40% to the health center as a performance incentive. This standard price will be maintained in the expanded program.

**Referral to health facility for severe malaria:** Referral level care for fever is available at local health center for complicated malaria and other causes of fever. The 2007 EIP HFA examined the quality of care provided and identified areas requiring improvement. While EIP's primary focus is at the household and community level, the program will coordinate with other partners such as the NMCP, the Twubakane Project, and the Ministry of Health to improve the quality of care for severe malaria cases in health facilities. Both Gisagara and Nyamasheke Districts are not supported by Twubakane Project funding for health facility IMCI. As no other donor is active in Gisagara, EIP will cover the cost of completing facility IMCI training for the remaining eight health centers in the district (four have already been trained). Family Health International (FHI) is active in Nyamasheke District and will cover the cost of facility IMCI training for district and facility levels there. IRC has already contributed funds to support facility IMCI training in Kirehe District. Twubakane will pay for facility IMCI training in Ngoma, Nyamagabe and Nyaruguru.

**Equity of access:** Mutuelle enrollment facilitates access to care at the facility level; families who are covered by the mutuelle are more likely to follow up on referrals from CHWs to seek care at the health facility for complicated malaria or for children with IMCI danger signs. Mobilization officers will work with sector-level CDCs to facilitate a participatory community process to identify very poor households who should receive assistance with mutuelle fees. This approach was chosen to enhance transparency in the pursuit of equity in the distribution of social welfare assistance, as the process is perceived to have been influenced by personal connections in the past. Program staff with extensive experience working at the community

level felt that this transparent process would not stigmatize or shame those who are identified as indigent, since people who are not among the very poor sometimes seek out this “indigent” label in order to be eligible for assistance. As described above, the program will also advocate for incorporation of CCM services into the mutuelle system, which will further increase access

## **b. Diarrhea Prevention and Control**

### **i) Objectives and indicators**

Control and prevention of diarrhea represents a 35% level of program’s total effort. The specific objectives are to:

- Increase use of oral rehydration therapy among children with diarrhea with from 19% to 50%
- Increase use of zinc treatment among children with diarrhea with from 5% to 50%
- Increase hand-washing with soap at critical times (after defecation, after handling children’s feces, before preparing food, and before feeding children/eating) from 2% to 25%
- Increase the proportion of children provided continued feeding during diarrhea from 22% to 50%
- Increase the proportion of children offered increased fluids during diarrhea from 36% to 60%

### **ii) Baseline situation recap**

The health system’s current performance is poor for most of the diarrhea interventions. Key findings from the baseline studies include:

- **Utilization of health center for childhood diarrhea is extremely low:** Diarrhea is prevalent among children (14%) of which one in five (18%) caretakers report presences of blood in stools; however very few are seen at the formal health services and less than one in five mothers of children with diarrhea in the last two weeks reported getting appropriate ORS treatment, and even this may be an overestimate. Health center records indicate less than 0.03 visits per child per year for the first half of 2006, whereas DHS and other data indicate that children are likely to have more than one episode of diarrhea per year.
- **Quality of care for diarrhea at health centers appears adequate,** with some three of four children seen getting appropriate ORS care. However, this is lower than for pneumonia and diarrhea treatment, and only half of the children surveyed received appropriate counseling.
- **Community treatment dramatically increases utilization.** In areas where community treatment is available, utilization is more than six-fold higher. Also, **community treatment for childhood diarrhea does not appear to reduce facility utilization**— facility utilization for diarrhea in areas in which community treatment is available is close to 50% higher.
- **Zinc does not appear to “replace” ORS.** ORS use is more than double in areas in which zinc treatment is available.
- **Community treatment is not enough.** Community treatment increases the number of children who access appropriate diarrhea therapy, but, even with this increase, utilization is

much lower than it should be, less than 0.3 cases per year per child. More work is needed to convince mothers to seek treatment for their child, even when the diarrhea is mild and does not worry caregivers.

- **Hand-washing coverage is extremely low.** This is due in part to a newer, much stricter definition used in the revised CATCH indicator, which requires a regular hand-washing place and the presence of soap. Hand-washing prevalence is much higher –though still low– in areas where the Care Group strategy has been used.
- **Appropriate liquids and feeding during episodes of diarrhea is poor,** with about a third of children getting increased fluids during illness, and one in five getting continued feeding.
- **Vitamin A coverage is relatively high** at 66%. Most vitamin A is currently delivered through campaigns, however, which are expensive and disruptive to the health care system.

Control of diarrhea disease will be addressed through culturally appropriate health education and increasing access to products and services. Strategies will include promotion of: key home practices for prevention (e.g. hand washing, proper disposal of feces, latrine use, safe water use), appropriate home care practices (increased frequency of breastfeeding, continued feeding with increased frequency of small portions, use of home available fluids for ORT), and care-seeking for diarrhea treatment with zinc and ORS.

### iii) Promotion of Key Family Practices for Prevention

The program will train CHWs to effectively promote the adoption of following key prevention behaviors:

*Optimal breastfeeding practices: immediate, exclusive and complementary.* **Immediate breastfeeding** is low with only one in three newborns (38%) are breastfeed within the first hour following birth in the project area while *exclusive breastfeeding* of infants to six months is nearly universal. Misbeliefs about colostrum and separation of mother from the newborn at birth at the health facility and during home visits are important barriers. Project staff will promote optimal breastfeeding through interpersonal communication with expectant and new mothers and community mobilization to reinforce consistent messages about breastmilk as optimal nutrition for children under six months and to decrease pressure from influential groups (such as husbands, grandmothers, and other opinion leaders) who may advise mothers to offer the child other foods or fluids. CHWs will promote early breastfeeding through home visits at day one of delivery. Key messages will focus on: helping mother to put newborn baby to the breast within the first hour; exclusive breastfeeding for the first 6 months (no other liquids), breastfeeding on demand, day and night (i.e., usually 8-12 times/day), and adequate time at each feeding, optimal complementary feeding starting at 6 months and continued breastfeeding until age 2 or beyond.

**Hand washing** with soap is essential to prevent transmission of enteric pathogens. The program will use behavior change communication and community mobilization to promote hand washing with soap or appropriate substitutes (e.g. ash). The BC strategy for hand washing includes interpersonal communication about the importance of hand washing for diarrhea prevention, key junctures for hand washing to prevent transmission of pathogens. CHWs will teach mothers and caregivers to wash hands after defecating, before preparing food, before eating/feeding children, and after handling children's feces. Building on WR's

success in Kibogora Health District, where hand washing practices increased from 34% to 94% from 2001 to 2003, CHWs will also mobilize families to establish “hand washing stations” in their homes. These stations are a specific place in the household with clean water and soap in a receptacle, such as a bottle or bucket with soap/ash, that allows washing to be done frequently without separate trips to a distant water source. In addition to household level health education and problem solving to facilitate hand washing, community opinion leaders will be mobilized to reinforce key messages in community gatherings.

Safe storage and effective treatment of drinking water are important strategies to prevent transmission of diarrheal agents. ***Point-of-use (POU) water treatment*** is an effective and popular strategy to improve the safety of drinking water. PSI Rwanda distributes a POU product, *Sûr'Eau*. In the previous WR CSP, the program partnered with PSI to supply *Sûr'Eau* to the program’s Care Group network for community-based sales. PSI supplies the product to health centers or other designated distribution points where it can be supplied to community-based distributors through the same system that is used for drugs used for community case management. PSI experienced a gap in supply between September 2006 and April 2008, but expects to have *Sûr'Eau* back on shelves in Rwanda within the next month. During the Diarrhea training, CHWs will learn how to use and promote the product. Collaboration with PSI to develop a detailed plan for supplying and tracking sales of *Sûr'Eau* by CHWs has been initiated. CHWs will also learn about alternative strategies for treating drinking water, such as boiling and solar irradiation, to assist families who cannot afford to purchase a packaged POU product.

***Latrine use and safe disposal of children’s feces*** are also important for prevention of diarrhea. CHWs will promote latrine use and maintenance, and safe disposal of children’s feces (see TRM for what is allowable). The program will not provide direct assistance for latrine construction, but will rather leverage existing support for latrines. Latrine coverage is one of a select set of health-related indicators that are tracked and reported by local administrative bodies, such as cellule- and sector-level CDCs, rather than or in addition to monitoring by the health system. (Other examples are LLN ownership and cultivating a kitchen garden). CDCs have the power to fine households that do not have an adequate latrine; however, in the case of widows or other indigent households, the CDC will usually provide assistance with latrine construction rather than levying a fine. The program staff will work with the CDC to ensure that indigent and vulnerable households are reached through existing channels for assistance with latrine construction. Program staff will also mobilize community opinion leaders to reinforce key messages about latrine use, maintenance, and strengthen positive social norms for household and community hygiene.

In addition, promotion of Vitamin A supplementation (see Pneumonia case management) also contributes to diarrhea prevention and management.

#### **iv) Promotion of Key Family Practices for Home Care**

CHWs will be trained to promote the following key practices for home care for children with diarrhea. Messages will be shared through home visits and other health education venues, and reinforced in households with sick children and during counseling when care is sought (see below).

**Early recognition of signs of dehydration** is important for initiation of appropriate home care behaviors and in prompting decisions to seek care outside the home, whether at a facility, from a qualified community-based provider, or in the private and/or traditional sector. CHWs will be trained to recognize and will teach mothers to recognize and respond to the following signs: sunken fontanel, slow skin pinch, general weakness or loss of appetite, and dry lips.

**Essential nutrition actions** for care of sick children include: continued feeding, increasing the frequency of breastfeeding, and offering increased fluids during illness; as well as “catch-up” feeding for two weeks following the illness episode. Key messages will include aggressive continuation of feeding during diarrhea, with increased frequency of feeding of small amounts of food to eight or more times daily. For children not exclusively breastfed, use of available food-based fluids (such as soups, rice water and yoghurt drinks, but not including heavily salted soups or very sweet drinks) immediately after diarrhea episode is detected and/or use of ORS and increasing fluids is recommended. Mothers will be encouraged to give extra fluids until the diarrhea stops by offering frequent small sips from a cup, and if the child vomits, to wait 10 minutes and then continue more slowly. Recommendations for children exclusively breastfed include continued breastfeeding in small amounts during diarrhea and catch up breastfeeding with increased frequency and amounts following the diarrhea episode.

**ORS/ORT with home available fluids** The project will promote care-seeking for diarrhea and encourage mothers to administer ORS mixed from UNICEF low-osmolarity packets with water that has been stored safely and properly treated. CHWs will also learn about alternative home available fluids (such as rice-based gruels) for ORT when ORS is not available.

**Rational drug use:** CHWs will be trained to discourage the ineffective and often harmful use of antibiotics and antidiarrheals. The program will increase access and promote care-seeking from qualified community-based providers (CHWs). WR staff observed that private drug sellers in the former project area often went out of business as care-seeking shifted to trained CHWs. The program will reinforce rationale drug use messages at the health center level through QA processes.

**Vitamin A for children and new mothers:** EIP staff and partners will work with Districts and national Ministry officials to integrate vitamin A provision into routine practice. At the moment, the government relies primarily on campaigns to achieve high vitamin A coverage. Such a strategy has benefits, but it is inherently fragile, since campaigns are sponsored on a case-by-case basis, and do little to boost coverage among new mothers. The EIP strategy will use the following strategy:

1. EIP Managers will advocate for CHW authorization to distribute vitamin A. Such authorization should not be difficult to obtain, since the majority of distribution during campaigns is already done by community workers.
2. CHWs will be given a small stock of vitamin A, and monitor the vitamin A status of all children under five in their work area. They will be trained to record this status on the child’s immunization card, and to give vitamin A to any child under five who has not received vitamin A in the last six months.
3. Similarly, CHWs will give vitamin A to all new mothers within a few days of delivery, and record this dose on their register and on the child’s new card.

4. Senior EIP staff will document the results of this strategy and advocate for allocation of money from the national level to fund this strategy, from resources normally allocated to campaigns.

**v) Community Case Management for Diarrhea**

All children who present to CHWs with diarrhea will be assessed, treated with zinc and ORS as appropriate/specified below. Very young infants under two weeks and children who present with IMCI danger signs for seeking immediate care will be referred to the health center for assessment and care.

**Assessment and referrals:** CHWs will be taught, according to the C-IMCI protocols, to look for signs of dehydration by checking eyes, lips, thirst, and respiration rates; to check for fever to exclude possible co-infection; and to identify cases for referral. All young infants with diarrhea less than two weeks of age and any child exhibiting danger signs (blood in stool, signs of severe malnutrition, acute watery diarrhea with dehydration, and persistent diarrhea lasting 14 days or more) will be referred to health facilities for appropriate care.

Building on the IRC's successful experience with the introduction of *zinc treatment for diarrhea* into an existing network of HBMF distributors in Kirehe and Ngoma District, the project will expand access to community case management with zinc for children with diarrhea throughout the six EIP districts. CHWs will provide zinc treatment (10-day supplementation during and after diarrheal episode) for children 2-59 months with diarrhea. CHWs will be trained to provide quality care including appropriate management of co-morbidities. Children presenting with fever and diarrhea will receive both anti-malarials and zinc, even if the diarrhea can be attributed to the presumed malaria. The same approach will be used for children with pneumonia (diagnosed according to IMCI criteria) and diarrhea, who will receive both amoxicillin and zinc. The treatment algorithm is as follows: 20 mg of elemental zinc daily for 10 days to children 6 months of age or older, and 10mg per day for 10 days to children under 6 months of age. Mothers will be counseled to give the zinc tablets once a day for the full 10 days. Zinc is procured by the project from Nutriset for the first three years working. The project will work with UNICEF and the IMCI Task Force to promote longer terms strategies for supply through CAMERWA, stored in health center pharmacies, and supplied to CHWs during monthly meetings in blister packs of 10 doses.

In all both the IRC and WR CSP areas, CHWs were trained to sell/distribute **ORS**. This intervention will be new in Gisagara, Nyaruguru, Nyamagabe and part of Nyamasheke districts. As zinc treatment is introduced, CHWs will be trained to provide both zinc and ORS to children with diarrhea. All children with diarrhea will be treated with ORS. Supply by the CHW will be based on two-day treatment as follows: children under two years – 500 ml/day; children two to five years 1000 ml/day.<sup>13</sup> CHWs will be trained to demonstrate accurate measurement and preparation of ORS to mothers/caregivers. Children under two weeks will be referred to the health center, and mothers will be encouraged to increase breastfeeding of all children with diarrhea who have not yet been weaned. For children exclusively breastfed, mothers will be encouraged to give ORS or clean water in addition to breastmilk. For children not exclusively breastfed, mothers will be encouraged to give one or more packets of properly mixed ORS. CHWs will distribute the low osmolarity ORS that was recently introduced by

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<sup>13</sup> MoH protocols from IMCI module consultation, September 2005  
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WHO and UNICEF. ORS is in principle supplied by UNICEF to the MOH, stocked in health center pharmacies, and supplied to CHWs on the basis of past or projected sales. However, a buffer stock for the first three years is planned by the PVOs based on actual field situation.

Initially all child consultations under CCM will be subject to a small fee 50 Rwandan francs (about \$0.08), inclusive of drugs and supplements regardless of diagnosis and treatment. The proceeds from drug sales will accrue to the CHW association, rather than to the individual CHW as described in section 3.a – strategy two. Under performance contracting with the districts, CHW Supervisors will monitor stocks of zinc during routine supervision visits to provide quality assurance for supply and maintenance of stock monthly. CHWs will be equipped with a mixing jug, drinking cup, and spoon for mixing and administering ORS.

In addition to providing zinc and ORS treatment, CHWs will *counsel mothers to reinforce key messages for appropriate home care* for children with diarrhea. Key messages will be to increase frequency of breastfeeding, to offer increased fluids, to continue feeding the sick children (in small, frequent feedings), and to increase food and fluids for two weeks following the diarrheal episode to reduce the impact of illness on the child's longer term nutritional status and growth. CHWs will make *follow-up home visits* to families with sick children to encourage adherence to zinc regimen, and reinforce messages/assist families to adopt key home care practices, and promote continued attention after the illness episode for catch-up feeding.

#### vi) Quality Assurance

*CHWs* will receive an initial training of 16 hours, which includes demonstration on accurate measurement and preparation of ORS to mothers and caregivers as well as the inclusion of zinc as part of treatment. Ongoing commitment to quality will be promoted through review of cases and role play during routine CHW meetings with the CHW Supervisors. The supervisors will also conduct direct supervision of CHWs on a quarterly basis that will include register review, verbal review of treatment algorithms, and spot checks with mothers of recently treated children to assess whether CHWs are providing correct home care advice to mothers of sick children. Due to the greater complexity of causes and management of diarrhea in infants, children under four months will be referred to health facilities for assessment and care. The program is coordinating with the national IMCI Task Force and other health actors for facility C-IMCI training to improve quality of referral care.

The protocols and QA strategy are consistent with *MOH recommendations* for home care and treatment of diarrhea in children under five. MOH policy on treatment of dehydration concurs with the WHO promotion of oral rehydration treatment (ORT) using either a prepared solution of ORS or a recommended home available fluid (such as rice gruel), as well as offering increased liquids to sick children. Recommendations for continued feeding during illness and catch-up feeding following illness are consistent with WHO/UNICEF C-IMCI key family practices that form the basis for the MOH C-IMCI messages.

The program will ensure the supply of drugs, including ORS and zinc (through UNICEF). Through performance contracting with districts for CHW supervision and in coordination with the Health Center Management Committees (COSAs), the program will monitor drug supply at the level of health facility pharmacies and individual CHWs. This system will also ensure that

CHWs receive timely supplies of both ORS and zinc in keeping with utilization/sales rates. CHWs participate in routine meetings at the sector level (roughly equivalent to a health center catchment area) and have regular contact with health centers, which are consistently within a 2-3 hour walk from intervention areas.

### **vii) Equity and Access Strategy**

The program will improve access to ORS and zinc treatment for diarrhea through community case management, reducing geographic barriers to seeking care from qualified providers equipped with appropriate drugs for quality case management. Given the global evidence that fees for service serve as a barrier to health service utilization, this program takes a strong stance in favor of free or deeply subsidized community care. Financial barriers will be reduced by maintaining very low fees for treatment by CHWs (50 francs per treatment, roughly \$0.08). To ensure sustainability of supplies beyond the program, the program will engage in advocacy and facilitate discussions in each district to promote the inclusion of community care services through the country's health insurance "*mutuelle de santé*."

CHWs will promote equity of access for prevention and home care behaviors by (a) encouraging CDCs to assist indigent and vulnerable households with latrine construction; (b) teaching alternative water treatment methods for families who cannot afford POU water treatment products; (c) promoting ash as a substitute for soap among families who cannot afford commercial soap; (d) discouraging use of anti-diarrheal products and antibiotics, thus reducing expenditures on ineffective or harmful products among families who may be concerned about going to the health facility because of the cost of care; and (e) encouraging mutuelle enrollment and transparent processes for identification of indigent households by CDCs for assistance with mutuelle fees.

## **c. Pneumonia Case Management**

### **i) Objectives / Indicators**

Pneumonia case management represents a 30% level of program's total effort. The specific objectives are to:

- Increase the proportion of children with pneumonia who receive appropriate treatment from 13% to 50%
- Increase by 50% the number of sick infants under-two months seen at health facilities in the program area
- Increase the proportion of children 6-59 months who receive vitamin A from 66% to 90%

### **ii) Baseline situation recap and strategy**

The health system's current performance is weak regarding pneumonia as indicated from the following baseline highlights:

- **Utilization of pneumonia treatment is low.** It is not entirely clear how low, as information from the KPC and from health center reports does not correlate well. Less than one in seven KPC respondents indicated proper treatment for a respiratory illness, as compared to one in five for diarrhea, whereas health centers reported seeing many more cases of pneumonia (classified as "lower respiratory tract illnesses"), and the health facility

assessment showed five in six of these treatments to be done correctly. The difference is likely due to several factors. First, as per clinical protocols, children with cold symptoms without respiratory distress should not get antibiotics, and would be classified as correct treatments; with the KPC tool, it is harder to distinguish real pneumonia from upper respiratory symptoms, so more children may be classified inappropriately as treated incorrectly. Secondly, in the KPC, several children were marked as not receiving appropriate antibiotic treatment because they received cotrimoxazole instead of amoxicillin, whereas in fact cotrimoxazole is still accepted as correct treatment by the Ministry of Health. Third, diarrhea treatment was higher because, in two of the six Districts surveyed, it is available at community level: indeed, if community treatment areas are excluded, KPC coverage for diarrhea falls to 12%, below the figure for pneumonia treatment. Of note, health center reports suggest that utilization of health centers for childhood pneumonia is much higher for Nyamasheke—more than double the overall average.

- **Quality of pneumonia treatment appears reasonable**, with 83% of children getting correct treatment, according to the health facility assessment. However, less than a third of parents sampled in the health facility assessment had received appropriate counseling and there were issues with administration of non-front line antibiotics (amoxicillin) despite availability in stock.
- **CHWs are not equipped to detect or treat pneumonia**, while the HBM malaria algorithm includes referral of children with fast, difficult breathing, they have no timers to accurately assess who could have pneumonia. To date there has been no community case management for pneumonia in the country.

The proposed intervention includes four major components: **prevention of pneumonia** through zinc treatment and through distribution of vitamin A; **promotion of prompt care-seeking** for respiratory symptoms; **community case management**, including treatment and referral; and **improvement of quality** at facility level.

The program includes activities designed to prevent and treat pneumonia. **Preventive activities** include zinc treatment for diarrhea, which is described in the diarrhea section, vitamin A supplementation for children and postpartum moms, and maintenance of high vaccination coverage. This helps reduce mortality from pneumonia and other infectious diseases. Zinc treatment is described in more detail in the Diarrhea section. **Treatment activities** will include providing first-line antibiotic treatment at the community level (amoxicillin), improving quality of treatment for complicated cases at health facilities, and promoting prompt referral of complicated cases, particularly for infants less than two months of age. The following diagram outlines how project staff and partners, including communities, will work together to decrease mortality from pneumonia.

### iii) **Community case management**

The IMCI task force has begun the process of defining norms and drafting tools, after community pneumonia treatment was approved in principle in December 2006. Amoxicillin has been determined as the first-line antibiotic by the MoH in order to preserve cotrimoxazole for the prevention and treatment of opportunistic infections in people living with HIV. Community health workers will use the same first-line protocol as facility providers; the



protocol is spelled out in the table below. A child’s respiratory rate will be measured using a UNICEF-built timer especially designed for this purpose (see figure). The EIP QA and M&E Managers and the IRC backstop will provide additional support to complete this task, using existing WHO documents and protocols from IRC and BASICS (largely adapted from WHO documents in other countries).

The following table represents WHO recommended treatment *UNICEF timer* guidelines.

<u>Age Group</u>	<u>Criteria for treatment</u>	<u>Amoxicillin treatment</u>
Children 2-11 months	> 50 breaths per minute	125 mg three times/ day for 5 days
Children 12-59 months	> 40 breaths per minute	250 mg three times/ day for 5 days

As described earlier, the MoH has recently sanctioned the field demonstration of CCM using pneumonia in a subset of the project area. This will be conducted in year one in four health center catchment areas with selected CHWs in Gisagara, Kirehe, Ngoma and Nyamasheke for a period of three months. Results of the pilot will be thoroughly documented and shared with the IMCI task force to determine implications for national roll-out through C-IMCI. This workplan has been developed under the scenario that roll-out through the entire six district area is recommended.

The planned training strategy for CHWs is described in sections 3.e and 7 with the pilot areas conducted in year one and the remaining areas in year two. It will cover the assessment and treatment algorithm, general danger signs, integrated management with malaria and diarrhea, counting respirations, counseling, when to refer, record keeping, and drug supply management.

CHWs will learn how key danger signs that caretakers of children need to know such as fever, cough with difficult breathing, fast respirations, and/or chest indrawing and promote these as described in the behavior change strategy in section 3.c.

**iv) Referrals**

Referrals to health centers have been a major issue in community case management efforts to date. Few of the children referred by CHWs actually arrive in health centers, because of families’ concerns about distance, cost, and quality. EIP staff and partners will make it a priority to address this issue, since pneumonia mortality is particularly high among young infants which should be referred for more aggressive treatment at the health center. They will do so through a three-step strategy:

1. The EIP M&E team will establish a system to measure referrals, including outcomes with the IMCI task force. Draft protocols were shared at the April 2007 consultation. This system will consist of a self-copying transfer register, with one copy staying in the community worker’s book, and two copies going to the health center with the patient. Of these two copies, one will be kept at the health center and one will be sent back to the community worker with comments and information about the case. The project’s health information system will capture the number of children referred, the number of these that actually make it to the health center, and the number of counter-referral forms given back to the referring community worker. It will also track the number of sick

- infants under-two months seen at the health center and strive towards better diagnosing and recording pneumonia cases.
2. District and EIP staff will use this system to assess the situation, and identify low-referral areas.
  3. District and EIP staff, led by the Quality Assurance team, will work with community member and health center staff to analyze the reasons for low referral, design solutions, and pilot those solutions.

The CHW Supervisor will be visit each CHW once per quarter in their communities as previously described. Supervision reports and CHW reports will be closely reviewed, particularly during the initial pilot.

#### v) **Supplies**

**Timers for CHW:** will be initially procured in bulk from UNICEF with matching funds. An initial supply has already been purchased and is ready for use in-country for the pilot. Given the limited lifespan of 10,000 counts or three years due to the non-replaceable battery, one set of replacement timers are budgeted by the project for Year Five. The functionality of timers will be checked during quarterly supervision and replaced as needed. The project will advocate for national replacement of timers to UNICEF and also explore options through the CHW association funds (the cost is just over \$4 per timer including shipping from China).

**Amoxicillin:** EIP is actively finding a supply of amoxicillin in scored tablets (250mg tabs that can be easily broken in two for young child dose) which is not yet available in country (currently talking with international pharmaceutical providers, including IDA, to get quotes on the provision of scored tablets in age-specific blister packs). Once at least one supplier has been identified, arrangements will be made through CAMERWA, the government's central pharmacy, for price negotiations and importation. Blisters will then be passed along the existing supply chain of District and Health Center pharmacies as described previously. The project has the provision to finance community supply for the first three years and will advocate for longer term sourcing systems.

CHWs will report on amoxicillin supply and timer functionality in their monthly reports. The drug supply report at the District, HC and community levels will be reviewed and forecasts made by the QA Officer with the District Pharmacist. Stock-outs will be acted upon immediately through local quality assurance processes.

#### vi) **Quality assurance in communities and health facilities**

The team will use the quality assurance approach described at the outset of the intervention section, involving small teams working within health centers, Districts, and the program area to identify problems and test solutions. The teams will address several issues particular to pneumonia treatment, including:

- Proper treatment of young infants once at the health center, including provision of intravenous antibiotics
- Appropriate assessment of pneumonia at the health center, including the use of timers and IMCI criteria in lieu of current practices, which are variable and centered on stethoscopes. EIP will provide at least two timers for each health center in the program area.

- Transition from the current widespread use of cotrimoxazole in facilities to the new first-line treatment, amoxicillin
- Proper instructions to parents to improve compliance with the five-day treatment course
- The use of job aids to improve accuracy in dosing, and compliance.

Quality at the health center will be tracked through quality assurance indicators, such as indicators for correct assessment and treatment. Refer to M&E Plan in Annex G.

#### **f. Addressing barriers to access**

The program will improve access to immunizations and vitamin A supplements and assess coverage with special attention to stratification across all wealth groups using HDDS and local mapping to promote infection prevention. Access to first-line treatment with efficacious antibiotics for pneumonia will be enhanced through community case management, reducing geographic barriers to seeking care from qualified providers equipped with appropriate drugs for quality case management. Given the global evidence that fees for service serve as a barrier to health service utilization, this program takes a strong stance in favor of free or deeply subsidized community care. Financial barriers will be reduced by maintaining very low fees for CHW consultations at 50 francs per treatment (roughly \$0.08) including CCM treatment. CHWs and CDC members will promote membership to mutuelles and funding schemes to improve affordability of families with young children, including matching indigent families with mutuelle fee exemption schemes.

### **5. Program Monitoring & Evaluation**

#### **a. Current information system in the target area (community, district, region, etc.)**

The main health information system currently being used in the program area, as in all of Rwanda, is the GESIS. Health center managers report their monthly clinical and other activities to the District in paper form; District staff enter the information into GESIS, an Access-based program developed by a Belgian University and in national use in Rwanda since 1998. District pass on the information by diskette or flash drive to the national level. The information includes clinical consultation data organized by age group and disease; data for preventive activities such as prenatal visits, immunization, and growth monitoring; and financial data such as income and expenses. It includes almost no community data.

Some changes have affected the GESIS system, with more changes due soon. In 2006, the Rwandese government decentralized and re-organized its local governance system, putting health within the realm of a larger administrative District. The new Districts have less than half the health staff of previous health districts and with an average of 33% more health facilities to cover; in practice, the reduced staff have not been able to keep up all their reporting duties. The Ministry of Health is currently planning an overhaul of the GESIS system, most likely based on MS-SQL Server, a more powerful, server-based version of Access.

There are other health information systems in use which are of interest to the child survival program:

- The government's **TracNet system** is a server-based on-line information system designed to monitor HIV programs. Health center managers communicate data about the number of

patients treated, and supply of key inputs, using cell phones; central and District planners can then access the information through a web page. The system functions well technically, but has been plagued by poor data quality. It is designed and maintained by a private US company, Voxiva, with funding from CDC.

- The National Integrated Malaria Control Program's **community health information system** serves to record data related to community treatment of malaria. Community providers record data for each patient in a simple register (see picture) with duplicate pages; they then give one of the duplicate pages to health center staff, who compile the information to the District, which compiles it again and passes it on to the national office, where the information is entered in a simple Access database. In addition, each of the organizations involved in implementing the community malaria treatment program (including Concern, the IRC, and World Relief) has the option of entering the data separately for its own District for its own uses. The strength of this community information system is that the registers are user-friendly, and the register's self-duplicating mechanism has worked well. The weakness of the system is in its computer data-entry: this data-entry comes very late in the system, at the national system, and the database is not user-friendly, or routinely accessible to most of the actors in the system.

In addition, there are several efforts underway to create or upgrade community information systems.

- The government is looking to integrate community health indicators into its routine reporting system, as this system is being overhauled; this system, which is reportedly still in a very early phase of design, would include both health and non-health community information. In its present form, the system does not include many data points needed by the expanded impact program.
- Twubakane has hired consultants to design a complete community health information system; the consultants have produced draft forms, which were piloted on a small scale and are currently being revised.
- The IMCI Working Group, with support from BASICS, has been developing a reporting system for community IMCI activities. Draft manuals and forms have been produced, and are currently being reviewed by partners. These systems all have considerable overlap with each other. The Ministry of Health is working to insure that the systems complete rather than compete with each other, but has been constrained by limited staffing.

In this context of multiple concurrent efforts to improve community health information systems in Rwanda, EIP has a unique opportunity to be a full partner in building the national community health information system in Rwanda. EIP managers are working with partners, including the Ministry of Health (both the HIS and IMCI groups), the National Integrated Malaria Control Program, and Twubakane, to assist in developing the national community health information system, and insure that any new system meets the needs of EIP program. We are working on the following elements:

- Registers: EIP staff are advocating for expansion and adaptation of the existing community treatment system developed by the national malaria control system.
- Database: Given that there is no common community health database, we are working to develop a database on UNICEF's DevInfo platform; both Twubakane and the IMCI working group are aware and have approved this development. This interface is compatible with the MS SQL-Server database envisioned by the Ministry of Health. If the database proves successful and well suited to the needs of all partners, it can be integrated

with minimal efforts into the general information system.

The new program's information system is based on the experiences of all three PVOs in their previous child survival projects. The M&E team, including the technical advisor, reviewed registers, data, and database formats from Kibilizi, Kibungo, and Kibogora, analyzing both strengths and areas in which more work was needed. The system also builds on the National Malaria Control Program's information system. In general, the new system conserves much of the existing register system, which has been working well, adapting it to use for treatment of three rather than one disease, while developing a more powerful and less error-prone electronic database.

The new community information system will be integrated with the facility system in several ways. First, as outlined above, the new database can be integrated into the larger Ministry of Health database. Secondly, and most importantly, the systems can be integrated at District and health center level, when managers and supervisors review community information along with facility data, integrating both to improve decision-making. For example, managers may look at facility and community utilization rates to determine areas of high malaria prevalence, which can be prioritized for prevention activities.

#### ***b. Measurement Framework***

**See Annex G**

#### ***c. Ensuring data quality***

##### KPC Surveys and Periodic Performance Assessments (PPAs)

Managers and supervisors will ensure data quality by:

- Giving enough time for surveys, to avoid interviewer fatigue and to give enough time for thorough field-testing of the questionnaire
- Adequate training (at least a full week) prior to assessments for skill building
- Intensive supervision: we will insure that each questionnaire is reviewed at least once by another person while still in the field
- Use of PDAs to reduce data entry errors.

##### Monthly data from health centers and CHWs

Managers and supervisors will ensure data quality by:

- Providing user-friendly registers with large print and easily recognizable icons
- Analyzing the data monthly, and providing feedback, including on inconsistent or surprising results
- Supervising each community worker at least once a quarter, to insure that registers are filled in neatly, and that the data is accurate (this will be verified by interviewing the caregivers of children treated by the community worker).

#### ***d. Monitoring tools and methods***

The program will use three major monitoring methods, as described in the proposal:

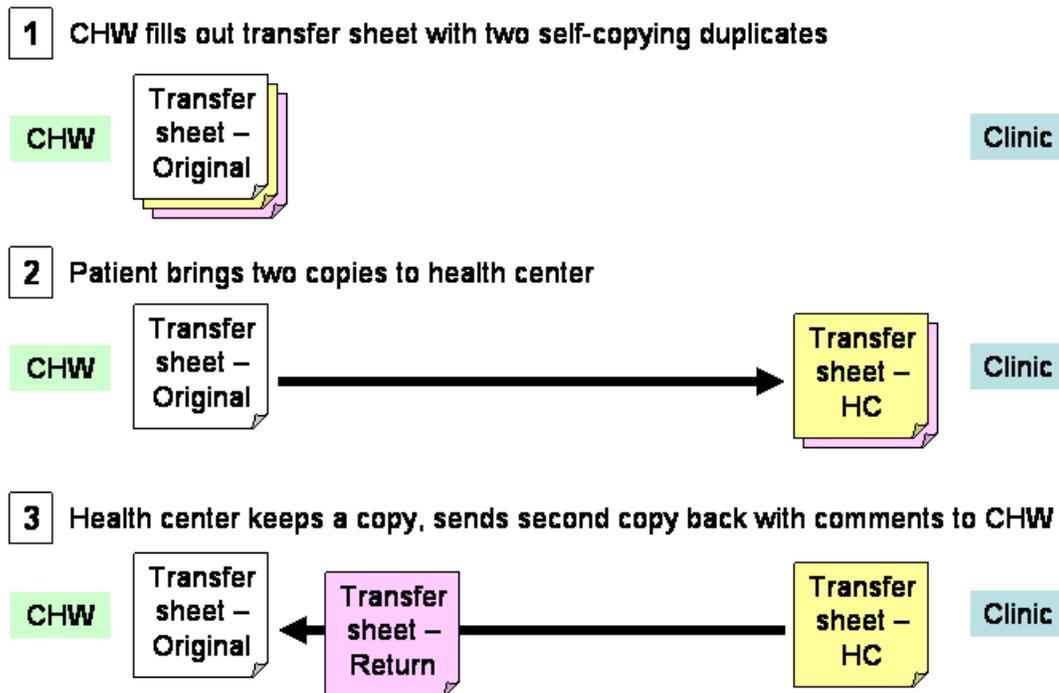
**1. Periodic performance assessments (PPAs):** Program staff and partners will conduct a qualitative and quantitative assessment of the program's performance every six months, Rwanda Expanded Impact Program – DIP July 2007

modeled after World Relief's Local Rapid Assessments. The assessments will have as their basis as shortened KPC questionnaire, including only those indicators that will be the focus of efforts in the previous and following six months of activities. We will use LQAS sampling: staff in each of the project Districts will chose 19 points at random; data from all six Districts will be put together to get an overall estimate. Staff from District and health centers will interview mothers at each of the 19 points over a two-week period, as they travel to the selected communities in the course of their regular work, to collect qualitative and quantitative data. Districts that are under-performing will be identified using LQAS cut-offs. Teams will gather at district and national levels to review the data gathered and make recommendations, and the M&E Manager will produce a written report.

**2. CHW monthly reports:** CHWs will continue to record information about the treatments they give, using treatment registers adapted from the ones currently in use. As with the current system, they will give a copy of each register sheet to their supervisor at the health center. The supervisor will compile the information and pass it on to the District, where it will be entered in a database. (EIP Monitoring and Evaluation Officers will also pilot the introduction of PDAs: some health centers supervisors are given a PDA, which they will use the information directly, leaving District supervisors to download the data.) District supervisors will analyze the information and prepare graphs, which will be used to give feedback at health center and community level. District supervisors will also pass along the information at national level, to Ministry of Health as well as EIP Managers, for further review.

CHWs will have two other registers, which will also be compiled at the health center. The first is a transfer register, which will be used to track all children transferred by the CHW. The family of the child transferred will be given two copies of the transfer sheet, with a third copy remaining in the CHW's register. The family will give the two copies to the health center or hospital: one will be returned with comments to the CHW, the other will be kept at the referral facility. The sequence is illustrated in the figure below.

**Figure: recording of transfers between CHWs and clinics**



CHWs will also have a mortality register. They will give the family of the deceased person a small sheet with basic information: name, age, gender, date of death, and location of death, as well as any information about the circumstance and cause of death. The CHW will remain with a second copy of the death certificate, and will pass on a third copy to the health facility, where basic information will be entered in the database.

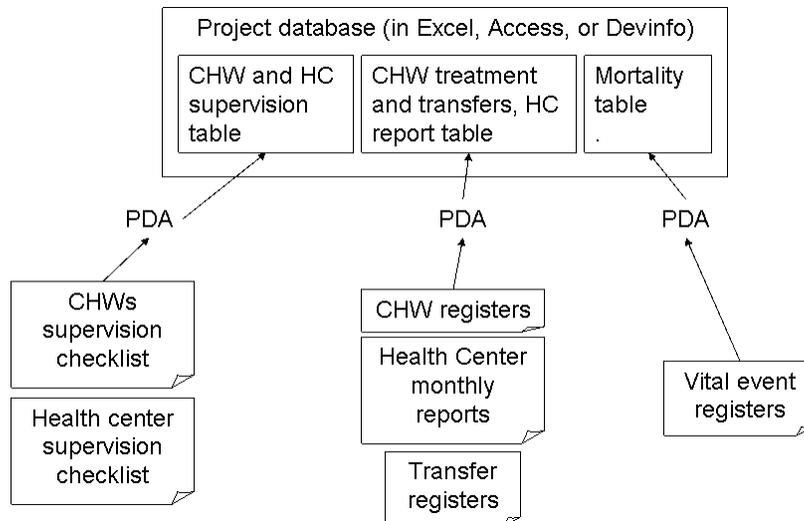
As noted at the beginning of the M&E section, the tools and registers are being developed in coordination with other community health partners in Rwanda. EIP managers will advocate for adaptation from the tools currently being used for community malaria treatment, which have been working well.

The community health information database will be complemented by relevant information in the facility database; this relevant data, which includes the number of children seen for malaria, diarrhea, or pneumonia at the health center.

**3. Supervision checklists:** District and health center supervisors will use supervision checklists –based on those used for home-based treatment of malaria, already in use– to monitor quality of care, including stocking, at both community and facility level. The supervision of health centers will be led by hospital supervisors, as per Ministry of Health policy. The supervision of CHWs will be done by staff hired for this purpose by the health center, as described in the intervention section. The checklists will be entered into the project database. It is expected that, over the life of the project, the checklists will evolve in response to observed gaps in quality. The National manager, District and health center staff, and supervisees will all have a say in reviewing and improving the supervision checklists.

**Integration of the different systems** - The diagram below illustrates how the three different systems will be incorporated into one database for analysis and use in decision-making.

Figure: How the different monitoring methods will be integrated into one database.



The M&E team will conduct operational research in a few HC areas to focus on several aspects of PDA use, including time taken for data entry, error rates, and users' perception of the ease and "user-friendliness" of PDAs. These will all be assessed in pilot PDA-use health centers and in control health centers using existing paper formats. In addition, the research team will evaluate qualitative elements, such as vulnerability to data loss. Where PDAs are not available, compilations will be done using Excel.

**e. Data Collection**

***i) Process to determine the population denominator and how eligible women, children, newborns and others will enter and participate in the program.***

We have used community health workers to identify the population in each health center area, in preparation for the KPC survey. A first count has yielded numbers consistent, though slightly below, the 2002 census, adjusted with the yearly population growth. The more recent count is on average 10% below the calculation based on the 2002 census. This may be explainable by the rural to urban migration in the intervening period, and the tendency of the more recent count to not count families which have residence but do not in fact live in their home village. We will be investigating the cause of this small discrepancy through spot checks.

We rely on percentages in national use, based on the 2005 data, to estimate the number of specific target groups, including children under five and other target sub-groups.

***i) How program staff (including that of the grantee and partners) and beneficiaries will participate in data collection.***

Beneficiaries and partners, as well as program staff, have already played, and will continue to play, an essential role in data collection. For the baseline survey, community workers worked

with community leaders to gather lists of households for all of the program area. CHWs in areas selected for surveys helped to find the selected household. Health center staff in those areas were part of the interviewing team, working with program staff to conduct survey interviews, and helping to weigh children.

The role of beneficiaries and partner staff is even greater for routine data collection. CHWs provide monthly reports; health center staff compile and pass them on. District staff and the EIP Officers will oversee the process and quality-check the data with random checks.

*f. Data analysis and use to improve program processes and program performance*

The Ministry of Health and all three PVOs involved in this program understand that analysis is a key function of the health information system, and one that needs to occur at every level in which health decisions are taken, from households to the national level.

At the community level, CHWs will discuss the previous month's data when they have their monthly meeting with health center staff. District and program staff will provide health center staff with graph print-outs to visually present this information, and facilitate discussion. The CHWs will be encouraged to take the graphs back to their communities for discussion. Once a year, health centers will organize, with funding from the program, a one-day Quality Improvement Review with all the CHWs and local leaders to review the past year's number, and make recommendations for the coming year.

At the health center level, the HC supervisor and the health center staff will review and analyze the information as they compile it to pass on to the District. The District will pass along graphs to health center staff each month, for their own review and to facilitate discussions with the community. The information will also be discussed during the monthly meeting of health center managers at the District level.

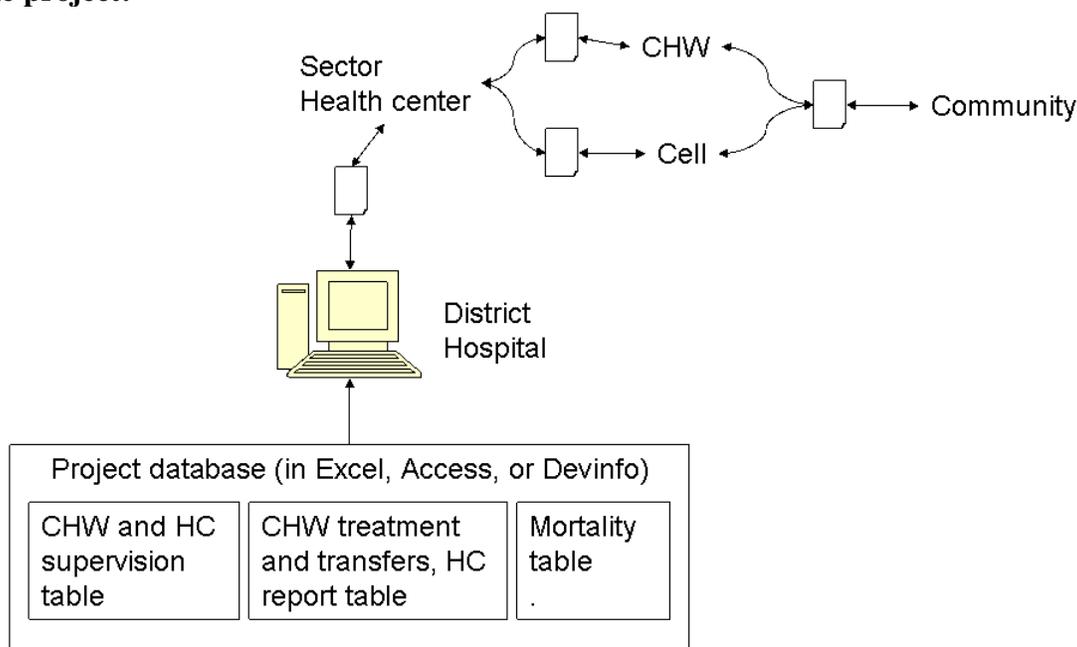
At the District level, information will be entered into an Access database, and analyzed primarily using the UNICEF DevInfo platform, but also with Excel, and Epi Info. District and child survival program staff will discuss the information informally on a daily basis, and more formally during their monthly meetings. District health staff will also prepare a monthly report for the Mayor summarizing the analysis of the previous month's data.

At the national level, the Team Leader and the project Managers will also analyze the information using the DevInfo platform. The M&E Manager will prepare a summary report for all six Districts, to be distributed internally and to project partners. In particular, the report will be distributed to the IMCI working group, and discussed during their regular meetings. A draft template of this report has already been prepared; it is expected to evolve in response to partner comments. The M&E Manager will lead a discuss with all project officers during their quarterly meetings. He will also work individually with the M&E Officer in each District to address any concerns about data quality.

Finally, the information will also be analyzed and discussed at HQ level. The IRC HQ child survival team will take the lead on this analysis, but will involve Concern and World Relief HQ teams as well, particularly on areas directly relevant to their roles within the program. For example, if supervision data shows a persistent problem with one specific aspect of quality of

service at the community level, this problem will be discussed with the Concern child survival team. Periodically, the HQ teams may use the data to write international and national-level advocacy papers to share lessons learned or push for policy changes justified by the data.

**Figure: How computer analysis of routine data will be shared back at different levels of the project:**



The following table gives examples of decisions to be made with program data, and the people who will make those decisions. The table only includes data collected from routine or semi-routine mechanisms (not the KPC).

	<b>Data and source</b>	<b>Decisions</b>	<b>Decision-makers</b>
1.1.3	% households which have at least one LLN, from CHW periodic reports	- Decide to conduct supplemental bednet distribution, or behavior change campaign, in low-coverage areas	- CHWs - HC staff - District staff
1.2.3	Treatments / child / year, from CHW monthly report	- Identify areas with high prevalence for more intensive preventive intervention - Identify areas with low utilization for management interventions	- CHWs - HC staff - District staff
1.2.4	% CHWs supervised who don't have a stock-out on the supervision day, from supervision checklists	- Identify stock-outs early for appropriate intervention	- CHWs - HC staff - District staff
1.2.5	Medication gap (blisters given – children treated – blisters remaining), from CHW monthly report	- Identify any “leaks” in the system for investigation	- HC staff - District staff
1.2.6	Deaths / 1,000 children / month, from CHW mortality reports	- Identify areas with high mortality for further investigation and appropriate action	- CHWs, community - HC staff - District staff
1.2.9	% children transferred, from transfer sheets	- Identify areas with low transfers for appropriate action	- CHWs, community
1.2.10	% effective transfers	- Use data to evaluate efficacy of different interventions to increase transfers	- HC staff
1.2.11	% transferred with feedback		- District staff

1.2.12	% CHWs giving monthly report, from health center compilation of CHW monthly reports	- Identify areas with management, motivation problems	- CHWs - HC staff - District staff
1.3.2	Number of IPT2 given / expected, from health center monthly reports	- Identify areas with low coverage for appropriate action - Use data to evaluate efficacy of different interventions to increase coverage	- CHWs, community - HC staff - District staff
2.2.1	% children 0-23 months whose mother cites correct hand-washing knowledge and practice, from periodic performance appraisals	- Evaluate efficacy of previous BCC efforts in this area	- HC staff - District staff
3.1.13	Children under 2 months with pneumonia treated at the health center / target population / year	- Identify areas with low utilization - Use data to evaluate efficacy of interventions to increase detection and treatment of pneumonia in young infants	- CHWs, community - HC staff - District staff
3.2.2	Number of vitamin A doses given for children / expected	- Identify areas with low coverage for remedial action	- CHWs, community - HC staff - District staff
3.2.5	Number of vitamin A doses given for mothers of newborns / expected		

***g. On-going assessments of essential knowledge, skills, practices and supplies, pharmaceuticals and equipment of health workers and facilities to improve the quality of services***

The Program team will use several tools to assess practices, supplies, and equipment on a regular basis. The QA Officer in each District will work with District and health center staff, using quality assurance methods to identify key practices and supplies to follow, and do assessments and follow-up as needed. The quality assurance teams will take as a starting point the results from the baseline health facility assessment. The teams will also use the IMCI tools currently being developed and abstract the most basic skills –for example, assessment of respiratory status– for priority tracking. The QA Officer, along with the M&E Officer, will also regularly monitor data from the supervision checklists, which will be entered in a database. This database will allow District and project staff to track key quality indicators including stock-outs and performance on basic skills, such as assessment and treatment.

***h. M&E skills strengthening***

The M&E skills of local staff and partners will be assessed according to two main criteria: competence in using the tools of the health information system, and in understanding of the information (including the ability to share that understanding with others). For competence in using the information system, the M&E Manager will work with the M&E Officers and coach them in the use of the system, assessing to and responding to gaps. In turn, the M&E Officers will work with their District counterparts, as well as with health center staff, to help them build competence. Competence with the system should be fairly straightforward to gauge using basic tasks as benchmarks: ability to enter data; ability to produce tables, graphs, and maps with the data; ability to maintain a clean, error-free database.

Competence in understanding the data, and sharing that understanding, will be build more gradually. The IRC HQ backstop, working with Concern and World Relief counterparts, will draft and describe key competencies in this regard, including: selecting data for display; Rwanda Expanded Impact Program – DIP July 2007

choosing the appropriate type of display (graph or map, for example); choosing the appropriate type of graph for a particular type of data or decision to be made; using Excel and other graphing programs to produce graphs; avoiding misleading displays; ability to provide concise, informative, useful reports tailored for different levels. The HQ backstop will work with the M&E Manager, both in person and through phone calls and on-line exchanges; the M&E Manager will work individually and as a group with M&E Officers to build their capacity; and M&E Officers will work with their project colleagues and counterparts, including health center staff, to increase their capacity to analyze data and use it for decision-making.

**i. Sustaining key aspects of the M&E system**

The monitoring system as described is intended to be sustained in its entirety. The community won't be expected to sustain the entire system, because the system involves both the community and the health facilities; indeed the information system is a major bridge between community and facility, and as such is expected to be sustained both by community interest – fed by their perception of obvious benefits, such as leading to more resources being spent in the community by community decisions– and by the health center and District staff, fed by their own perceptions of benefit, such as documenting District achievements which contribute to good evaluations of District performance from national authorities.

**j. Operations research and special assessment plans**

The program has the opportunity to investigate a number of topics. Many of these will relate to community case management and to social behavior change strategies for which there is little documentation of good practices.

The following research topics are planned (\*indicates strong potential but additional funding would be required):

1. Effectiveness of PDAs on Health Center Data Management (vs. traditional paper system)
2. Cost-per-treatment of community vs. facility first-line treatment for uncomplicated illness (a research intern has already been identified for this activity)
3. Factors associated with treatment-seeking for diarrhea
4. Influence of religion on perceived causes of child illness
5. Coverage and health practices comparisons between Care Group vs. standard CHW operation areas
6. Impact of performance-contracting approach on specific indicators of coverage and quality
7. \*How CHWs and caretakers deal with co-morbidity (currently negotiating with CORE and other funding partners for this activity)
8. \*Sensitivity and specificity of fever diagnostic criteria, vs. RDT vs. thick smear
9. \*Impact of community pneumonia treatment on antibiotic resistance

**k. *Contribution to CSHGP Program Results***

**PR1.1 Improved health practices related to key health interventions**

The program will contribute to this program result primarily through its behavior change approach, detailed in the intervention section, including the use of the BEHAVE approach, implementation of Care Groups, and use of changing cycles, with each cycles involving the Rwanda Expanded Impact Program – DIP July 2007

selection of a subset of key messages for intensive dissemination. All project indicators will reflect efforts to change health practices, but the following will be particularly relevant:

	<b>Indicators</b>	<b>Source / Method</b>	<b>Frequency</b>
2.1.1	% children under five with diarrhea in past 2 weeks who received oral rehydration therapy	Periodic Performance Assessments	6 months
2.2.1	% children 0-23 months whose mother can cite a designated site for hand-washing, show soap at that site, and who wash their hands after using the toilet and on at least one other key occasion	Periodic Performance Assessments	6 months
2.4.1	% children 0-23 months whose mother offer more liquid than usual to their child with diarrhea	Periodic Performance Assessments	6 months
2.5.1	% children 0-23 months whose mother offer the same or more food than usual to their child with diarrhea	Periodic Performance Assessments	6 months
3.1.13	Children under 2 months with pneumonia treated at the health center / target population / year	Health center reports	Monthly

### **PR1.2 Improved quality and accessibility of services at facilities and within communities**

This result is at the core of the project's efforts, and nearly every indicator will relate to it in some way, since the project's main objective is to make IMCI-quality case management available. The following indicators are particularly related to service quality and accessibility.

	<b>Indicators</b>	<b>Source / Method</b>	<b>Frequency</b>
1.2.2	Number children with fever seen by CHW	CHW treatment registers	Monthly
1.2.3	Treatments / child / year	CHW treatment registers	Monthly
1.2.4	% CHWs supervised who don't have a stock-out on the supervision day	Community supervision checklists	Monthly
1.2.5	Medication gap (number of blisters given – number of children treated – number of blisters remaining)	CHW treatment registers	Monthly
1.3.2	Number of IPT2 given / expected	Health center reports	Monthly
2.3.1	% children under five with diarrhea in past 2 weeks who received zinc treatment	Periodic Performance Assessments	6 months
3.1.1	% children under five with cough or respiratory difficulty in past 2 weeks who received correct first-line treatment from a trained provider	Periodic Performance Assessments	6 months
3.2.2	Number of vitamin A doses given for children / expected	Health center reports	6 months

3.2.5	Number of vitamin A doses given for mothers of newborns / expected	Health center reports	6 months
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**PR1.3 Increased capacity of communities, local governments and local partners to effectively address local health needs**

The program will also work towards this result, since the strategy involves building systems within the existing Ministry of Health and District structure, rather than in parallel. Capacity indicators will be developed over the next few months.

**PR2.1 Increased population reached through the use of partnerships and networks**

EIP itself represents a step towards this result, with three PVOs joining together to cover six Districts, one fifth of the population of Rwanda. The project also represents the achievement of partnership in other ways, since we could not reach this scale with close partnership with the Ministry of Health, administrative Districts, health center staff –who do most of the day-to-day work of supporting community health workers– and, last but not least, the community health workers themselves. The following indicators will be used to monitor the scale of the program:

	Indicators	Source / Method	Frequency
1.2.2	Number children with fever seen by CHW	CHW registers treatment	Monthly
2.1.2	Number children with diarrhea seen by CHW, and treated with ORS	CHW registers treatment	Monthly
2.3.2	Number children with diarrhea seen by CHW, and treated with zinc	CHW registers treatment	Monthly
3.1.2	Number children with pneumonia seen by CHW	CHW registers treatment	Monthly
1.2.3	Treatments / child / year	CHW registers treatment	Monthly

**PR2.2 Improved health systems and policies that support effective health programs and services at the national level**

The project will play a major role in achieving this result, building on the achievements of the three PVOs in the previous programs. The following benchmarks will help document achievements in this project cycle:

- Community case management for pneumonia adopted as national policy (achieved December 2006)
- Health information system, including electronic databases, in place and used as national standard
- Set of tools, including registers and supervision checklists, in place and used as national standard

**PR2.3 Improved collaboration with USAID Missions or Bi-lateral programs**

The project proposal was developed after extensive consultation with the USAID Mission. The project’s scope fit in within several priority Mission programs, including those related to

the President's Malaria Initiative. The following benchmarks will serve to document the project's fit with Mission priorities:

- Project reports regularly on PMI indicators
- Mission uses project data in its internal and external reports
- Mission continues to invest financially in the project

### **PR3.1 Increased technical excellence**

The following indicators will help to document technical quality:

- Health information system used as national standard for community activities
- Number of presentations on technical aspects of project at major conferences
- Number of publications on technical aspects of project in peer-reviewed publications
- Project tools used as basis for child survival programs in other countries
- Report of external facilitator after mid-term and final evaluations

### **PR3.2: Improved recognition and visibility of PVO work in health**

The following indicators will serve to document the project's effectiveness in documenting PVO visibility in health:

- Number of presentations on technical aspects of project at major conferences
- Number of publications on technical aspects of project in peer-reviewed publications
- Government of Rwanda official recognition of program

#### ***l. Contribution to USAID Mission Program Results***

The Mission is not currently using a results framework. The PMI MOP was reviewed and monitoring indicators incorporated in the M&E plan. The project will report quarterly to the Mission using all of the monitoring indicators in Annex G as well as share all annual and evaluation reports.

#### **m. Plan for evaluations**

Participatory evaluation methodologies will be used for both mid-term and final evaluations; all three PVOs leading the project have extensive experience with this evaluation method. Each PVOs will send at least one headquarter technical backstop person to participate in the evaluation. The midterm and final evaluations will be preceded by a KPC survey. The community organization capacity assessment and rapid child health service provision assessment tools will be repeated at the final evaluation only. Tools for the latter may be adapted and simplified from the tool used in the baseline assessment.

We propose the following times for the evaluations:

- Mid-term: July-August 2009
- Final: July-August 2011

## ***6. Program Management***

### **a. Roles of the three PVO partners:**

Programs operating on a large scale require solid coordination, planning, and logistics for good performance. In addition, the scale and number of partners require strong and flexible management mechanisms to ensure program success. This section includes information about program staffing structure, coordination with PVO Public Health professionals at HQ, working with MoH counterparts, planning and coordination meetings, and an advisory committee for collaboration with external agencies. Further information and organization charts are presented in **Annex I-1** clearly showing relationships and management lines between the partners at field and HQ levels.

**Concern's role** will be in the area of partnership, Quality Assurance (QA) and overall program management and coordination. The agency will take on overall responsibility for management of the grant and building up the team to bring out the best of all the partners. Concern will also work with other health programs in Rwanda to ensure mainstreaming of interventions and coordination of resources. The **IRC's** role will be in the area of monitoring and evaluation, and health information systems strengthening. This includes setting up information management systems and the design and management of surveys. **WR's** role will be in the area of community mobilization, social behavior change, and scaling up an adapted care-group approach in all six districts

## **b. Program Staffing**

Interviews for project staff were carried out using a panel of staff (including HR managers) from each of the PVOs. It was felt important that each PVO had the chance to interview and express any potential concerns. The process took longer than individual PVO recruitment but the benefits of the joint approach far outweighed the additional time taken. Recruitment during the course of the project will continue to use the same approach.

### Kigali-based EIP Staff

A **Team Leader (CW)** will head the program staff and will be supported by a Kigali-based team of managers listed here (with their organization affiliation in parentheses):

- The **Mobilization Manager (WR)** will ensure technical standards of the program for community mobilization approach; lead the behavior-change strategy and implementation and will participate in relevant national technical forums.
- The **Monitoring & Evaluation Manager (IRC)** will manage the baseline, midterm and final surveys; refine the monitoring and evaluation system; build district and staff capacity in the use of the system; and lead operations research activities.
- **Quality Assurance Manager (CW):** will oversee adherence to case management technical standards; oversee the CCM strategy and requisite tool development; build district and project staff QA processes within the program; liaising with MSH/RPMPLUS with drug supply management; management program pharmaceutical procurement; and fostering continuous quality improvement reviews and actions at the community, health center and program levels.

An **Administrative Assistant** provides administrative and finance support to the Team Leader and the three Managers. The key support will be organizing and coordinating office services

such as cash management, procurement, filing, basic logistics, transport coordination and other administrative duties. The Administrative Assistant will also coordinate communications and manage the office while the Team Leader and the Managers are in the field (districts).

The EIP Kigali Office has been established in its own premises in the centre of Kigali. The previously considered options of locating the office space either within the MoH Maternal and Child Health Unit or the Twubakane project were not feasible. Having a dedicated office space has helped give the project and the team a greater sense of identity, while still facilitating the contact and support provided by the respective PVO head offices in Kigali.

### District-based EIP Staff

**At the district level**, the program will be staffed by a small team based in each of the six districts comprised of three officers, an administrative assistant, and three promoters. The team will be based in an office within the district health centre or close by, depending on availability of space. Each of the organizations will have staffing affiliation in all six districts in accordance with their technical niche as shown in the figure below:

**Each district has been assigned a lead agency among the 3 PVOs as follows:** the IRC will manage Ngoma and Kirehe Districts; WR will manage Nyamagabe and Nyamasheke Districts; and Concern will manage Gisagara and Nyaruguru Districts. Lead district functions are to ensure cross-functionality of managers, an appropriate level of technical and administrative oversight, and continuity of institutional presence in former child-survival districts. The officer from the lead agency in each of the districts will also carry a special role in terms of representational duties, team coordination and supervision of the administrative assistant.

**See Annex I-1 for organization charts.**

The roles for the officers are allocated as follows: the **Mobilization Officer** plans with DHMT for BCC/Mobilization, and leads TOT in intervention topics; the **QA Officer** plans for and leads TOT topics related to QA/IMCI; the **M&E Officer** plans for and leads TOT activities related to M&E, integration of data into the district system, and monthly CIMCI district reporting. Each officer will work with a DHMT counterpart for skills transfer and supervision and integration of activities.

In addition, the **Officers** will have shared roles for project implementation in a sub-area of three to four health centers each, as well as a technical liaison role with one of each of the three Kigali-based managers. Their responsibilities include training, support and supervising district trainers of CHWs team, overseeing the M&E system, coordinating with DHMT, and facilitating CDC health leadership and health center outreach. Their role is to mentor and support the program but not to “implement it”.

In each district, the Mobilization Officer will manage 3 **Promoters**, who will implement an extended community mobilization in 2 health center zones to develop Care Groups of 10-15 CHWs. Refer to section 3.a – strategy three, for further description of the Care Group strategy.

## **C. Internal project staff supervision and coordination**

### National level:

The national EIP team has its own office in Kigali, helping to give the project and the team a greater sense of identity, while still facilitating the contact and support provided by the respective PVO head offices in Kigali.

Supervision and team management will be carefully coordinated through monthly visits of managers to all districts, as well as regular meetings as follows:

- **A weekly coordination meeting for Kigali Managers** chaired by the Team Leader at their shared office space. Review plans and priorities for the week, observations from the field, and vehicle schedule.
- **A monthly Country Director meeting (10<sup>th</sup> of the month)** at which the Team Leader and the three Managers will brief the three Country Directors on general progress and any key issues that need discussion.
- **A monthly Finance meeting (18<sup>th</sup> of the month)** chaired by the Team Leader and attended by the three managers and the Finance Manager from each PVO, to discuss issues arising from the monthly cash forecasting, review financial status, raise issues about financial reports and requests for reimbursements, and review policies and other administrative issues. It is envisaged that this meeting will become quarterly as the systems become established.
- **Quarterly staff meetings** at rotating locations across the six districts and Kigali. These 2-3 day meetings will include a review of progress, joint field site visits and skill-building sessions, and will allow time for sector-specific team work (e.g. mobilization team, M&E team, etc). The team will review performance against the annual plan and prepare detailed quarterly plans.
- **An annual internal review** scheduled by the Team Leader with the M&E Manager for the project staff with support of the Program Advisory Committee to analyze performance towards objectives, document achievements, problem-solve around constraints and challenges; and develop the next annual workplan.

As part of the overall co-ordination process and the meetings outlined above, the following reporting schedules have been agreed:

- By the 16<sup>th</sup> of the month a **finance report** will be submitted to each of the PVO's Finance Manager.
- By the 8<sup>th</sup> of the month the Team Leader will submit a brief report to the three Country Directors that will form the basis for discussion at the monthly CD meeting.

### District level

The EIP District level offices are located in the health centre or hospital compounds or in the immediate vicinity and this will create more opportunities for continuous sharing and exchange of information and resources. Regular supervision and technical consultation visits to each of the six sites will be undertaken by the Managers (at least once in two months). The Managers will play a key role in facilitating the coordination between the district partners and the EIP Kigali office.

- **A weekly coordination meeting for district officers with District Health Management Team** at the District Office. Review plans and priorities for the week, observations from the field, and vehicle schedule.
- **A monthly District Staff Meeting** led by the Manager, with lead responsibilities for given district meetings with Officers, Admin, Promoters and District Health Director to review progress, achievements, constraints, priorities for the month, as well as program updates and issues.

Considerable time has been invested in establishing the operating systems at each of the six district-level offices. The key issue has been to get a system that was acceptable to each of the three PVOs (in terms of compliance with respective rules and regulations) but also that was as simple and efficient as possible. A number of basic principles were established and these were used to develop a range of procedures from cash forecasting and release of funds, to reporting of expenditure, authorization rights and communication channels.

The basic principles that were established are:

- 1) The lead PVO in the district (e.g. WR in Nyamasheke and Nyamagabe) is responsible for managing the EIP district-level office (e.g. motorbikes, fuel, allowances, admin support, IT, asset maintenance etc.). The level and extent of support provided by the provincial or Kigali offices will be determined by each PVO.
- 2) Each member of staff is still responsible for the appropriate care and use of the assets allocated to them by their PVO, wherever they are being used. They will be expected to follow the appropriate policies of their own PVO.
- 3) Although the lead PVO in the district is responsible for managing logistics, admin and finance in that location, costs will be apportioned between all three PVOs based on their use of resources. (E.g. fuel and maintenance costs for the QA officer motorbike in Nyamasheke will be apportioned by WR to Concern).
- 4) The three EIP Managers (QA, mobilization and M&E) must approve activities and the associated expenditure that will be carried out by their respective officers (e.g. Mobilization Manager approves activities for mobilization in all six locations). This enables clear budget management for each of the three PVOs.
- 5) Each PVO will determine and apply their own authorization limits and delegation frameworks. These will be distributed amongst the PVOs to ensure limits are clearly understood by all parties and to ensure strong control systems and accountability across the entire program.
- 6) Clear segregation of duties will be maintained, i.e. different staff requesting, authorizing, carrying out and recording transactions, wherever possible.
- 7) The Human Resources manual of each PVO will be applicable to those EIP staff employed by that PVO. A separate document will detail procedures in cases where line management is not within the same organization.

**Staff development:** Each of the PVOs has their own system for staff appraisal or performance management which is carried out at least once per year. An integral part of the process is the identification of career development plans and the associated training needs.

**Conflict Resolution:** In recognition of the somewhat complex staffing and management structure, in which staff from three different PVOs work in seven different offices, with some staff reporting to people from a different organization, there is the need for clear procedures for conflict resolution. Such a mechanism will ensure that all appropriate parties will have a voice, and that consistent and equitable procedures can be followed.

Any conflict within the district offices will be managed through a program of progressive actions. Whenever possible, informal means of conflict resolution will be attempted before beginning a formal process. Where direct reporting lines exist (within each organization) any resolution will follow that organization's standard procedures. Where reporting lines are between staff who report to different organizations, the following steps will be used:

- Conflicts that can be solved informally among staff within a district office will first go to the manager of the lead agency for that district.
- If the conflict persists, resolution should be sought by the team of the three managers plus the Team Leader.
- In the event that organizational issues cannot be resolved between the Managers and Team Leader, a panel of the PVOs' country directors will convene to review and analyze the situation and make recommendations. Decisions will be reached through consultation and majority vote if required.
- Agency HQs may be involved if there are issues that mandate broader organizational consultation. As Lead Agency, Concern will reserve the right to convene conflict-resolution meetings.

#### **d. Collaboration mechanisms with other stakeholders**

##### **National level coordination**

At Kigali level there are a range of coordination structures that meet on a monthly basis. The Team Leader and /or the three managers will represent the program at the following:

- Maternal and Child Health Unit Task Force on IMCI
- PNILP technical working group meeting
- PMI partners meeting
- MoH Community Health and Traditional Medicine Department

All the above groups are responsible for dealing with a range of issues – policy consultations and development, technical protocol issues, adherence to national policies, discussion and elaboration of workplans and general information sharing for best practices.

The Team Leader will participate in the USAID Child Survival Partners meetings and the quarterly USAID Cooperative Agency meeting to coordinate with other mission initiatives.

The three Country Directors will participate in the monthly International NGO Network meetings where wider issues of common interest such as the operating environment, the NGO law (draft), GOR policies and Sector Working Groups are discussed.

Following lessons from Concern's scale-up program in Bangladesh, a national **Program Advisory Committee (PAC)** will serve as a guiding body to review performance against plans, technical guidance, coordination with other major health initiatives, and advocacy for replication of C-IMCI across the country. A number of national level coordination and technical working groups already exist within the MCH sector. Following discussions it has been agreed that one of the existing structures will be used, in a slightly modified form, to serve as the PAC for the project. A sub-committee of the IMCI Task Force (composed of BASICS, USAID, MoH – Maternal and Child Health task force, PNILP, UNICEF, WHO, MSH/RPMPLUS, CS Partner NGOs, Twubakane) will be complimented by representatives from each of the six EIP Districts and will constitute the PAC. It will meet on a semi-annual basis with one of the meetings occurring just prior to the annual internal review of the program.

Utilizing an existing structure was seen as the most positive and efficient use of resources and people's time. It will avoid setting up another group, at a time when people already have many demands on their time. It will also be a way to maximize on the ongoing technical discussions and developments and ensure that these are captured and applied as the program evolves.

#### District-level

The program teams will work closely with the District Health Director, District Health Supervisors, and District Health Administrator to implement the program. The Director will assign each of the Officers to a supervisor and a set of health centers for joint technical and facilitation capacity building. The supervisors conduct regular visits to health centers, and will manage logistics and the health information system. Their roles in this program include monthly meetings of all health staff for districts which will include all partner agencies; training health center staff; training CHWs and Health Center staff; and data analysis and reporting including monthly CIMCI district report.

Every district offers a different set of partners: IntraHealth's Twubakane Project works on reproductive and child health in Nyamagabe, Nyaraguru, Ngoma and Kirehe Districts; Food for the Hungry works in nutrition in Ngoma District; GTZ works in health system strengthening in Nyaraguru and Gisagara Districts; Health Unlimited has radio health communications in Nyaraguru and Gisagara Districts; and PEPFAR and MAPS partner in VCT, PMTCT and care and support interventions throughout the country.

#### **e. HQ supported technical assistance and skill transfer**

Training and technical assistance were identified as part of the DIP preparation with the EIP staff members. These needs will be revisited during annual reviews and prior to TA focused Backstop visits. All EIP Managers will require on-going skill transfer under the leadership of their agencies respective backstops. This will be achieved through hands on support during regular field visits, sharing key technical documents (all Managers can read English), coaching through regular email and phone communications regarding progress and challenges, and

identification and participation in appropriate Africa and International technical and capacity building events.

Skill transfer and capacity building for Program Officers is the responsibility of each individual's manager through on-the-job coaching, quarterly team meetings/training which may include engagement of national resource persons (e.g. technical update on malaria resistance and the use of Coartem), and organizing external training as per needs identified in individual performance review. Initial needs have been identified and address in the training and quarterly staff meeting topic plan (see section 6 Training Plan for further details).

The use of external, non-Rwandese consultants is not planned for during the life of the project given the skill set and experience of the HQ Backstops and resources available to them through CSTS+ and CORE. Consultants will only come in for the midterm and final evaluation. In the event that unavailable skill sets are required, the option to substitute field visits with consultants is possible subject to negotiation with the CW Backstop who will require pre-approval form USAID Cognizant Officer.

The CW/US Backstop ensures regular communication between the Team Leader regarding program implementation, progress reports, and working with external partners and the IRC and WR Backstops. The CW/US Program Officer monitors subagreement compliance and financial reporting and fund transfers.

Between the CW/IRC/WR backstopping team, at least four annual person trips are planned to Rwanda to support the Expanded Impact Program. Trips are on average two full weeks in lengths and may be longer or shorter based on the nature of the assignment. At least Backstop will participate in the annual program reviews and efforts will be made to coordinate visits with quarterly staff meetings where appropriate. All travel is agreed in the workplan and specific purpose, tasks, outputs and schedule written in advance by the implicated individual. These are reviewed and approved by the Program Team Leader.

The CW/IRC/WR HQ teams hold quarterly coordination calls and maintain ongoing regular phone and email communications. Face to face meetings are held during semi-annual CORE and other USAID sponsored events whenever possible.

## 7. Training Plan

No.	Title	Content	Delivery Strategy	Duration in Days	Participants and number per training	Number of Trainings per Area							Facilitators	Timeframe	
						Gisagara (old Kibilizi)	Gisagara (new)	Kirehe	Ngoma	Nyamagabe	Nyamasheke (old Kihogora)	Nyamasheke (new)			Nyaraguru
<b>A. DISTRICT LEVEL</b>															
1	C-IMCI orientation for all sectors	<ul style="list-style-type: none"> <li>Child health situation in the District</li> <li>Program goal and objectives</li> <li>Three components: partnerships, CCM, and family practices</li> <li>Negotiating a supportive supervision system</li> </ul>	Sector level one day meeting by District Health staff and EIP officers. Participatory and orientation.	1	HC staff, COSA, sector-level CDC (25 participants)	12		12	14	16	15		15	EIP Officers with District Health Staff (2 per mtg)	Yr 1 – Qtrs 3-4
2	TOT Community Case Management of Malaria, Pneumonia, and Diarrhea	Development of lesson plans for the CHWs on: <ul style="list-style-type: none"> <li>General danger signs and referral</li> <li>CHW algorithms for diarrhea, malaria &amp; pneumonia (diagnosis &amp; tx)</li> <li>Counseling and key messages (including nutrition)</li> <li>Record keeping and reporting</li> <li>Drug supply</li> <li>Certification of CHWs</li> </ul>	District team develops lesson and training plan for CHWs based on generic national modules. Includes CHW training delivery strategy.	5	Designated CHW supervisors (either HC or COSA): 12 in Kirehe 12 in Gisagara & Ngoma; 13 in Nyamagabe & Nyaraguru; 16 in Nyamasheke ; Nyaraguru 13	1		1	1	1	1		1	EIP Officers with District Supervisors	Yr 1 Qtrs 3-4
3	CHW Supervision Orientation	<ul style="list-style-type: none"> <li>Supportive supervision</li> <li>CHW Supervision forms</li> <li>Practice /role play</li> <li>Performance contracting</li> </ul>		1	Designated CHW supervisors as above	1		1	1	1	1		1	EIP M&E + QA Officers with District Supervisors	Yr 2 – Qtr 1 except in Nyamagabe & Nyaraguru

No.	Title	Content	Delivery Strategy	Duration in Days	Participants and number per training	Number of Trainings per Area							Facilitators	Timeframe	
						Gisagara (old Kibilizi)	Gisagara (new)	Kirehe	Ngoma	Nyamagabe	Nyamasheke (old Kibogora)	Nyamasheke (new)			Nyaraguru
		standards and agreements												Year 2, Qtr 3	
4	F-IMCI Gisagara District	<ul style="list-style-type: none"> <li>District child health situations</li> <li>General danger signs</li> <li>Assessment/Diagnosis</li> <li>Treatment</li> <li>Counseling</li> <li>Reporting</li> </ul>		5 days classroom and 6-7 days OJT	2 nurses from the 8 HCs to be trained (16)	1		0	0	0	0	0	0	District F-IMCI facilitators	Yr 2, Qtr 1
5	CDC/COSA Mobilization and On-Going Capacity Building	<ul style="list-style-type: none"> <li>Child health interventions vis-à-vis community development</li> <li>Program goal and objectives</li> <li>Family practices Key messages</li> <li>Framework for Behavior Change strategy</li> <li>Administrative supervision of CHWs activities</li> <li>Partnership</li> </ul>	Series of 8 semiannual meetings	1	CDC members (sector level)	12		12	14	16	15		15	Mob. Officers and Promoters	Yrs 2-5 (2x yr)
6	CHW HBM with Coartem (refresher)	<ul style="list-style-type: none"> <li>Drug resistance and rationale to change</li> <li>Review Malaria algorithm (diagnosis &amp; tx)</li> <li>Review counseling and key messages (including nutrition)</li> </ul>	Training org by Desig. CHW Supervisor (avg about 6 groups per trainer)	1	CHWs (15-20) (calc based on avg 18)	51	0	67	68	0	43	0	0	HC staff, district supervisors, with support from EIP officers	Yr 1 Qtrs 3 (Kirehe) & 4 (others)

No.	Title	Content	Delivery Strategy	Duration in Days	Participants and number per training	Number of Trainings per Area							Facilitators	Timeframe	
						Gisagara (old Kibilizi)	Gisagara (new)	Kirehe	Ngoma	Nyamagabe	Nyamasheke (old Kibogora)	Nyamasheke (new)			Nyaraguru
		<ul style="list-style-type: none"> <li>• Drug supply</li> </ul>													
7	CHW Diarrhea and Malaria	<ul style="list-style-type: none"> <li>• Roles and responsibilities of CHW</li> <li>• Project goal and objectives</li> <li>• Child health situation</li> <li>• General danger signs and referral</li> <li>• Malaria and diarrhea algorithms (diagnosis &amp; tx)</li> <li>• Counseling and key messages (including nutrition)</li> <li>• Record keeping and reporting</li> <li>• Drug supply</li> </ul>	<p>Training org by Desig. CHW Supervisor (avg about 6 groups per trainer)</p> <p>Number of days reduced to 3 for those already trained in HBM and 2 days for Kirehe &amp; Ngoma (refresher only)</p>	4	CHWs (15-20) (calc based on avg 18)	51 - 3 days	27	67 - 2 days	68 - 2 days	84	43 - 3 days	52	69	Designated CHW Supervisor with support from EIP Officers	Yr 2, qtrs 1&2
8	CHW Pneumonia	<ul style="list-style-type: none"> <li>• Quick review gen'l danger signs and malaria + diarrhea algorithms</li> <li>• Pneumonia algorithm (diagnosis &amp; tx)</li> <li>• Use of timers</li> <li>• Counseling and key messages (including nutrition)</li> <li>• Record keeping and reporting</li> <li>• Drug supply</li> </ul>	<p>Training org by Desig. CHW Supervisor (avg about 6 groups per trainer)</p>	2	CHWs (15-20)	78		67	68	84	95		69	Designated CHW Supervisor with support from EIP Officers	4 events in Yr 1 Qtrs 3&4 in Old Gisagara, Old Nyamasheke, Kirehe & Ngoma. The rest for Yr 2 Qtrs 2 & 3
9	M&E analysis and feedback	<ul style="list-style-type: none"> <li>• Review quality of HC child health records</li> </ul>	Series of 10 ½ day sessions at	½ day	HC Staff and CHW	120		110	120	130	160		130	M&E and QA Officers	Yrs 2-5

No.	Title	Content	Delivery Strategy	Duration in Days	Participants and number per training	Number of Trainings per Area							Facilitators	Timeframe
						Gisagara (old Kibilizi)	Gisagara (new)	Kirehe	Ngoma	Nyamagabe	Nyamasheke (old Kibogora)	Nyamasheke (new)		
	skill building for HC Teams	<ul style="list-style-type: none"> <li>Analysis of child health records</li> <li>CHW reporting and validity checking</li> <li>Data analysis and graphing</li> </ul>	HC with District Supervisor		Supervisors									
10	Annual CHW quality improvement reviews	<ul style="list-style-type: none"> <li>Review performance</li> <li>Highlight strong and weak areas</li> <li>Select key performance areas to address and analysis barriers</li> <li>Establish action plan, targets and monitoring plan</li> <li>Reward highest performers</li> </ul>	Annual meeting at HC with CHW Supervisor and all CHWs	2 days	100 CHWs	12 x 4	11 x 4	12 x 4	13 x 4	16 x 4	13 x 4	Titulaire, EIP Officers, and District Supervisor	Yrs 2-5, Qtr 4	
11	Advanced data analysis for M&E Officers and District Supervisors	Advanced excel ACCESS & GESIS Mapping	During routine district supervision visits will be are four computer based training sessions from M&E Mgr	½ day	District Supervisors and Officers	16	16	16	16	16	16	M&E Mgr	Yrs 2-5	
12	Practical quality assurance applications	<ul style="list-style-type: none"> <li>Review prioritization of problems</li> <li>Discuss analysis of problem and solutions</li> <li>Test how solutions working</li> <li>Consider ways to</li> </ul>	During routine district supervision there will be a HC QA review twice a year	½ day	District Supervisors & QA Officers	8	8	8	6	8	6	QA Mgr	Yrs 2-5	

No.	Title	Content	Delivery Strategy	Duration in Days	Participants and number per training	Number of Trainings per Area							Facilitators	Timeframe
						Gisagara (old Kibilizi)	Gisagara (new)	Kirehe	Ngoma	Nyamagabe	Nyamashoke (old Kibogora)	Nyamashoke (new)		
		strengthen the plan												
13	Community Mobilization Advanced Skills	<ul style="list-style-type: none"> <li>Methodology of Adult Education</li> <li>Counseling</li> <li>Procedure of Home visit</li> </ul>	During Care Group trainings										Mob Mgr	

#### B. PROGRAM LEVEL (National or across all six districts)

	Training Event	Content	Duration (in days)	Participants	Total number of participants	Trainers/Facilitators	Time Period
14	Mayor's Orientation Meeting	<ul style="list-style-type: none"> <li>Program Overview</li> <li>Partnership</li> <li>Issues for MoU</li> <li>Other actors</li> </ul>	2	Mayors, District Health Directors, and Hospital Directors	15	EIP Team Leader & Managers + SMT	Yr 1, Qtr 1
15	KPC Survey	<ul style="list-style-type: none"> <li>Review and translate questionnaire</li> <li>Sampling</li> <li>Selection of respondents</li> <li>Interview skills</li> <li>Field test</li> <li>Data checking &amp; management</li> </ul>	5	EIP M&E Officers, District staff	2 groups x 20 participants	M&E Mgr & IRC Backstop	Yr 1, Qtr 2
16	Health Facility Assessment	<ul style="list-style-type: none"> <li>Purpose</li> <li>Review tools and adapt</li> <li>Field test</li> <li>Data collection management</li> </ul>	3	EIP QA Officers, District staff	1 group x 15	TL & QA Mgr	Yr 1, Qtr 2
17	Partners Workshop for DIP Preparation	<ul style="list-style-type: none"> <li>Review results of surveys</li> <li>Analysis of care seeking practices</li> <li>Establish Targets</li> </ul>	4	3 District Reps, National Partners, and 4 EIP Officers	25	TL & QA Mgr + Backstops + HIV & AIDS Mgr	Yr 1, Qtr 2

	<b>Training Event</b>	<b>Content</b>	<b>Duration (in days)</b>	<b>Participants</b>	<b>Total number of participants</b>	<b>Trainers/Facilitators</b>	<b>Time Period</b>
		<ul style="list-style-type: none"> <li>Review core strategies</li> <li>Review partnership agreements</li> </ul>					
18	Quarterly Staff Meetings	<ul style="list-style-type: none"> <li>Technical team plan reviews</li> <li>Review program strategies</li> <li>Tech updates</li> <li>Performance review</li> <li>Qtry planning</li> </ul>	3	Full EIP team	24	TL & Mgrs (+backstops when available) may include national resource person as appropriate	Yrs 1-5, starts Qtr 3
19	Annual Project Review Meetings	<ul style="list-style-type: none"> <li>Review performance by objectives</li> <li>Highlight achievements and challenges</li> <li>Review management issues</li> <li>Articulate lessons learned</li> <li>Develop next workplan</li> </ul>	2 (in addition to 3 in qtrly mtg)	Full EIP team and 3 reps per Districts	32	TL & Mgrs + Lead agency backstop + national resource persons (2)	Last quarter of years 1-5
20	Master District CHW CCM Trainers (in Kigali)	<p>Adult learning methodologies Role of CHW Supervisors Review and practice generic lesson plans for the CHWs on:</p> <ul style="list-style-type: none"> <li>General danger signs and referral</li> <li>CHW algorithms for diarrhea, malaria &amp; pneumonia (diagnosis &amp; tx)</li> <li>Counseling and key messages (including nutrition)</li> <li>Record keeping and reporting</li> <li>Drug supply</li> </ul> <p>Discuss certification of CHWs process</p>	5 days	Six EIP Officers and Eight District Supervisors	14	IMCI Task Force Member (1) and QA Manager	Yr 1, Qtr 3
21	Midterm Survey Preparation	<ul style="list-style-type: none"> <li>Review tools and sampling</li> <li>Revisions</li> <li>Field testing</li> <li>Data quality control</li> </ul>	5	EIP Officers, District (3) Supervisors (2) and national reps (35)	35	EIP Managers + M&E Backstop	Year 3, Qtr 2
22	Final Survey Preparation	<ul style="list-style-type: none"> <li>Review tools and sampling</li> <li>Revisions</li> </ul>	5	EIP Officers, District (3) Supervisors (2) and	35	EIP Managers + M&E Backstop	Year 5, Qtr 2

	Training Event	Content	Duration (in days)	Participants	Total number of participants	Trainers/Facilitators	Time Period
		<ul style="list-style-type: none"> <li>Field testing</li> <li>Data quality control</li> </ul>		national reps (35)			
<b>C. STAFF TRAINING (INTERNAL)</b>							
23	Promoter Orientation to EIP	<ul style="list-style-type: none"> <li>Child health situation in the District</li> <li>Program goal, objectives and interventions</li> <li>Promoters roles and Responsibilities</li> <li>Care Group Approach</li> <li>Partnership</li> </ul>	2	Promoters	9	EIP Managers, Mob. Officers	?
24	Promoter Mobilization Training and Care Group Orientation in Kibogora CSP Umucyo Site	<ul style="list-style-type: none"> <li>Introduction to IMCI components</li> <li>Key family practices</li> <li>Key messages on Diarrhea, malaria, pneumonia and integrated nutrition</li> <li>Methodology of adult education</li> <li>Care group Management</li> <li>Visit to Care groups in Nyamasheke</li> </ul>	3	Promoters	6	EIP Mobilization Manager, Mob. Officers, Kibogora Training Coordinator (Daniel)	?
25	EIP PDA skills training on data management	<b><u>Under development</u></b>	1-2 days	EIP Managers & M&E Officers	7	IRC Backstop	?
26	Best practices in quality assurance	<ul style="list-style-type: none"> <li>Change management and team work promotion</li> <li>Identifying and prioritizing performance gaps</li> <li>Tools for analyzing causes and solutions</li> </ul>	5 days	All EIP Officers and District Supervisor	24	QA Mgr + CW Backstop (or consultant)	Yr 2, Qtr 2

	<b>Training Event</b>	<b>Content</b>	<b>Duration (in days)</b>	<b>Participants</b>	<b>Total number of participants</b>	<b>Trainers/Facilitators</b>	<b>Time Period</b>
		<ul style="list-style-type: none"> <li>• Widening participation</li> <li>• Setting action and monitoring plan</li> <li>• Assessing change</li> </ul>					
37	BEHAVE Framework Training of Trainers	<ul style="list-style-type: none"> <li>• Defining appropriate behaviors</li> <li>• Priority and support groups</li> <li>• Key factors</li> <li>• Activities</li> <li>• Key messages</li> <li>• Monitoring</li> </ul>	5 days	All EIP Officers and District Supervisor	24	WR Backstop	Year 2

The following staff development trainings are planned as part of the routine quarterly staff meetings which dedicate 1 day for the sub-technical area teams (Mobilization, M&E, and Q&A) plus 1 day for full staff training/updates, and 1 day for quarterly planning.

<b>Topic</b>	<b>Responsible Person</b>	<b>Time Period</b>
Introduction to IMCI	Team Leader with all 3 Managers	Year 1, Qtr 3
EIP Team Approach Orientation	Team Leader	Year 1, Qtr 3
EIP staff HBM refresher training on Coartem	TL with PNILP	Year 1, Qtr 3
EIP staff Community Case Management of Malaria, Pneumonia, and Diarrhea	Team Leader	Year 1, Qtr 4
EIP staff on CHW Supervision tools	QA with M&E Manager	Year 1, Qtr 3
EIP staff on QA implementation strategy	QA Manager	Year 2, Qtr 1
TOT on Behavior Change Prevention Interventions (C-IMCI Key Family Practices)	Mobilization Mgr	Year 2, Qtr 2
EIP staff on Integrated Nutrition Strategy	Team Leader with Mobilization Manager	Year 2, Qtr 2
EIP Finalized version of M&E system, including C-HIS, data collection, indicators, EIP-INFO, excel	M&E Manager	Year 2, Qtr 1
Review of QA case studies from supervision visits	QA Manager	Year 3, Qtr 2

## 8. Workplan

Workplan for the Life of the Program (5 years) Oct. 1st 2006 - 30th Sept. 2011			YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5			
(version April 21, 2007)			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity	Responsible	Unit																				
<b>1. PROJECT START-UP</b>																						
1.01	Recruitment and orientation of personnel (3 Managers, 12 Officers, and 5 Admin Assistants)	TL & Mgrs	Staff contracted	20																		
1.02	Mayor's Workshop for all six EIP Districts	CWR ACD & TL	Events	1																		
1.03	Establish sub-agreements with IRC & WR and introduction to national partners	CD & CW/US	Non-specific	X	X																	
1.04	DIP planning with Backstops	TL & Backstops	Events	1																		
1.05	Baseline KPC Survey in six districts	M&E Mgr	Districts		6																	
1.06	Baseline Health Facility Assessment for 30 HCs and 150 CHWs	QA Mgr	Districts		6																	
1.07	Baseline Community Capacity Assessment	Mobilization Mgr	Districts		6																	
1.08	DIP Partners Workshop	TL & Mgrs	Events	1																		
1.09	Complete MoUs with Districts	TL & District Leads	Districts			6																
1.10	Technical consultations with national partners on workplan	TL	Non-specific		X	X																
1.11	Completion of 5-year Detailed Implementation Plan	CD/TL & Backstops	Non-specific		X	X																
1.12	Establish performance incentives agreements with Districts for CHW support	TL + District Leads	Districts			2	2	2														
1.13	Recruit and orient staff for Nyaraguru and Nyamagabe areas (6 Officers, 2 Admin Asst)	TL & Mgrs	Staff contracted				8															
<b>2. Community Mobilization</b>																						
2.01	Complete CHW Selection in Gisagara, Kirehe, Ngoma and Nyamasheke	District Leads	CHWs selected			7064																
2.02	Finalize selection of care group demonstration sites in Gisagara, Kirehe, Ngoma, Nyamasheke	Mobilization Mgr	HC catchment areas			8																
2.03	Recruit and Orient Promoters for Gisagara, Kirehe, Ngoma and Nyamasheke (3 promoters per district)	Mobilization Mgr	Promoters			12																
2.04	Orientation for care groups Gisagara, Kirehe, Ngoma and Nyamasheke	Mobilization Officers	HC catchment areas completed			8																
2.05	Complete community selection of CHWs in Nyaraguru and Nyamagabe	District Leads	CHWs selected				2950															
2.06	Finalize selection of care group demonstration sites in Nyaraguru and Nyamagabe	Mobilization Mgr	HC catchment areas				4															
2.07	Recruit and Orient Promoters for Nyaraguru and Nyamagabe (3 promoters per district)	Mobilization Mgr	Promoters				6															
2.08	Orientation for care groups in Nyaraguru and Nyamasheke	Mobilization Officers	HC catchment areas completed					4														
2.09	Qualitative assessment on key factors affecting diarrhea care practices (internship)	WR Backstop	Report					1														
2.10	Apply integrated behavior change message skill building in staged manner during routine CHW meetings	Mobilization Officers	see below					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
a)	Preparation for module 1 Malaria (local assessments, preparation of facilitators)	Mobilization Officers	module prepared					1														
b)	Module 1 (Malaria) roll-out to CHWs	Mobilization Officers	Non-specific						X						X							
c)	Preparation for module 2 Diarrhea (local assessments, preparation of facilitators)	Mobilization Officers	module prepared							1												
d)	Module 2 (Diarrhea) roll-out	Mobilization Officers	Non-specific								X											
e)	Preparation for module 3 Pneumonia (local assessments, preparation of facilitators)	Mobilization Officers										1										
f)	Module 3 (Pneumonia) roll-out	Mobilization Officers	Non-specific										X									

(version April 21, 2007)				YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5			
Activity	Responsible	Unit	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
2.11	Conduct semi-annual CDC mobilization and capacity building days at the sector level	Mobilization Officers					24	31	40	46	40	46	40	46	40	46	40	46	40	46	16	15	
2.12	Assess motivation of CHWs												X										
2.13	Documentation of care group vs. standard CHW model effect on community child health practices	Mobilization Mgr																	1				
<b>3. Roll-out Community IMCI and CHW CCM</b>																							
3.01	C-IMCI Sector Orientations (94 sectors)	District Leads			30	34	15	15															
3.02	Finalization of C-IMCI training modules with IMCI Working Group	TL & QA Mgr			x	x																	
3.03	District TOT for CHW Diarrhea, Malaria, & Pneumonia strategy	District Leads			2	2	2																
3.04	HBM Area CHWs update on Coartem® in old Kibilizi, Kibogora and Kirehe & Ngoma Districts (4122 former Distributors)	District Leads			675	3447																	
3.05	CHW Training Diarrhea & Malaria	District Leads					3182	2596	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
3.06	CHW Pneumonia Pilot	District Leads			216	216																	
3.07	CHW Training Pneumonia roll-out	District Leads					3510	1602	2754														
3.08	Revision of CHW Supervisors working tools	M&E + QA Mgrs			1																		
3.09	District CHW Supervisors Orientation	District Leads				2	2	2															
3.10	Routine CHW Supervision by HC personnel (2 visits per CHW per year)	District Leads					1097	2125	2899	2899	2899	2899	2899	2899	2899	2899	2899	2899	2899	2899	2899	2899	
3.11	Complete Clinical IMCI training in Gisagara	QA Officer/Gisagara					18																
3.12	Monthly CHW Association and Care Group Meetings	All Officers			353	531	531	753	753	753	753	753	753	753	753	753	753	753	753	753	753	753	
3.13	Annual CHW Quality Improvement Reviews	QA Officers							61				61				61					61	
<b>4. Strengthening Health Service Delivery System</b>																							
4.01	Complete procurement and monitoring plan for essential drugs for CCM (includes liaison with NMCP & UNICEF)	QA Mgr				X																	
4.02	Manage procurement and distribution of EIP CCM supplies (timers, ORS, zinc, and Amoxicillin)	QA Mgr			X	X	X	X	X	X	X	X	X										
4.03	Monitor, Document and early follow-up on CCM essential supplies situation	QA Mgr + Officers					2	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	
4.04	Review and document HC/CHW team QA efforts during monthly supervision	QA Mgr					2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	
4.05	Monitor and strengthen HC supervision situation with District Supervisors	QA Officers					2	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	
4.06	Study drug uptake and costs and assess community willingness to pay	QA Mgr						1										1					
<b>5. Monitoring &amp; Evaluation</b>																							
5.01	Develop 10 module data analysis and feedback package for HC teams	M&E + QA Mgrs			X	X																	
5.02	Staged M&E analysis and feedback skill building with HC teams	M&E + QA Officers					51	51	51		77	26	77	26	77	77	77	26	77	77			
5.03	Review and adapt community activity monitoring tools and forms (With BASICS + IMCI TF partners)	M&E Mgr + Officers			1																		
5.04	Introduction to select district personnel use of PDAs in routine monitoring	M&E Mgr					1	1			3	3											
5.05	Operations research on PDA use at HC level	M&E Mgr + Officers					2	2	4	4	10	16	18	18	18	18	18						

(version April 21, 2007)			YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5				
Activity	Responsible	Unit	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
5.06	M&E needs assessment for CHW Supervisors and HC personnel	M&E Officers			X			X			X				X				X				
5.07	Advanced data analysis and reporting skill transfer for District Supervisors and EIP M&E Officers	M&E Mgr	Training sessions				4	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
5.08	Monitor compliance to CHW Supervision performance incentives plan and manage payments to district	District Leads	HC team performance per stds				65%	70%	75%	75%	80%	80%	85%	85%	90%	90%	95%	95%	95%	95%	95%	95%	95%
5.09	Strengthen data analysis and reporting practices by District & HC personnel through coaching during monthly meetings	M&E Officers	Districts		2	4	4	5	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
5.10	Capacity building the health centres to organize and implement LQAS mini survey at health centre level for CHW performance monitoring	SE	Mini-surveys						X				X			X						X	
5.11	Strengthen disease surveillance system at HC and District levels for malaria, pneumonia and diarrheal diseases outbreaks/epidemics	M&E Mgr	surveillance reports of outbreaks/epidemics				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5.12	Supervision des Care Groups	Promoters	Care groups supervised			126	126	126	126	126	126	126	126	126	126	126	126	126	126	126	126	126	126
5.13	Semiannual client satisfaction surveys	QA Officers	Districts					4			6			6			6				6		
5.14	Quarterly Program Reporting and Staff Meetings	TL & Mgrs	Meetings	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
5.15	Annual internal review and report	TL + CW Backstop	Annual Reports						1				1				1						1
5.16	Midterm and Final KPC Surveys	M&E Mgr	Districts								6								6				
5.17	Final HF Assessment	QA Mgr	Districts																		6		
5.18	Final Community capacity assessment	Mob Mgr	Districts																		6		
5.19	Externally led participatory midterm and final evaluations	IRC Backstop w/TL	Evaluations										1										1
<b>6. Advocacy</b>																							
6.01	Participate and contribute at the national level in developing tools for the community information system	M&E Mgr	Meetings			X	X	X	X	X	X												
6.02	Collaborate with BASICS to update C-IMCI algorithms for pneumonia, diarrhea and newborn care with the IMCI Working Group	TL & QA Mgr	Non-specified			X	X																
6.03	Establish and implement advocacy strategy for inclusion of CCM in mutuelles and/or other financing schemes	TL & QA Mgr	Non-specified									X	X	X	X								
<b>7. Technical Assistance</b>																							
7.01	Attend CSTS PDME Backstop Institute	M&E Mgr + Backstops	Persons	3																			
7.02	Participate in BEHAVE training in Mali	Mob Mgr	Persons		1																		
7.03	Refinement of social behavior change strategy with EIP Team and partners	WR Backstop	Person weeks				2																
7.04	Monitoring system review and refinement and advanced PDA training	IRC Backstop	Person weeks					2															
7.05	Quality Assurance Strategy refinement with EIP Team	CW Backstop	Person weeks					2															
7.06	Facilitation of 2nd annual review and partnership assessment	CW Backstop	Person weeks							2													
7.07	midterm survey preparation	IRC Backstop	Person weeks								2												
7.08	MidTeam Evaluation participation (tentative June 09)	CW/IRC/WR backstops	Person weeks									9											
7.09	Refine M&E based on Midterm Findings	IRC Backstop	Person weeks											2									
7.10	Review modified CG approach in demonstration sites	WR Backstop	Person weeks														2						
7.11	Refine QA based on Midterm Findings	CW Backstop	Person weeks													2							
7.12	Final evaluation survey preparation	IRC Backstop	Person weeks																2				
7.13	Final Evaluation participation (tentative July '11) and documentation of lessons learned	CW/IRC/WR backstops	Person weeks																				9
7.13	Finance and administration support	CW US	Person weeks				1				1							1					1