

CONCERN WORLDWIDE

USAID Child Survival & Health Grants Program

FIRST ANNUAL REPORT

KABEHO MWANA

“Life for a Child”

**An Expanded Impact Child Survival Program (EICSP) in
Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke,
and Nyaraguru Districts, Rwanda**

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

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List of Acronyms

ACT	Artesunate Combined Treatment (Coartem)
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CAMERWA	Central Purchasing Body for Medicines in Rwanda (Centrale d'achats de Medicaments du Rwanda)
CCM	Community Case Management
CDC	Community Development Committee
CHW	Community Health Worker
C-IMCI	Community IMCI
COSA	Comite de Sante
CSHGP	Child Survival Health Grants Program
CSP	Child Survival Program
CTO	Cognizant Technical Officer, USAID
CW	Concern Worldwide
DIP	Detailed Implementation Plan
EICSP	Expanded Impact Child Survival Program
GoR	Government of Rwanda
HBMF	Home-Based Management of Fever
HC	Health Center
HFA	Health Facility Assessment
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Prevention Treatment
IRC	The International Rescue Committee
IT	Information Technology
LLIN	Insecticide Treated Bed Nets
JAF	Joint Action Forum
KPC	Knowledge, Practice and Coverage survey
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MOH	Rwandan Ministry of Health
MOU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
NMCP	National Integrated Malaria Control Program
ORS	Oral Rehydration Salts Solution
PAC	Program Advisory Committee
PDA	Personal Data Assistant
PMI	Presidents Malaria Initiative
PVO	US Private Voluntary Organization (refers to CW, IRC and WR)
QA	Quality Assurance
RDHS	Rwanda Demographic & Health Survey, 2005

SBC	Social Behavior Change
SP/AQ	Sulfadoxine/pyrimethamine and amodiaquine
TBA	Traditional Birth Attendants
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WR	World Relief
WRA	Women of Reproductive Age

Introduction

With a population of approximately 9 million people inhabiting some 26,338 square kilometers Rwanda is the most densely populated country in Africa (340 persons per square km). It is estimated that one-third of families live in extreme poverty with less than a dollar per day.¹ The child mortality rate of 152/1000 has declined by 20% over the last five years,² 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.

The *Kabeho Mwana* Program is a collaborative effort of Concern Worldwide (CW), International Rescue Committee (IRC) and World Relief (WR), building on the successes and lessons learned from all three partners' previous child survival programs in Rwanda and elsewhere. This Expanded Impact program is the first ever to have been implemented in Rwanda and will see activities implemented in six out of the 30 districts of Rwanda, covering approximately one-fifth of the country. 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 provides 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. To do this the program harnesses a network of 7,187 community health workers (CHWs). It is the intention of the three PVOs 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 intermittent presumptive treatments of Fansidar (IPT) 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 from 19% to 50%

¹ UNICEF, State of the World's Children 2005

² Demographic Health Survey, Rwanda 2000 and Preliminary Report November, 2005

- Increase use of zinc treatment among children with diarrhea 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). Concern Worldwide is responsible for quality assurance and overall coordination and grant management.

This report describes the activities implemented, achievements to date and also the constraints from the first year of the five-year expanded impact program, specifically October 2006 – September 2007. The program annual review process was facilitated by the Team Leader and was focused around two two-day workshops for the EICSP team. The first workshop focused on sharing the reporting guidelines and clarifying the information needed from district level. The officers, notably the lead officers for each of the districts, then spent time discussing with district authorities to verify data, discuss progress to date, as well as their perceptions of the first year. A second workshop, held in early October, served to collate all this information, discuss and verify key points and develop the work plan for year two. In addition, meetings were held with the directors of IRC and WR to discuss main accomplishments and any potential issues for year two.

A.i. Main Accomplishments

The scale-up 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 the supply of drug, training and supervision inputs as well as quality improvement processes. 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.

Working with the IMCI task force which harnesses expertise and operational efforts of multiple actors including BASICS, Twubakane, WHO and UNICEF as well as the MOH and the National Malaria Control Program (NMCP) 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.

The main accomplishments from the first year are described below and are followed by tables that show the status of activities in relation to the three strategic objectives.

Firstly, it must be mentioned that setting-up this large scale program as a consortium of three PVOs was a huge accomplishment. It necessitated the establishment of harmonized systems and procedures that were acceptable to all three organizations. A high degree of planning, open discussion, adaptation and flexibility were needed by all parties to have reached this point. A prime example is the harmonization of the salaries and basic allowances across the program so that staff receive the same regardless of which PVO they are employed by. This was a large contribution to reducing potential tensions and assisted with building up the team.

It is a very positive milestone that at the end of the first year, all the people working on the program, as well as key stakeholders, see *Kabeho Mwana* as its own entity rather than an amalgam of the three PVOs. It shows that three PVOs, while each very distinct, can work together well. It is this ability to work together where each PVO brings its own strengths to the table that will make it possible to achieve the desired scale in this program and contribute to sustaining good practices and achievements. This is particularly important at the national level where the program is already contributing to a number of technical working groups, such as the group that is developing the tools and documents as part of the national C-IMCI strategy.

Bringing community case management to scale quickly with over 77,900 sick children under five being treated at community level. .With a focus on driving out services to the community level, the program quickly scaled up treatment to remaining villages in the four districts so that from October 2006 to September 2007, CHWs had provided screening, treatment and referral services to 73,357 children with fever in four districts of whom 90% were treated within 24 hours of the onset of symptoms. Setting an example for CHWs across Rwanda, workers in Kirehe and Ngoma saw 4,513 children with diarrhea who were given ORS and therapeutic course of Zinc. The success and imminent scale-up of diarrhea treatment by CHWs to the remaining four districts in the coming months is described in the highlight Section O of this report.

Election of 4,452 Community Health Workers (CHWs) in four districts. Following the national 2006 district restructuring where community delineations were redrawn, each imidugudu was

tasked to elect two CHWs who serve as the backbone of the C-IMCI strategy. From May to August, the program staff worked diligently in the four districts worked to improve the quality of the selection process and advocate for the retention of active, well performing Distributions and Animators into these newly designated volunteer posts. Staff were able to draw on the experience of earlier HBMF work to remind communities of the important role undertaken by the CHWs in relation to treatment at community level and how this role would become wider as C-IMCI was rolled out. Over half (58%) of the elected CHWS were previously trained as Distributors in areas previously served by Home Based Malaria.

Table 1: Summary of CHWs elected by sex and outcomes for former Animators and Distributors by district*

Districts	Number of CHWs by Gender		TOTAL number of CHWs	Number of Elected CHWs who were former Distributors	Number of Animators and Distributors not re-elected
	Women	Men			
Gisagara	525	525	1,050	292	294
Kirehe	625	625	1,250	646	111
Ngoma	475	473	948	522	363
Nyamasheke	700	504	1,204	365	173
TOTAL	2,325 (52%)	2,127 (48%)	4,452	1,825	941

* From June to August 2007, each *imidugudu* in the four EICSP districts elected Community Health Workers composed of a male/female *binôme*, ensuring gender equity and they form the link between the health centers and the communities.

Despite pretty good retention, 941 animators and distributors were not re-elected. This was partially because there were more male distributors than is required (each *imidugudu* should have one male and one female CHW) as well as some dismissal of low performing or inactive Distributors. Non re-elected Distributors were obliged to discontinue malaria treatment and return their kits to the district so that they can be recycled for the newly elected CHWs. The program is advocating for the Community Health Desk of the MoH to consider these skilled community resource persons for areas where additional number of CHWs might be needed for CCM and/or health promotion. As it is now, the implementation plan for this vast CHW network is still in progress with the MOH Community Health desk.

Informing the national C-IMCI guideline development from our home based malaria experience. As a full member of the MOH/MCH/IMCI task force, the program team was able to ensure that the recently validated and endorsed CIMCI guidelines reflected the tools and learnings from the home based management of fever in regards to integration, training, supervision, data information systems, and motivation of community workers. The program team actively participated in planning and accelerating the implementation community case management, not only for malaria, but also for the other leading childhood killer diseases of pneumonia and diarrhea. In year one, a complete guideline was validated by the MoH which includes CHW friendly algorithms, training content, supervision and logistics strategy, as well as M&E tools. The final C-IMCI Guideline is attached in Annex 5 in French.

Formalized partnerships with district authorities. With such a large program it was an obvious priority to ensure that key stakeholders at the district level were informed about the program rationale, interventions and activities. Meetings were held district by district where the program was presented to Mayors and the District Heads of Health. This was followed up by a two-day national workshop in December at which the work plan for year one was discussed, the C-IMCI approach was presented and the concept and draft contents of the MOU were debated. In addition, a French version of the original proposal was also disseminated. A follow up workshop was held in

March at which the baseline assessment findings were shared and proposed interventions for the DIP were discussed. Memoranda of Understanding, which set out the roles and responsibilities of the program and the districts, were then finalized and signed with each district mayor. Dissemination workshops were also held at sector and cellule level where baseline survey findings were shared and discussed.

In addition, the District Health Director has appointed a local counterpart among the district hospital personnel to each of the three EICSP Officers in the first four districts. These counterparts, or “homologues” already have a responsibility for health services supervision. The counterpart strategy intention is to ensure maximum possible options for program communications, skill sharing, and institutionalizing health center supervision and community health services monitoring.

Design and implementation of three large baseline studies across such a wide geographic program area provided excellent district-wise data for planning the detailed implementation plan (DIP). Despite considerable logistical challenges, the program team with support from the district personnel completed the KPC, HFA and the capacity assessments of COSAs and CDCs and also held workshops where the basic findings were disseminated and discussed with stakeholders during the period of January to March, 2007. At the June DIP review, the review panel gave very positive feedback on the quality of the DIP and how it illustrated the collaborative efforts of the three PVO partners, and how it built on their respective strengths. The reviewers also considered the baseline studies as of high quality, well designed and incorporated innovative elements such as the Capacity Assessment and application of the new rapid child health service provision assessment.

In summary, the focus of the first year has been to establish the systems, structures and relationships necessary to move forward in the coming years. In the four initial districts the program is now fully operational and has successfully carried out baseline surveys that will inform measurement of impact. The program is working at all planned levels, from the sector level where trainings for HBMF have began through to planning CCM drug management and supply at the district level, to policy engagement concerning IMCI at the national level. This report describes program progress to date. After only one year it is too early to expect significant measurable impact against the strategic objectives. More detailed results will be presented in the second annual report. For now the overall progress is as expected and consortium members are satisfied that the program is on track for strong results in year two and beyond.

A.ii. Summary of Program Progress towards achieving Objectives

Key Activities (as outlined in the DIP work plan)	Status (“Achieved”, “On track” “Not on track”)	Explanatory Comments and remarks
Strategic Objective One: Increasing access to prompt first-line treatment for young children with malaria, diarrhea, and pneumonia		
1.1 Expanding access to community case management		
District Training of Trainers (TOT) for CHWs training in Diarrhea, malaria & pneumonia community case management in four districts	Achieved for malaria (HBM training only) On track for diarrhea and pneumonia in year two	Given the delays in finalizing the CIMCI modules, the project proceeded to roll-out district malaria training of trainers. A total of 125 health facility staff (39% women) from 53 health centers and 6 hospitals in the initial four districts. A district training of trainers for CHWs training in community-IMCI (diarrhea, malaria and

Key Activities (as outlined in the DIP work plan)	Status (<i>“Achieved”</i> , <i>“On track”</i> <i>“Not on track”</i>)	Explanatory Comments and remarks
		<p>pneumonia included) was completed in Kirehe district. Twelve health center staff were trained.</p> <p>The national guidelines were presented and accepted in June to the Government of Rwanda Ministerial Committee. Then, with the technical support from BASICS and other institutional partners (UNICEF, PCIME, PNLIP, Twubakane, Community Health), a five-day workshop for district trainers to validate and test the C-IMCI tools for all three diseases was completed in July 2007. It included teams from 7 selected staff of Kirehe district health centers and 10 CHWs and the EICSP district team and managers, who are now ready to roll-out CHW training once supplies are all in place.</p>
CHW update on @Coartem in old HBMF areas for 4,122 former distributors	On track	Ultimately full home based malaria training for 3 days was required for the old working areas rather than simply an update on the use of Coartem due to the large non-reelection of former Distributors as the new CHWs. Training was completed for all 2,636 CHWs in Kirehe District and the former Kibogora intervention area (part of Nyamasheke District). Training for the former Kibilizi District (now Gisagara) and Ngoma was delayed due to national shortage of community packaged Coartem, CHW drug kits, and other training materials from the NMCP side. The supply situation has improved and training to be completed in the first quarter of the coming year.
CHW Pneumonia pilot in two HCs in each of the 4 districts	Not on track	There was a disagreement within the IMCI Task Force about the selection of sites for community case management pilot of pneumonia and ultimately all parties decided the introduction should be limited to three districts ³ of which only Kirehe is in the project area. In July 2007 BASICS validated the protocol and collaborated in the training of teams of district trainers in pneumonia, malaria and diarrhea case management for CHWs. Start-up of CHW training was delayed by problems in securing amoxicillin (see section B for further details). As of the time of writing the report, the MoH has declared that it is ready to roll-out the whole CCM package without doing a specific pilot so EIP should be able to proceed with integrated training in all districts in the coming year.
1.2- Strengthening health service delivery system		
Complete procurement and monitoring plan for essential Community Case Management drugs (includes liaison with NMCP & UNICEF)	On track	Delays in national procurement and packaging of Amoxicillin and Coartem are described in section B. The EIP helped the national pharmaceuticals store, CAMERWA, to source a supplier of packaged Amoxicillin as well as advocated for national procurement of Zinc and low osmolarity ORS. These items will then be purchased by EIP

³ Ruhango, Nyanza and Kirehe

Key Activities (as outlined in the DIP work plan)	Status (<i>“Achieved”</i> , <i>“On track”</i> <i>“Not on track”</i>)	Explanatory Comments and remarks
		<p>from CAMERWA directly.</p> <p>The program currently has in stock 500 timers, 234,000 zinc tablets, 70,200 ORS packets, 1998 MUACs for CCM activities. An additional 9000 timers are on order from UNICEF and expected to arrive in December 2007.</p> <p>Tools for monitoring availability of essential supplies at the CHW, district and national level are under-development and to be completed and applied in the coming year.</p>
1.3. To establish performance contracting for CHW supervision		
Establish performance incentives agreements with districts for CHW support	On track	Draft contracts have been prepared and discussed with each district. These will be finalized in early year two. All the 53 health centers in 4 districts have already agreed to designate one or two qualified staff with the responsibility of supervising a CHW once every quarter based on existing personnel. EIP management modified the diminishing contribution to district for the first three years, instead providing a median level of financial support so it is seen as an incentive.
1.4. National C-IMCI strategy development and district roll out.		
Introduction to district partners of the partnership and the C-IMCI approach	Achieved	33 officials (District Mayors, Vice-Mayors, Executive Secretaries, Health/Medical Directors, Sector representatives (11 women and 22 men) from the 6 program districts attended a 2-day program orientation workshop in Kigali in December 2006.
<p>Collaborate with BASICS to update C-IMCI algorithms for pneumonia, diarrhea and newborn care with IMCI working group</p> <p>Finalization of IMCI modules with IMCI working group.</p> <p>Participate and contribute at the national level in developing tools for community information system</p>	Achieved	<p>Involvement of 10 program staff in the review, harmonization, testing and validation of the community-IMCI modules in three workshops organized by the IMCI working group. With a few modifications, the trainers and the CHWs are able to use the tools. The C-IMCI tools advised referrals of all newborn children from birth to two months of age to health facilities if they are ill. Because malaria infection in the mother can affect the newborn, the IPT preventive strategy of the program contributes to the newborn intervention.</p> <p>Monthly participation and involvement in the IMCI working group under the MCH Unit Task Force, in the NMCP technical working group meetings, and in the PMI implementing partners' meeting.</p> <p>Major input into the development and harmonization of the CHW training module by the Community Health desk after its recent structuring by the MOH to be the overall coordinating body for the country's community health program</p>

Key Activities (as outlined in the DIP work plan)	Status (“Achieved”, “On track”, “Not on track”)	Explanatory Comments and remarks
Complete clinical IMCI training in Gisagara district in order to improve and maintain good standards of quality referral care by CHW	Achieved ahead of schedule	<p>Activity originally planned for the beginning of year two; however, due to availability of trainers and delays in CIMCI training this was done in year one. EIP provided technical assistance and financial support to train 29 clinicians from the 12 health centers and 2 hospitals in Gisagara District on the full course of clinical IMCI. The strategy is now fully operational in all health facilities of the district.</p> <p>In addition, the project provided financial support to complete the training for 8 clinicians in Nyamasheke District. While Family Health International had committed to fund the training for whole district, it withdrew this support in June 2007 and only was able to fund the participation of clinicians from the two partnering health facilities.</p>
Strategic Objective Two: Increasing coverage of key preventive interventions (Vitamin A, Iron, IPT, vaccinations)		
2.1 Coverage Monitoring and targeting at district level		
Develop 10 module data analysis and feedback package for health center teams.	Achieved	One M&E tool was developed, which is a guide to M&E at the district level, containing topics on data management, analysis, reporting and dissemination, use of data to inform programmatic decision making, including a database excel program training guide containing 3 modules on data entry, summarizing techniques and graphical presentation.
Review and adapt community activity monitoring tools and forms (with the IMCI Task Force partners)	Achieved	<p>Introduction of a new tool for CHW by M&E team, a death and birth registry and a simplified CHW supervision checklist to be used at the community level.</p> <p>M&E tools were included in the C-IMCI manuals and guidelines including HBMF.</p> <p>The final versions are now being used for training after a series of NMCP organized technical meetings and 2 workshops (development and validation) organized by IMCI task force group (EICSP and BASICS were key partners in this process)</p>
M& E needs assessment for CHW supervisors and health center personnel	Achieved	M&E Officers based in the 4 districts have undertaken this task during routine hospital visits to District Counterparts and visits to the relevant staff in health center visits
Quarterly Program reporting and Staff meetings	Achieved	Four general program staff quarterly meetings have been held. Monthly management team meetings also held where activity plans are made and reviewed.
2.2. Improve targeting and increase breadth of preventive child health services through outreach		
Vitamin A supplementation outreach campaign in 4 districts	On track	District data from Nov 06 – Aug 07 indicates that sufficient capsules were distributed to cover all children under-five and postpartum moms across all four districts. However, considerable levels of

Key Activities (as outlined in the DIP work plan)	Status (“Achieved”, “On track”, “Not on track”)	Explanatory Comments and remarks
		stock out were noted in Kirehe and Ngoma during the year at the health center level.
Pregnant women receiving two observed intermittent presumptive treatments for malaria (IPT) in 4 districts	On track	Health Center data (October 2006 - August 2007) indicated that 22,037 pregnant women received two observed IPTs during last pregnancy. This data translates into an estimated coverage of IPT1 at 64% which is fairly uniform across the 4 districts ranging from 60-65%; however IPT 2 coverage was only 48% and ranged considerably by district with 57% in Nyamasheke, 55% in Gisagara, 41% in Ngoma and 35% in Kirehe. This is an improvement from the 31% baseline earlier in the year but still a ways to go to achieve the end of project target of 80%.
Distribution of Long lasting insecticide treated nets (LLINs) to pregnant mothers and children under five years in 4 districts	On track	Health Center data (October 2006-September 2007) shows that a total of 23,006 LLINs were distributed to approximately 25% of under fives and pregnant women. Proportionately more nets reached these target groups in Kirehe and Ngoma; however, distribution was fairly uniform in all four districts.
Strategic Objective Three: Increasing adoption of key family health practice		
3.1. Community mobilization and social behavior change		
Complete CHW selection and elections in Gisagara, Kirehe, Ngoma and Nyamasheke districts	Achieved	As described earlier, a total of 4,452 CHWs were elected. This is significantly lower than the 7,064 number listed in the work plan as elections were limited to two per <i>imidugudus</i> (villages) regardless to size of village and in the Care Group areas, only two members are CHWs while the remainder are titled Care Group volunteers with non-CCM responsibilities.
Qualitative Assessment on key factors affecting diarrhea care seeking practices (internship)	On track	Preparatory work in progress by an intern supervised by World Relief.
Complete C-IMCI sector orientations in 54 sectors in 4 districts	Achieved	These one day events were well attended and ran from June-September 2007. All sectors in the first set of four districts have been completed.
3.2 Care Groups		
Recruit and orient promoters for Gisagara, Kirehe, Ngoma and Nyamasheke districts	Achieved	12 promoters recruited and given 3-day orientation along with 8 health center staff from these four districts.
Finalize the selection of eight care group demonstration sites in Gisagara, Kirehe, Ngoma and Nyamasheke and orientation of members, including CHWs	Achieved	<p>The following eight sites were chosen as care group demonstration sites:</p> <p><u>Kirehe</u>– Rusumo and Nasho health centers <u>Ngoma</u>– Zaza and Nyange health centers <u>Nyamasheke</u>– Mukoma and Mugeru health centers <u>Gisagara</u>– Musha and Save health centers</p> <p>A total of 109 Care Groups were established (approx. 14 per demonstration site) with 1,451 members (an average of 13 members per Care Group) composed of newly elected CHWs and other volunteers (TBAs, and non-reelected Animators and Distributors). Most (93%) of the</p>

Key Activities (as outlined in the DIP work plan)	Status (<i>“Achieved”</i> , <i>“On track”</i> <i>“Not on track”</i>)	Explanatory Comments and remarks
		members received orientation sessions on the Care Group model and their roles and responsibilities.

B. Challenges

This section describes the main constraints that the program has encountered in year one. Where appropriate the corrective action or potential actions needed have been noted. Considering the scale of the program, the complexities of the set up and the fact that at national level there are so many more actors involved, there has not been significant delay with any of the activities from year one and the program remains on track.

A few key internal challenges that the EIP team is working on include:

1. Building up district-level ownership of the intervention: As the program was originally designed during district restructuring, there was initially low participation of the core district-level actors in decisions related to the strategy design beyond counterparts from the first series of child survival projects. Leading up to the DIP, the program involved its district authorities in a program orientation and dialogue event in December 2007 and recruited district counterparts in baseline studies and strategic planning workshops. Further, there have been multiple consultations on the now completed MoUs with each district.

In sum, there was much work accomplished but the program needs to ensure that dissemination of key documents continues as well as ensuring sufficient opportunities for discussion of these documents with various district counterparts. The DIP is lengthy and detailed and key sections are being translated into French and Kinyarwanda and shared in early year two. There is also the challenge of ensuring the relevant stakeholders read the key documents and can discuss at meetings or workshops as often the main interest can be focused on just the budget sections of documents. The program intends to use the quarterly meetings as a key forum for discussion and planning with district authorities which will begin in year two.

The system of quarterly EICSP co-ordination meetings with the district chaired by the Health Director has not yet become fully operational. There has been good exchange of information and work on planning of activities so far, particularly during the extensive baseline surveys, elections of CHWs and some of the initial trainings. However, the program would benefit from more formal opportunities for presentation of progress, discussion of key issues with the district authorities and so high priority will be given to getting these quarterly meetings established early in year two.

2. Maintenance and enhancement of joint operational structures with three PVOs. There will be ongoing challenges in terms of the operational structure that the program has established. The district offices are the focus of the activities and the programs needs to ensure that the systems are reviewed on a regular basis and that any minor issues are identified and dealt with before they escalate. The program also needs to pay attention to any harmonization issues as these could be a source of tension and disgruntlement resulting in a decrease of productivity. Prime examples could be potential salary changes caused by a salary review conducted by one of the PVOs, leave entitlements and also differences in medical benefits or insurance schemes that are offered to staff.

Furthermore, the program should maintain awareness that such a consortium approach can result in much longer time being needed for discussion and ultimate decision making for some of the larger

issues that are encountered. It is vital that the established monthly meeting for PVO directors is maintained as these are crucial in identifying key issues and working towards appropriate resolutions.

There will be a formal review of the systems in use held early in year two and this will allow necessary modifications to be made. Finally, the issue of staff salaries is something that should be discussed by the management team and the three PVO directors. While the current salary ranges appear to be satisfactory when compared to other PVOs, there are more organizations, including more bi-laterals now involved in the health sector and so the program does need to consider the implications of this on staff retention.

Some key external challenges that the EIP team is working on include:

3. Changes in CHW strategy and elections. In August 2007 the MOH stated its intention to accelerate the introduction of C-IMCI across all 30 districts. The responsibility for making this happen was given to the Community Health technical working group under the direction of the Community Health Desk. It was also decided that there will be additional tasks given to the CHWs, in addition to the community case management of pneumonia, diarrhea and malaria. TB, palliative for HIV&AIDS and MCH activities will be added to the range of services delivered at the imidugudu level. This will have implications in terms of the time and resources needed to consolidate the existing HBMF and C-IMCI tools into an integrated CHW training module. Adjustments to the originally planned year two activities will be required to accommodate the changes. The integrated CHW training module is still in draft format, although the implementation of some of the components is planned for the month of October 2007.

In the coming year, the program will work jointly with BASICS to help to MoH review its experience and options to promote integration and sustainability in establishing its CHW strategy.

The elections of the CHW “binomes” or pairs across the country were part of the MOH changes to the Community Health Policy and so the program needed to fit in with the overall timetable for these elections. The end result was that the elections took place approximately two months later than planned and this had a knock on effect in delaying some trainings for the CHWs.

Based on the established MOH ratios (1 trainer for 5 CHW for the C-IMCI training and 1 trainer for 10 CHW for the HBMF training) it will take longer than planned to provide the necessary training in the program districts. Training time will be doubled and will now last for two months.

The frequency of elections for CHWs is not clarified in the MOH policy and there is a risk that subsequent elections could disrupt ongoing program implementation. The program has raised this as a concern with the community health desk of the MOH.

4. Availability of Coartem and CHW kits. While well planned to start training of CHWs on community management of malaria and moving from the amodiaquine/SP regimeine to ACT (Coartem®) there was a gap in the national supply of the new drug due to delays of repackaging in country. Based on these issues it was decided to push back the training in Ngoma and Gisagara districts until October 2007 (year 2) by which time all the relevant supplies would be available. The overall result of this was approximately a one month delay to the training in these two districts. As the HBMF activities proceed it is envisaged that shortages of materials will not be an issue in the future.

During the gap period of April-July 2007 stock outs of community antimalarials were widespread and sick children were referred to the health centers. Such a scenario was obviously not ideal. As

of October 2007 the supply of drugs has been adequate and community case management is functioning again.

There is ongoing discussion concerning the provision of the kits that should be provided to the CHWs post training. The 2006 evaluation of the HBMF pilot recommended that kits be provided and planning work included this item. There is currently some discussion over who will be responsible for funding these kits but it is envisaged that this issue will be resolved early in year two.

5. Procurement of Amoxicillin. There were a number of meetings to discuss the specifications of drug needed (250 mg or 125 mg and also the packaging per age group - blisters or breakable according to age; 2-4 month, 5-12 month, 13-30 months and 31-59 months). Based on this it took longer than planned to place the order for the amoxicillin by CAMERWA. At the same time there were some delays in the finalization of the C-IMCI tools by the task force. The validation of the tools took place in August with the first training of trainers for C-IMCI at the end of September. Therefore the delay in the procurement did not have a significant effect on the program.

On a positive note, the program did give major input, together with the staff of Deliver, into clarifying the whole quantification issue and was able to assist in identifying a pharmaceutical company that could supply what was needed.

6. Allowances for training, workshops and meetings. This issue has arisen numerous times during the first year of the program and while it has not delayed activities to any significant degree, it has been a source of frustration that might become more of an issue in the future. Following discussions at the USAID All Partner meetings in 2006, an Action Memorandum was issued that clearly set out USAID's policy on allowances. The policy was based on a GOR presidential order and was to be strictly followed by all USAID implementing partners.

CW incorporated the new USAID policy and produced a policy that could be used for all its programs (not just the USAID funded ones). This was discussed at the EICSP monthly CD meetings and it was agreed that the three PVOs would adopt the same approach to enable consistency across the program. Unfortunately, despite the program having endeavored to be transparent and having shared documentation on these allowances with district authorities and participants, the program's experiences so far is that many participants either do not respect the procedures or have tried to manipulate the process. Besides causing frustration for program staff this can have a negative impact on the atmosphere of the event.

This issue is part of the overall USAID policy and therefore the program experiences and concerns have been formally raised at the USAID All Partner's meeting. The Team Leader is following up with the Mission and is discussing possible modifications that can be made to the policy. The main idea is the introduction of a flat rate payment rather than the current policy of claiming back against receipts.

C. Technical Assistance Requirements

Technical assistance needs were identified during the preparation of the DIP and no changes were made during the first annual review. The technical support sourced by the backstops from the three PVOs will visit to provide the following assistance during year two:

- **Financial and administrative systems review (CW)**

A support visit is planned by the Concern US Finance Director in the first quarter of year two to assist with the review and refinement of the modalities systems and processes and to look at compliance and reporting issues.

- **Neonatal health integration strategy for CHWs and Care Groups (WR)**

World Relief has identified a Fulbright Scholar, Ms. Christine Brackett, who will be working in neonatal health in Rwanda beginning January 2008. She will be the point person for weaving neonatal elements into the project's approach to C-IMCI and has already been in touch with the BASICS project to identify points of possible collaboration.

- **Quality assurance strategy refinement (CW)**

The five main objectives of the quality assurance strategy are outlined in the DIP (pages 74-75). The purpose of this technical support visit will be to work with team to see what modifications may be needed following the first 1.5 years of implementation particularly in light of the large turnover of CHWs and changes in the performance contracting approach for CHW Supervisors. The key output will be an updated quality assurance strategy and development of district quality score card system. This work will be done in consultation with BASICS and the IMCI desk so that it builds towards national expectations of a district quality assurance approach.

- **Social behavior change strategy refinement(WR)**

This process will involve local assessments to refine key messages and materials that will be incorporated into the overall social behavior change strategy of the program. It will take place after the additional formative research (planned for early year two) that will look at diarrhea classification and care-seeking. The key output from this visit will be an updated and refined social behavior change strategy reflecting qualitative research findings and input from national partners.

- **Monitoring system review and streamlining and operations research agenda (IRC)**

This visit will focus on assessing the performance of the program monitoring system to date with a particular emphasis on the three monitoring methods chosen by the program: the six monthly periodic performance assessments (PPAs), the CHW monthly reports, and the Supervision checklists. The issue of partner's skills in relation to using the health information system will be assessed following the first year's capacity building work by the M&E Manager and the Officers. Technical assistance will be provided in order to streamline and refine the existing database; establish clear reporting mechanisms; and ensure routine feedback and dissemination of results. Additionally, the IRC will be carrying out operations research to examine treatment of co-morbidities. The same monitoring system will be used to collect data and disseminate results of the research.

- **Partnership assessment and 2nd annual review (CW)**

This visit will assist the team in holding discussions with all the key partners – representatives from the six districts, MOH, NMCP, BASICS, Twubakane, MSH-RPM+, UNICEF as well as the members of the Project Advisory Committee. Meetings will also held with IRC and WR. The purpose of this partnership assessment will be to jointly review progress to date, identify strengths and also clarify gaps that will be used to inform the planning for year three and beyond. The CW Program Officer will lead the documentation for the annual report and workplan development.

There is the possibility that additional IT support may be sought in order that the program can establish an appropriate IT structure that covers all the seven program offices.

D. Substantial Changes

There are no significant changes that will require any modification to the Cooperative Agreement. However, a couple of issues to flag include:

Malaria burden in Nyaraguru and Nyamagabe. Despite findings to the contrary in the baseline assessments, the two EICSP districts where activities will commence at the start of year two (October 2007) are considered non-endemic areas for malaria transmission and as such HBMF is not being implemented. Since July the NMCP has been conducting operational research to determine the epidemiological pattern of malaria in these areas. Community case management of malaria as an integrated C-IMCI package in these two non-endemic districts will be further reviewed and assessed jointly by the malaria technical steering committee, chaired by NMCP and PMI, based on the results of the operational research.

Potential decline in number of CHWs. The program was designed with the intent to engage 8,299 CHWs for both health promotion and community case management functions. The number was based on an estimated ratio of 35 households with women of reproductive age and children under-five. However, to date we have been keeping in line with the MoH draft Community Health Policy which limits CHWs to two per village, regardless of the number or proximity of residents. Further, in the Care Group areas, additional volunteers are not designated as CHWs and do not have the CCM responsibilities as per the current thinking in the national policy. This could result in a decline in number between 1200 and 2300 CHWs. We would like to continue to plan for the original number as we continue to advocate for increasing them in areas that need more CHWs to ensure good access and realistic workloads.

E. Monitoring Plan

The M&E team built the monitoring systems on the strengths of the previous reporting systems from all three partner organizations.

- The **registers** have remained unchanged for the time being; we are awaiting new templates accounting for treatments of all three major childhood diseases. Of note, this new template was largely based on the model proposed by EIP managers.
- The **database** was improved from the past; it is still based on Excel, but takes a database format for easier analysis and eventual transfer to a full-fledged data infrastructure. Data is currently entered by the M&E officers in each district, working with their counterparts.
- There have been **regular meetings to review the data**. We have not yet finalized a template for corresponding written reports for Districts and the Ministry of Health.
- **Supervision checklists** have been developed and are in use. However, they have not yet been finalized, pending new community IMCI documents, and have also not be entered into a database or regularly analyzed.
- **Birth and deaths registers** have not yet been implemented. We have designed a template but have not yet tested it.
- The **database of community health workers** has not yet been completed but is in progress.

As it stands, the monitoring system gives essential data such as the number of people treated, and drugs consumed as shown in Table 2 below.

In the coming year, we will be working to:

- **Upgrade the database**; one option is to include signing on to the current on-line database used by HIV programs. We are in discussion with the technical provider.
- **Phasing in auxiliary databases**, including supervision, vital events, and community health worker records.

- **Increasing use of existing information**, in particular working to produce regular written reports for Districts and other stakeholders.

Table 2- Number of Malaria and Diarrhea Cases treated by CHWs at the community level and at Health Facilities in Kirehe, Ngoma, Nyamasheke and Gisagara Districts (Oct 2006 to Aug 2007)

Numbers of sick children under-five treated for	Kirehe		Ngoma		Nyamasheke		Gisagara		TOTAL	
	CHWs	Facilities	CHWs	Facilities	CHWs	Facilities	CHWs	Facilities	CHWs	Facilities
Fever	23,144	12,715	18,491	19,743	6,439	12,577	25,286	10,937	73,360	55,972
Diarrhea	2,081	3,232	2,432	2,663	*	3,181	*	1,423	4,513	10,499
Acute lower respiratory infections/pneumonia	**	5,664	**	4,003	**	11,102	**	3525	**	24,294
Total	25,225	21,611	20,923	26,409	6,439	26,860	25,286	15,885	77,873	90,765

* CHW management of diarrhea currently operational in Kirehe and Ngoma

** CHW management of pneumonia not yet operational

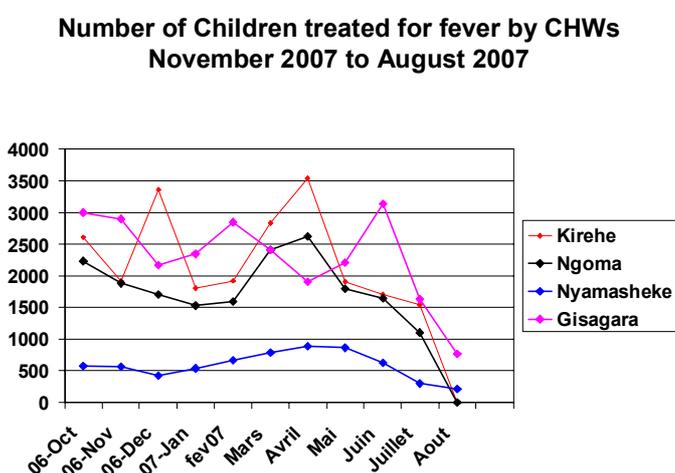


Figure 1 shows that there was a decreasing number of fever cases seen from July due to the transition from AQ/SP to Coartem. A total number of 73,357 under fives were seen by CHWs, of which 90 % were seen less than 24 hours of start of fever.

Proportion of children seen by CHWs with fever who recovered, died or referred Oct 06- August 07

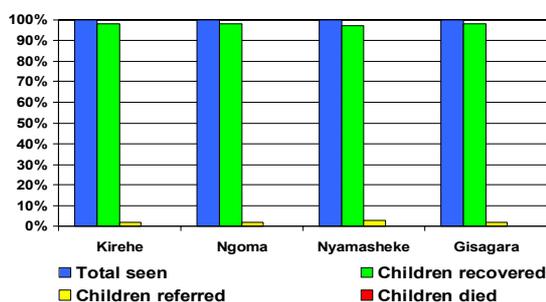


Figure 2 Ninety-eight percent of children seen improved with AQ/SP, 2 % were referred to Health facilities and 0.02% died (17 children), relatively consistent in each of the 4 districts.

F. Sustainability

As stated in the DIP the program will develop and apply the Child Survival Sustainability Assessment framework. The vision and broad goals were developed during the first annual review by the project staff and are shown below. Further discussion is required in the coming months with

our district counterparts and the Program Advisory Committee before it is finalized and a measurement plan established.

Vision	Communities where carers show consistent and positive care seeking behavior in relation to malaria, diarrhea and pneumonia and other childhood illnesses. Communities where children are not dying before their fifth birthday. Communities where community health workers continue to provide quality first line treatment.		
Goals	Health and Services Dimension	Local Organizational Dimension	Community & Social Dimension
	Improve the health of under fives through an effective referral health system and CHW monitoring and supervision	Improve the capacity of the local civil society leadership and CHW associations in order to become effective agents for behavior change and sustainable community health financing schemes	Strengthen the communities ability to manage their own health problems, building on their competence in administration, decision making and good governance in supporting child health
Elements or objectives	<ul style="list-style-type: none"> - Build skill and enable HC staff to train and supervise CHWs - Build skill of CHWs to provide CCM and maintain accurate records - Build COSA leadership for community-oriented health services - Ensure sound management of essential drugs and commodities 	<ul style="list-style-type: none"> - Strengthen CHW associations - Develop CDC leadership in health - Develop church leadership in health - Reinforce mutuelles associations 	<ul style="list-style-type: none"> - Build capacity for local problem solving among CHWs, community leaders and households with young children at the imudugudu level - Establish routine reporting system on key child health data

A measurement framework will be developed during year two and will be consolidated during the second annual review (September 2008).

Other key activities in relation to sustainability undertaken during the first year include:

- The community institution capacity assessments carried out in all six of the program districts serve to provide a baseline for CHWs and the COSAs against measurement will be made in subsequent years of the program.
- As part of the ‘strengthening health service delivery system’ component, the program has been working to establish systems with the districts to manage the supply of CCM drugs at all levels. This has also involved discussion and collaboration with the MOH pharmacy task force, who is the body charged with liaising with CAMERWA. Collaboration with RPMplus in year two will strengthen the supply and management of CCM drugs.

This program is using the C-IMCI approach and it should be noted that everything is being done with the context of the national IMCI Task Force. This has ensured maximum recognition for the program and created ongoing opportunities for discussion and sharing. The program is working within the developing IMCI arena and is contributing to developing strategy and strengthening government structures.

G. Specific Information requested from the DIP Review

All requested information was added to the DIP that was submitted and approved on 31st July 2007.

H. Social Behavior Change Strategy

The SBC strategy that the program has designed is included in the DIP (pages 67-70). The broad goals and objectives as well as how the strategy will be operationalized are described and the BEHAVE framework is included as an annex to the DIP.

This section of the report gives an update on the situation at the end of the first year. A qualitative research expert has started a participatory inquiry that will look at care seeking and uptake of recommended treatments for diarrhea at the household level. Questionnaires have been developed with the team and translated into Kinyarwanda. There will be a big emphasis on building the capacity of the program staff to design and conduct additional qualitative research that will inform behavior change activities and the mobilization strategy over the next four years of the program. The overall goals for the research are to identify barriers, facilitators and key messages appropriate for geographic and social contexts to increase home care, care seeking and prevention. The BEHAVE framework will be modified accordingly based on the outcomes of this research.

BASICS are undertaking similar research on malaria and the EICSP intends to conduct some research in relation to pneumonia. The two programs are working together to ensure that his formative research on care-seeking behavior and practices for the three diseases will be used to inform the MOH's national family health communications strategy.

I. Programs in Final Year

Not Applicable

J. Family Planning Program

Not Applicable

K. TB Programs

Not Applicable

L. Management Issues

A dedicated office in the center of Kigali was established for the EICSP and this has helped give the program and team a greater sense of identity, while still facilitating the contact and support provided by the respective PVO head offices in Kigali.

One of the most challenging tasks during the first year has been to design and set up operating procedures and systems for the program across all six district level offices and the Kigali EICSP 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. These procedures and systems were documented in a 'modalities document' and were first put in place as from April 2007, once the DIP had been completed, with the aim of testing them out and conducting a formal review after six months. CW did an internal review in June but it is planned that a complete review with all three PVOs will be undertaken during quarter one of year two. There has not been sufficient field activity to fully test

these procedures, therefore they will be reviewed during the first quarter of year two with appropriate modifications being made.

The DIP describes the composition of the Program Advisory Committee (PAC) and its role as a guiding body to review performance against plans and also how it will be used to advocate for replication of C-IMCI across the country. During year one the PAC has not been convened for any meetings. It was felt that during this first year, particularly with all the set up activities that there has been adequate communication and coordination, and that establishing the PAC at such a time was not the most efficient use of resources or time. Year two will see the launch of the PAC and the first meeting will be used to share the progress and key points as outlined in the first annual report.

- **Financial management system**

The modalities document that was agreed by the three PVOs outlines the finance procedures that are used by the six district offices and the links with the Kigali EICSP office. The basic principle established is that the lead PVO in each field office is responsible for the provision of cash and payments in that particular district office for all the activities. Through a system of recharges, costs on behalf of the other two PVOs are then charged back to them. This works across all six offices with actual reimbursements being made between the PVOs on a quarterly basis thus ensuring that the PVO's accounts are balanced ready for quarterly finance reporting and also means that each PVO can report on just their activities across all six offices rather than just their lead offices. The reporting of recharges saw some initial delays, however as familiarity is gained the system is working better and faster.

Advance monthly cash requests are used by each office and these are reviewed, consolidated and approved by the Kigali managers and the Team Leader. This ensures that expenditure for each month is planned and approved in advance and ensures that the offices can operate without the constant need to refer back to Kigali.

A clear segregation of duties has been ensured through the use of authorizations at the district level offices. Each PVO started by using their own limits but we have seen some convergence and continue to work towards having similar limits across the three PVOs. These have been shared to ensure that limits are clearly understood by all program staff.

The modalities for quarterly financial reporting have been set out in the sub-agreements signed between CW and IRC and WR (Annex Four: Amended Partner Sub-agreements). Quarterly reports are submitted to CW and are reviewed and feedback is provided to the IRC and WR. The consolidated quarterly reports are then submitted by Concern US. There have been issues with the quality and also late submission of the finance reports and this has resulted in more time being needed for discussion and feedback from CW. In addition, CW has also experienced some problems resulting from the new management information system that is being used. At the end of the first year it is acknowledged that the preparation of the quarterly finance reports is an area where improvement is needed. A finance training workshop was held in August for a range of program staff and served to review the first year and the key issues and problems that had arisen as well as issues still faced for the second year. More commitment is needed by each PVO in regards to the quarterly finance reports in year two, with a need to ensure that adequate time is allocated by finance staff to enable quality reporting.

The Concern US Director of Finance will visit in October 2007 to help the EICSP team look at general reporting requirements and compliance issues. The visit will include visits with PVO partners and discussions about their respective systems.

- **Human Resources (including communication and team development)**

The overall program is managed from the EICSP Kigali office where the Team Leader and the three managers – Mobilization, M&E and Quality Assurance – are based. An Administrative Assistant provides administrative and finance support to this office, coordinates communications and manages the office when the Team Leader and Managers are in the field.

At the district level, the program is being staffed by a small team based in each of the six district offices comprised of three officers, an Administrative Assistant and three promoters. Each of the three PVOs has staff in all six districts based on their technical niche (e.g. World Relief has Mobilization Officers in all six districts). Each PVO has been assigned two districts in which it is taking the lead (IRC lead in Ngoma and Kirehe, WR in Nyamagabe and Nyamasheke, and CW lead in Gisagara and Nyaraguru Districts). The lead district functions are to ensure an appropriate level of technical and administrative oversight, and continuity of institutional presence in former child survival districts. The officer from the lead PVO in each of the districts also has some representational duties, a responsibility for team coordination and the supervision of the administrative assistant. Experience from year one has shown that some of these additional tasks given to lead officer has, in cases, taken time from the technical work. During quarter one of year two there will be a review of this issue together with the role of the Administrative Assistant in order to determine how this can be addressed. A diagram to present the staffing structure is shown in Annex Three.

Recruitment for the initial team began in October 2006 and continued until early January 2007. A system was established whereby the three PVOs used a panel process (including the HR Manager from each PVO) to conduct all stages of the recruitment (short-listing and interviews) The process therefore took longer than individual PVO recruitment but the benefits of this joint recruitment have outweighed the additional time taken. It also meant that all the PVOs were able to fully assess and utilize the pool of former staff that had worked on the three earlier Child Survival programs. Subsequent recruitment exercises have maintained the use of the panel process for the interviews, while the initial short-listing is done just by the concerned PVO.

Based on the fact that the program would have offices with staff from the different PVOs it was agreed that there should be consistency in salaries and basic allowances for the program despite the individual salary structures of the three PVOs. It took time to explore this issue and work out details but a scale was devised and this has helped reduced tensions and potential conflict between all the program staff. It has also helped with giving the program a sense of identity.

Supervision and overall team management have been coordinated through monthly visits of managers to the districts, as well as clear schedule of monthly meetings. The main meetings being:

- Bi-weekly coordination meetings for the **Kigali Managers** chaired by the Team Leader.
- **Monthly Country Director** meetings where the Team Leader briefs the three PVO Directors on general progress as well as any issues that need senior level discussion.
- **Monthly Finance Manager** meetings for the three managers and the three PVO Finance Managers to discuss finance reports, reimbursement issues and review policies and other administrative issues. It is envisaged that this meeting would move to a quarterly basis during year two. Both of these monthly meetings have helped the senior staff from the respective PVOs better their understanding of the program and also develop a good working relationship from the outset. In addition they have provided the forum for open discussion and clarification during the early days when good clear communication was particularly important.
- **Quarterly full staff** meetings for between 2-3 days that were arranged around the key events of the first year – baseline assessments, DIP preparation and the annual review.

The above meetings are complemented by the following meetings that are held at the district level:

- Weekly coordination meetings for district EICSP officers with the District Health Management Team
- Monthly District staff meeting chaired by the Manager, with lead responsibilities, for the district level EICSP team and the district health director to review progress, constraints, and priorities for the month as well discuss any key issues.

As part of the overall management process and the meetings described above, the following reporting schedules were outlined in the DIP.

- A monthly finance report submitted to each of the PVO's Finance Manager
- A monthly narrative report submitted by the Team Leader to the three PVO directors that forms the basis for discussion at the monthly meetings.

To date, for a number of reasons, the program has not been fully utilizing the above reporting. The initial priority was on set up, baselines and DIP preparation and the monthly CD and Finance Manager meetings. As these meetings have enabled more open and faster communication the reports were not deemed vital. As the program moves into year two and there is a greater emphasis on monitoring of field activities this reporting schedule will be further developed now that the key relationships have been built.

The staffing and management structure for this program is certainly complex. Staff from three different PVOs work in seven different locations, with some staff reporting to managers from different organizations. A mechanism for conflict resolution has been put in place that ensures that all program staff are able to raise relevant issues and that consistent and equitable procedures can be followed. This mechanism could see the involvement of the three PVO directors if necessary as well as PVO HQ involvement in certain cases where broader organizational consultation is needed.

Each PVO has its own Human Resource Manual that applies to its staff. As stated above, the program has been able to get a consistent salary scale and also ensure that the same basic allowances are given to all program staff regardless of the PVO. However, there is potential for issues, based on differences in entitlements, to arise in the future (for example, overtime, annual leave entitlements, medical insurance, and personal use of phones or vehicles). In such cases, the program will utilize the existing management structures for resolution.

- **Staff development**

Each PVO has an established system for staff appraisal/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. The main trainings and workshops attended in year one were:

- The Mobilization Manager attended a week long training workshop on the BEHAVE behavior change framework in Mali.
- The M&E Manager attended a 10 day workshop on Program Design and M&E organized by CSTS in Washington DC. Two of the technical backstops were also able to attend this.
- One of the QA officers attended a BASICS-RQHC and USAID workshop in Nairobi on the subject of 'revitalizing the treatment of diarrhea through the use of zinc and low osmolarity ORS.'

In addition, there were a number of PVO specific workshops such as a CW workshop on partnership held in Tanzania, an IRC workshop in Kenya on BCC approaches, and a global health

CW conference in Tanzania that looked at best country practices to health programming that have been extremely useful for program staff. As part of the program's efforts to mainstream HIV&AIDS, the Kigali Administrative Assistant attended a week long training workshop on counseling skills for HIV&AIDS. Information and ideas from such workshops are shared amongst all program staff at subsequent program meetings.

There were a number of challenging issues with regards to Human Resources encountered during the first year.

- The general HR capacity for quality assurance (QA) in the country is limited. Whilst there are people with the theoretical knowledge the challenge has been to find staff that have more practical experience in order that QA principles can be related and applied into the program activities.
- A necessary cost to the benefit of the joint recruitment process used by the program was that it took longer. The program is content that greater participation and input during the recruitment has been very positive.
- The program has seen extensive turnover of staff at the country senior management level at each of three PVOs during this first year. This has presented some difficulties as the first half of the year was when all the systems and procedures were discussed and established. Such a consortium approach was new to all three PVOs and it was extremely important that considerable time was devoted to initial discussions and planning sessions.

The effects of this have been mitigated as far as possible by the following measures:

- The monthly Country Director and Finance Manager meetings that have ensured regular discussion of the key issues and clear documentation of all decisions taken and agreements reached.
- The US-based backstops have timed trips to Rwanda so that they could be here at the same time. In addition they all had a clear approach of providing assistance to the whole EICSP team.
- There has been strong continuity with the lead agency (CW). The Assistant Country Director - Systems acted as Country Director during a three month gap between CDs at the end of the first year.
- CW has been willing and able to devote time to sharing information and documents to ensure that new PVO staff were briefed and fully updated with program details and the key issues.
- The EICSP Team Leader and the managers have done some excellent work on team building with the staff from the outset. This has helped with the sense of program identity and bringing the team together as quickly as possible.

- **Relationships with program partners**

At district level the program has placed great emphasis on establishing relationships with the District Mayors and District staff responsible for health. Numerous meetings have been held in order to brief on the key points of the program and also to negotiate office space for the program in the initial 4 districts. In December 2006 a two day workshop was held in Kigali for Mayors and district health staff where the program was discussed in detail. The main objectives of the meeting were:

- to clarify roles and responsibilities of different actors
- to discuss the concept of an MOU between each district and the program
- to outline the DIP process and all the necessary baseline studies planned for early 2007
- to share the French translation of the proposal

In March 2007 there was a DIP workshop at which the findings of the various baseline studies were shared and discussed. The intervention strategies were presented and the objectives and activities were clarified. In addition, the MOUs were further developed.

Following the approval of the DIP, dissemination meetings have been held in each district with a particular emphasis on sharing the year one work plan and clarifying issues around the election of the CHWs in each district. The issue of allowances payable to district staff has been a complex and, at times, time consuming issue. The details of this are presented and discussed in section B.

At national level the program has developed relationships with a number of stakeholders and there have been considerable coordination and working meetings during the year, particularly through the IMCI Task Force and the NMCP HBMF implementer's network.

During the first year emphasis has been placed on developing a stronger working relationship with BASICS, both in field and at HQ level. Conference calls involving field and HQ staff have proved extremely useful tools in getting this off the ground and have identified a number of areas of common interest and collaboration, including:

District M&E system for C-IMCI: It has been agreed that BASIC and the program will work together to assist the C-ICMI task force develop core indicators and tools as well as a system for information collection at district level. The EICSP will field test this system across all six of the program districts.

District QA system for C-IMCI: Similar to the above, there will be joint work to assist the C-IMCI task force establish quality score card components. This will be informed by the experience of BASICS in Asia. The EICSP will be responsible for establishing minimum quality parameters and also for field testing in the six program districts.

Strategy for CHWs: Research is needed to fully explore a number of questions concerning CHWs. The roles and ratios of CHWs in both case management work and behavior change promotion should be informed by recent experience and this will then be shared with the MOH Community Health Desk in order that a decision about roles and ratios can be made. Both BASICS and the program can contribute experience to this debate and will consider the pooling of resources for study and dissemination of findings.

Behavior change strategies: The program is undertaking formative research in diarrhea perceptions and care seeking and plans to do research on ARI in the future. BASICS is doing similar research in relation to malaria. There is a need for collaboration to ensure that all these research efforts are synchronized in order to assist the MOH develop its strategy and materials on family practices.

- **General PVO coordination**

There are a number of mechanisms for general PVO coordination and information sharing. The International NGO Network meets monthly and is attended by PVO directors. This forum is used to discuss factors that affect PVOs as well as the general working environment in Rwanda. One of the main issues is the lack of NGO legislation from the GOR, while other issues include taxation, the implications of the recently established Joint Action Forums (JAF) and the proposed expansion of the Millennium village concept.

In addition, for organizations working in the health sector there are various coordination meetings, chaired either by MOH departments or USAID mission staff.

- **Other relevant management systems**

IT set up has proven difficult. The need to protect IT assets and program data is obviously great however each PVO has different equipment, systems and mechanisms for protection. It has been hard to establish a system that spans the consortium and all the offices in the various locations, especially with the general limited awareness of IT and related safety issues. The CW IT Manager has devoted considerable time and energy to this task but there is still a lot more that needs to be done with the other PVOs. As the program progresses and more data is being generated it is vital that this issue is resolved and will be a priority for early in year two.

The program has chosen to manage procurement, whenever possible, at the central level in order to get better choice and hopefully more competitive pricing. This will also help the district level staff focus on their technical roles rather than get sidetracked with this support function.

M. Mission Collaboration

The objectives of the *Kabeho Mwana* program are aligned with the USAID/Rwanda Mission strategic objective of **increased use of community health services** and its four intermediate results as follows:

- Reinforced capacity for implementation of the decentralization policy in USAID Mission focal districts of Kirehe, Nyaraguru, Ngoma and Nyamagabe.
- Increased access to selected essential health commodities and community health services for malaria, diarrhea, malnutrition and acute respiratory infections coordinated through networks of CHWs serving 30 households.
- Improved quality of community health services.
- Improved community level responses to health issues through participatory local situation assessments, C-IMCI orientation and local strategic plans, health planning with CDCs and leveraging resources from reproductive and child health programs such as Twubakane and other USAID initiatives.

This expanded impact program is a first for Rwanda and the Mission has shown great interest in supporting the initiative and assisting with coordination efforts. During the preparation of the proposal and since its approval there has been constant contact with the Mission. An initial program briefing was presented to the Mission, child survival partners and other relevant stakeholders in June 2006. This gave the opportunity to discuss collaboration issues with other USAID partners in the six target districts and also at the national level. Draft work plans were shared with the Mission for comment and suggestions.

A specific meeting was held with USAID and Twubakane to clarify and document the roles of the EICSP and the Twubakane project at the various levels (community, District and National). This presentation was then shared with the MOH MCH Task Force. The program maintains close links with the Twubakane project at the national and district levels. There is a strong emphasis on ensuring the complementarity of services in the four districts where both are present, with Twubakane focusing on district/facility level while the EICSP focuses at the community level. The program was able to show great flexibility when it provided financial support to the clinical IMCI training organized by the C-IMCI task force in Gisagara and Nyamasheke districts which are not served by the Twubakane project).

Mission staff attended the December 2006 Mayors and Heads of Health orientation workshop in Kigali and also took part in a range of consultation meetings during the baseline design and

implementation work (January – March 2007). Meetings were arranged with the Mission whenever any of the three backstops were visiting so that updates on the work plan could be given as well as general discussions on the establishment of the various baselines.

There has been a high turnover of Mission staff with responsibility for this program; however program staff have always placed emphasis on briefing incoming staff and also being available for any clarification that was sought from the Mission.

With the arrival of PMI in December 2006 there were numerous meetings concerning the malaria component of the program, links with PMI and the overall work plan with the NMCP. There was some misunderstanding over the proposed reporting demands from PMI compared to the reporting requirements from CSGHP. During the Mini University in Baltimore (June 2007) where the DIP was presented, the opportunity was taken to bring the relevant people together so that this issue could be resolved. This was followed up by a conference call in July (joined by: PMI Kigali, PMI Washington, CSGHP, USAID Mission Kigali, Technical backstops from the three PVOs and the CD and ACD Systems from CW) that clarified outstanding issues in relation to work plans and reporting requirements. Annex K of the DIP provides documentation in relation to these clarifications.

The July 2007 visit from the US based CTO included some productive field visits by program and the Mission staff to field sites to meet program participants and some of the district mayors. A few lingering issues concerning the MOUs were resolved during these field visits.

The three PVOs were involved as part of the USAID commissioned evaluation of the HBM pilot that took place in November 2006. In addition, the program was represented at the Regional Africa Malaria Day celebrations for 2007 that were held in Rwanda.

In addition, the PVO directors attend the quarterly USAID All Partners meetings where wider issues of concern to the PVO community are discussed, for example the policy of allowances and per diems introduced by USAID Rwanda and how it was working at field level.

N. Timeline and changes to the Work Plan

Annex One shows the work plan for year two. The key tasks for year two are listed below:

- The program will expand into the two remaining districts of Nyamagabe and Nyaraguru. This will require recruitment of staff and office set up. Selection and orientation of CHWs on C-IMCI and the establishment of care groups will follow.
- Completing training on fever case management for CHWs in Gisagara and Ngoma.
- Continue to work with the MOH Community Health Desk to roll out the whole package of training for CHWs including diarrhea and pneumonia for all six districts
- Once the NMCP has completed its operational research concerning non-endemic areas for malaria, the program will work with NMCP, PMI and BASICS to clarify the modalities for CCM in the two non-endemic districts of Nyaraguru and Nyamagabe.
- To finalize the Performance Based Financing contracts in relation to CHW supervision and ensure that it is rolled out in each of the six districts.

- To continue working with the MOH, BASICS and Twubakane to develop and finalize the Community Health Information system that will be used country-wide.
- To complete the formative research in relation to the three main disease modules (malaria, diarrhea and pneumonia) and finalize the behavior change strategy.

There will be a formal review of the systems and procedures modalities document held early in year two. Amongst other issues this review will look at the role of the administrative assistant at the district level and also how the cash forecasting can be streamlined.

It should be noted that a number of activities planned for year one were either not completed or moved into year two. These are noted below together with their corresponding activity number as shown in the work plan.

Translated versions of the DIP will be produced and disseminated in early year two. This activity will seek to reinforce the initial dissemination meetings held in year one.

O. Results Highlights

BEYOND MALARIA TREATMENT- SCALE-UP OF ZINC TREATMENT

While malaria is the leading cause of child disease and mortality in Rwanda, diarrhea is just in its shadows. The EICSP baseline highlighted showed that 14% of children had recently suffered from but very few received any treatment outside of the home and rehydration practices are often harmful due to withholding fluids to the sick child.

While community treatment of diarrhea through the promotion of oral rehydration therapy has long been known as a proven intervention to reduce child mortality, the more recent scientific discovery of zinc supplementation during an episode of diarrhea breathed new energy into improved home treatment interventions. The addition of a 10-day course of zinc does exactly what mothers of sick children want, reduce the duration and severity of the episode as well as reduce the incidence of future diarrhea episodes. However, there has been little scale-up of this effective intervention to date, and little documentation of related social behavior change practices.

IRC laid the groundwork for the scale-up of zinc treatment during its original child survival program in Rwanda from 1999-2005. During this time the organization successfully lobbied national health officials for permission to start zinc treatment for diarrhea on a small scale. In 2006, the IRC used the existing network of Home Based Management of Fever (HBMF) Distributors to introduce zinc at the community level in Kirehe District in January 2006, marking the first such use of zinc in Rwanda. From January to September 2006, the intervention was applied in 19 health center catchment areas and provided treatment to thousands of children under-five with diarrhea.



CHW explaining use of zinc.



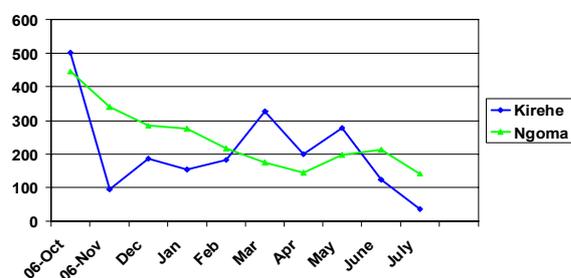
CHW administering zinc treatment.



Zinc tablets.

Based on its partner's experience, the EICSP seeks to expand access to community case management of diarrhea with ORS and zinc throughout 79 health center zones through a network of 7187 Community Health Workers (CHWs). From October 2006 – August 2007, CHWs in Kirehe and Ngoma Districts treated 4,513 diarrhea cases with ORS and zinc. Of the cases seen, 97% of the children recovered and 3% were referred due to serious illness. As the intervention expands, logistics have proven to be a challenge, particularly in terms of timeliness of clearing zinc supplies through customs. With USAID support, this hurdle was resolved, with zinc being added to the national list of essential drugs.

Children < 5 years treated in the community for diarrhea, October 2006 to August 2007 for Ngoma and Kirehe Districts



Following the selection of CHWs and strengthening the logistics chain, zinc treatment for diarrhea will be rolled out to CHWs working in the remaining four districts in 2008, reaching an estimated 35,000 children with diarrhea. Further the experience has made it possible to also introduce community case management of pneumonia which is expected to roll-out in an integrated fashion with the CHW diarrhea training. This is an excellent example of how the EICSP is building on

each of the PVOs' previous experience in using operational research to influence policy decisions, as well as the piloting locally with district health departments. With a grant from CORE and USAID, the EICSP will conduct a study to research how treatment of co-morbidity is currently handled by CHWs to inform scaling up of appropriate, integrated care at the community level and ultimately save lives.