



## **CONCERN WORLDWIDE**

### **USAID Child Survival & Health Grants Program**

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## **KABEHO MWANA**

### **“Life for a Child”**

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

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

## **SECOND ANNUAL REPORT**

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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-Integrated Management of Childhood Illness
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	Long Lasting 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	Sulfdoxine/pyrimethamine and amodiaquine
TBA	Traditional Birth Attendants
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
WHO	World Health Organization
WR	World Relief
WRA	Women of Reproductive Age

## **Introduction**

The Kabehe 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, entering its third year, is the first ever to have been implemented in Rwanda. The program operates 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.

The Second Annual Report describes the key role of the Kabehe Mwana program in the integration of the community case management activities into the broader context of the national Community Health package, outlines key achievements to date, as well as discusses the opportunities and challenges from the second year of the five-year program, specifically from October 2007 to September 2008. The program's Annual Review process was facilitated by the Team Leader and focused on two three-day workshops for the EICSP team, consolidating the data collected from the communities and the health facilities, analyzing the achievements and activities, and developing a workplan for Year Three. Another Annual Review workshop was held in mid-October with 15 representatives from the MoH district health team, including three Directors of Health.

## **A. Main Accomplishments**

The Kabehe Mwana program has made good progress and is generally on track. Major successes include initiating pneumonia case management, launching the program in two new districts, and transitioning to artesunate-combination Coartem® treatment. Overall, the Kabehe Mwana team has developed a positive reputation as “doers” and the program is viewed as a model at national level. Moreover, the program has established strong collaborative relationships with key Desks and technical working groups within the Ministry of Health and National Malaria Control Program.

For the second year of the program, the focus was on integrating home-based management of fever *with* Community IMCI and *into* the overall Community Health structure of the MoH. As the C-IMCI package became integrated into the fast emerging Community Health national policy, the role of the CHWs (*binomes*) expanded to include a wider range of community services (please see Challenges). In addition to the case management of three childhood illnesses—malaria, diarrhea and pneumonia—the expanded role of the CHWs in community health promotion and intervention will now include environmental health and hygiene, nutrition, outreach and vaccination campaigns, community based family planning services, and care for PLWHA.

The program supported the training of 668 CHWs in Kirehe district—the first group of CHWs in the country to be trained on the expanded package of community IMCI. This initial group represented 11% of the targeted 6,186 CHWs to be trained by Kabehe Mwana. The number of CHWs trained is lower than the target because of a delay in the start of the training. In keeping with the new Community Health protocol, the MoH restructured and expanded the package of community IMCI. Accordingly, the training tools needed to be revised, finalized, and printed, which ultimately delayed the program's CHW training schedule (please see Challenges section). As of October 2008, the Community Health integrated package training has already commenced in one

district, Kirehe, and is expected to be completed by the second quarter of Year Three in all six districts.

The main accomplishments from the second year are described below:

**1. Start-up of program in remaining two districts** Kabeho Mwana established programming in the remaining two new districts, Nyaruguru and Nyamagabe, in the Southern province. The program recruited and hired all program staff, including Program Officers who are established within the health facility structures and Promoters. The program staff participated in the community sensitization in the selection of CHWs in the two new districts, which resulted to the election of 1,738 CHWs, of which half are women.

**2. Leadership in national behavior change strategy development** As per the DIP, Kabeho Mwana conducted qualitative research on factors affecting diarrhea care practices (refer to Annexes IX and X). A master's student from Johns Hopkins School of Public Health trained selected staff in qualitative research methods to conduct formative research for the diarrhea intervention. These results were disseminated during a workshop with MoH, UNICEF and project staff, and then used to update the project's BEHAVE Framework and identify key messages for behavior change communication. The MoH IMCI Desk embraced the findings, requesting that Kabeho Mwana repeat the process for the remaining C-IMCI topics to inform nationally standardized, culturally specific BCC key messages. Christine Brackett, a Fulbright Scholar working in conjunction with EIP, picked up leadership of this activity which was carried out in partnership with the MoH and UNICEF. Findings from nation-wide formative research conducted by Kabeho Mwana staff were used in September 2008 to elaborate BCC key messages. At a project level, BEHAVE Frameworks for malaria and pneumonia were also updated to reflect the formative research findings.

After presenting BCC key messages to the MoH IMCI Desk, the program was asked to take the lead on developing standardized training module templates for CHWs and supervisors as tools in which to disseminate BCC key messages. In partnership with the MoH IMCI and Community Health Desks and partners, and drawing on already existing project-based training tools, Kabeho Mwana is scheduled to complete the training modules by December 2008. After tools are approved by the MoH IMCI and Community Health Desks (estimated March 2009) Kabeho Mwana will make the transition to using these nationally standardized training modules, which are not expected to differ greatly from existing project training tools, to train CHWs and CHW supervisors. In the meantime, the program is authorized to continue scheduled trainings with established project tools.

**3. Development of integrated nutrition plan** Although nutrition was not a component of the program at the time of its inception, the positive outcomes from the Community-based Therapeutic Care (CTC) project of Concern in two health centers in the Southern province (Gikore and Kibayi), IRC's community kitchens project in the East (Kirwa), and the WR extensive experience of Positive Deviance/Hearth approach for moderate malnutrition in the Western province, provided the expertise for developing an integration plan for nutrition intervention into Kabeho Mwana and scaling-up in order to strengthen and expand the role of Community Health Workers (CHWs), and most notably to effectively address malnutrition in the districts where we operate.<sup>1</sup> Furthermore, the Kabeho Mwana's role in the national arena of C-IMCI will facilitate advocacy efforts to integrate CTC into the existing national Community Based Nutrition Programme strategy and national nutrition protocol on severe acute malnutrition, as well as promoting local production of Ready to Use Therapeutic Food (RUTF). The program continues to meet and dialogue with the MoH regarding the integrated nutrition plan (refer to Annex XI).

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<sup>1</sup> Nutritional rapid assessment with MUAC shows (March 2007) that 2% children were measured with MUAC <110mm while 9% measured MUAC between >110mm and <125mm).

#### 4. Pioneering integration of community treatment of pneumonia

For the first time in the country, the community treatment of pneumonia cases started in Kirehe district. Since the first case was seen and treated in February 2008, CHWs have treated over 1,000 cases (refer to Annex V Results Highlight). In addition to increasing access to treatment for pneumonia, the program expanded its community treatment of malaria and diarrhea.

#### Children Treated in Year 2

- 108,547 cases for fever
- 4,068 cases for diarrhea
- over 1,000 cases for pneumonia

There is high utilization of community case management of malaria with the new anti-malarial drug: 108,547 children seen by CHWs for fever in four districts, of whom 96% improved after treatment and 85 % were treated within 24 hours of the onset of symptoms. The program successfully implemented the Roll-out of the HBM intervention to all the Phase 1 districts, with 4,495 CHWs trained on HBM. CHWs in Kirehe and Ngoma treated 4,068 children with diarrhea who were given ORS and therapeutic course of Zinc, 96 % improved with treatment. Lastly, the Periodic Performance Assessment (PPA) conducted in June and July 2008 confirmed good progress toward achieving objectives as shown in the summary table in Annex VII.

### B. Key Activities' Summary of Program Progress towards achieving Objectives

Key Activities (as outlined in the DIP work plan)	Status of Activities (“Completed, On Target, Not yet on target”)	Explanatory Comments and remarks
<b>Strategic Objective One: Increasing access to prompt first-line treatment for young children with malaria, diarrhea, and pneumonia</b>		
<b>1.1 Expanding access to community case management</b>		
Phasing-in of two additional districts of the program, to a total of six districts	Completed	Two EIP offices established in Nyaruguru and Nyamagabe districts, Southern province and team hired: 6 officers, 6 promoters and 2 Admin Assistants. 1,738 CHWs (50% women) were elected to provide community treatment and health promotion. The CCM training on integrated C-IMCI package was affected by changes in the Community Health structure and revisions of the protocol for community management of fever for non-endemic areas (Please see Challenges).
Annual CHW Quality Improvement reviews	On target	The review was conducted in seven health centers in three districts to look at the management of fever by community health workers who were trained, equipped and supported to treat malaria, identify problems and find feasible solutions jointly with the district MoH. Mothers were also interviewed to assess client satisfaction of CHW services. This evaluation is ongoing and has so far interviewed 460 (11%) of the targeted 4,495 CHWs and 135 mothers and caretakers.
Operational research on case management of multiple diseases by CHWs	Not yet on target	The research timetable corresponded to finalizing the national community health tools and training of CHWs. With the launch of CHW training in Community Health package in Kirehe district, the research team completed the pre-test/post test; all research tools are being finalized; the research protocol was presented to the Community Health Desk, district health authorities and two health center sites. The two staff required for the research has also been recruited. This research is funded by the CORE group through IRC.
<b>1.2- Strengthening health service delivery system</b>		
Complete procurement and monitoring plan for essential Community Case Management drugs (includes liaison with NMCP and UNICEF)	Completed	All C-IMCI drug and other commodities are now in country (respiratory timers, low-osmolarity ORS, amoxicillin antibiotic, Zinc, and MUAC). All requirements for Kirehe District have been distributed; distribution and monitoring plan is in place for remaining districts for Yr Three roll-out of CCM for pneumonia and diarrhea. In 2008, the program received 80 to 100% of all required drug commodities.

<b>Key Activities (as outlined in the DIP work plan)</b>	<b>Status of Activities (“Completed, On Target, Not yet on target”)</b>	<b>Explanatory Comments and remarks</b>
<b>1.3. To establish performance contracting for CHW supervision</b>		
Establish performance incentives agreements with districts for CHW support	Not yet on target	Five of the six districts have signed performance contracts. Only one district (Ngoma) has not yet signed because the proposed amount is insufficient to cover supervision costs. Discussions and negotiations are on-going with relevant health authorities and with involvement from a senior MoH official.
Monitor and Strengthen HC Supervision with District Health Supervisors	Not yet on target	The program target is to supervise all CHWs four times per year in malaria CCM; instead, each CHW was supervised between one and two times in Yr Two due to staff shortage and the sheer numbers of CHWs per health center zone (100-150), and the amount for supervision on a PBF scheme was not sufficient. To solve this problem, CHW cell coordinators are being elected among the 20-25 CHWs in their respective cells to alleviate workload demands on the CHW supervisors based at health centers. The program has trained the cellule coordinators to monitor the work of their peer groups and provide incentives on a MoH results-based financing scheme to be channeled into the association groups’ accounts based on CHW supervision indicators.
<b>1.4. National C-IMCI strategy development and district roll out.</b>		
C-IMCI sector orientation in 30 sectors of Nyaruguru and Nyamagabe Phase 2 districts	Completed	Two district program orientation sessions were completed in Nyaruguru and Nyamagabe, where a total of 55 sector leaders including Health Center directors actively participated.
District Training of Trainers (TOT) for CHWs Diarrhea; refresher malaria and Pneumonia strategy	One of six districts completed (Kirehe); not yet on target for other five districts	Forty-eight health center staff were trained in the new community health package (one of the eight modules is the C-IMCI package) in Kirehe District (15% of the total health center staff targeted in the program). The remaining districts have not been trained because it took longer than expected to integrate and finalize C-IMCI into the national Community Health strategy, and identify additional funding for CHW training tools.
Complete CHW malaria update in old Kibilizi District and Ngoma for 100% of CHWs	Completed	The remaining 1,886 CHWs received training on home based management of malaria bringing to a total of 4,495 CHWs trained (100% of the target)
CHW Training: 100% of CHWs trained in diarrhea & pneumonia, refresher malaria (added)	Not yet on target	668 CHWs were trained in Kirehe district in the community health integrated package (11 % of the targeted CHWs in the 6 districts). Delays occurred due to integration of C-IMCI into the Community Health strategy. CHW training included other community health topics: national community health policy, community level primary care, nutrition, and reproductive health.
Quality Assurance Strategy refinement	Not yet on target	C-IMCI Bulletin has been shared with Health Districts for feedback and refinement of indicators, definition of measurements, and the process to achieve the bulletin, including outputs. Not yet on target for CHW supervision or supply drug chain and procurement. District Scorecards developed to promote focus on critical standards that need to be maintained by the Districts with support from the central level.

<b>Strategic Objective Two: Increasing coverage of key preventive interventions (Vitamin A, Iron, IPT, vaccinations)</b>		
<b>2.1 Coverage Monitoring and targeting at district level</b>		
Review and adapt community activity monitoring tools and forms (with the IMCI TWG partners)	Achieved	Newly developed Community Health tools were lacking a facilitators’ guide. A three-day workshop financed and initiated by the program in collaboration with Community Health Desk and MSH, was attended by the Community Health TWG (including two health center trainers from Kirehe), who developed the guide for facilitators. This guide was reviewed and validated during the actual CHW training in Kirehe.

<b>2.2. Improve targeting and increase breadth of preventive child health services through outreach</b>		
Vitamin A supplementation outreach campaign in 4 districts	On target	The Vitamin A campaign was one of the activities in the MoH-organized "MCH week." The program's role was to mobilize CHWs and Care Groups volunteers, provide transport assistance in some districts and provide 699,300 Mebendazole tablets. The campaign was successful with almost 100 % coverage for Vitamin A in five program districts (Ngoma data not available at the time of writing).
Pregnant women receiving two observed intermittent presumptive treatments for malaria (IPTp) in 4 districts	On hold	IPTp on hold because of concern about SP resistance. <sup>2</sup> On the recommendation of PMI in country, we are maintaining this objective as IPTp may be reinstated. If it is not, we will increase focus on symptomatic treatment, and continue our efforts to increase coverage of LLINs for pregnant women; we will amend our indicators accordingly. Antenatal clinics and CHWs are intensifying the promotion of LLINs in their health education messages.
Distribution of Long lasting insecticide treated nets (LLINs) to pregnant mothers, children under five years in 6 districts	On target	49,728 LLINs have been distributed in six districts, which is twice as many as last year's target.
<b>Strategic Objective Three: Increasing adoption of key family health practice</b>		
<b>3.1. Community mobilization and social behavior change</b>		
Training local leaders in behavior change messages and skill building	Achieved	1,275 people (28% of whom were women) were trained including COSA members, CDC members, Cellule leaders, teachers, and women's group representatives from the sector level. COSA and opinion leaders were trained in BCC messages in diarrhea.
Training of CHWs and Care Groups in malaria and diarrhea	On target	Average Care Group attendance by the 1,852 Care Group members during meetings with training on malaria, diarrhea and nutrition was 71% during malaria training and 81% during diarrhea training. Because pneumonia was a new intervention and formative research was delayed to accommodate the MoH, the project instead moved forward with nutrition education. Attendance at CG meetings for nutrition education averaged 94%.
Training of CHWs who are not members of Care Groups in key messages.	Trainings on target; attendance at meetings has room for improvement	CHWs(binomes) in non CG area trained on Malaria key messages 69% (3699/5332); CHWs(binomes) in non CG area trained on Diarrhea key messages 69% (3661/5332) ; CHWs(binomes) in non CG area trained on Nutrition key messages 63% (3367/5332) Training took place as planned during CHW meetings at health centers. Those not trained reflect lack of attendance at HC meetings.
Qualitative Assessment on key factors affecting care seeking practices in diarrhea, malaria, pneumonia, malnutrition, and maternal/newborn health	Achieved	Preliminary research and training of program staff completed in January 2008 in diarrhea. In partnership with the MoH and UNICEF, program staff completed research in all other areas in August 2008.
Key Behavior Change Communication messages elaborated, targeting barriers and facilitators of care seeking practices in local communities	Achieved	Program staff, in partnership with MoH, BASICS, UNICEF, and other partners, elaborated key BCC messages (community level) in a 5-day workshop in September 2008
Updated BEHAVE frameworks based on qualitative assessment	Achieved	Based on qualitative research completed by program staff in Year Two, BEHAVE frameworks in malaria, pneumonia, and diarrhea have been updated (refer to Annex X).
<b>3.2 Care Groups</b>		
Conduct Care Group activities in Nyaruguru & Nyamagabe	Achieved	CGs were implemented in four districts during Yr One. During Yr Two, 35 more CGs were added to the remaining two districts in two HC areas per district (399 members, 50% binomes/50% volunteers).

<sup>2</sup> Report from PNILP was not officially available at the time of writing. The decision for the policy change was disseminated in the malaria technical working group monthly meeting. Prevention of malaria in pregnancy without IPT will likely focus on improving coverage and usage of nets and ensuring prompt and effective case management.

Program-wide Care Group implementation	Achieved	Project-wide, by the end of FY08 there were 144 Care Groups, with 1852 members (47% binomes and 53% volunteers). 14% of total binomes project-wide are members of the CGs. Demand for additional CGs has been strong from health facility staff and community leaders.
Care Group best practices: household hand washing stations	On target	Thus far, 43% of the targeted 4,630 hand washing stations have been built in project households. 60% of stations were built in Gisagara because of the committed involvement of community leaders to mobilize the population. Hand washing stations were a suggested activity in the BEHAVE frameworks, Diarrhea #4; refer to Annex X.
Care Groups: home visits (by CG members to educate families and disseminate malaria, diarrhea, and pneumonia messages)	On target	Every month, each CG member is expected to conduct home visits with 10 families. With 1,852 members, the target equals 18,520 households. During roll-out of the malaria intervention, an average of 10,384 households (56%) were visited per month. For diarrhea, visitation averaged 11,582 visits/month (63%); for nutrition an average of 16,529 visits (89%) took place monthly. As mentioned previously, due to the delay in pneumonia formative research, nutrition education was substituted in accordance with overall program goals.
<b>3.3 Other Activities</b>		
Monitoring and evaluation: introduction to select district personnel use of PDAs in routine monitoring	Not on target	Potential for PDA use for M&E has expanded beyond what was initially budgeted for. Nine district personnel were trained in PDAs but have not yet received PDAs to use for monthly HIS reports. Program is in the process of identifying means to source additional PDAs.
Staged M&E analysis and feedback skill building with HC teams	On target	Each month at district meetings, program staff presented feedback from M&E data to local health authorities. In other program districts, some meetings were held quarterly rather than monthly.
Advanced data analysis and reporting skill transfer for District Supervisors and the program's M&E Officers	On target	<ul style="list-style-type: none"> <li>• 24 officers and upper level staff were trained in qualitative data collection techniques and BEHAVE framework</li> <li>• 24 officers and staff were trained in key behavior change communication message development (UNICEF)</li> <li>• M&amp;E MoH taskforce organized workshop: program and district staff trained on data entry and analysis using SQL database program compatible with Excel</li> <li>• 25 health facility staff and 26 cellule coordinators were trained in cluster sampling methodology and in PPA inquiry methods</li> <li>• Each district is doing quarterly staff and program meetings with district officials; EIP has had three quarterly reviews in 2008 with district participation.</li> </ul>

### **C. Challenges and Constraints**

**Delay in Roll-out of C-IMCI Training (Revised National Community Health strategy)** As the program entered its second year, the Rwandan Ministry of Health, after several years of implementing community health services, decided to broaden and develop the National Community Health policy to guide and increase access and availability of community health services.<sup>3</sup> The policy is in line with the country's set targets under its Vision 2020 and its Economic Development Poverty Reduction strategy to contribute to its international commitments to the Millennium Development Goals and the Lusaka Declaration on Decentralization of Health Services Health. This policy was designed to help build stronger partnerships between all stakeholders, while providing a better guide to these partners. In line with this structure, the Kabehe Mwana became a major player in the integrated package of community health that includes:

- Community Case Management (C-IMCI) for Malaria, Diarrhea, Pneumonia, Malnutrition
- Integration of Community Based Nutrition Programs, Community Therapeutic Care, Positive Deviance Hearth
- Immunization outreach and campaign, including Mother and Child (MCH) biannual campaign
- Maternal and newborn health

<sup>3</sup> In December 2007 during a weeklong workshop with senior health facility staff, the MoH issued the revised guidelines and oriented them on the strategy and the intention for the Community Health desk to absorb all community-based IMCI activities.

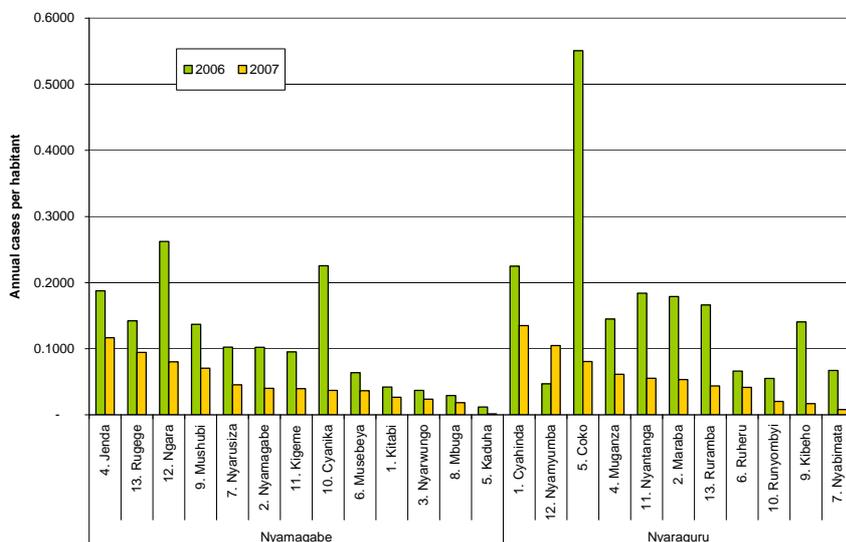
- Environmental health
- Community based DOT Tuberculosis Program
- Community based distribution of FP
- Community surveillance

While the intended purpose is to streamline community-based care for more comprehensive services, there have been challenges. Most notably, considerable delays have occurred in the program’s roll-out of CHW training for CCM for pneumonia and malaria, and now malnutrition, because the finalization of training modules by the MoH, followed by its subsequent printing. In terms of financial implications, the EIP budget has also been strained because of the incorporation of other CHW activities into the CHW training (e.g. number of training days, per diems for CHWs and Trainers, printing and lamination costs, etc). These challenges are difficult to overcome, but EIP recognizes the value of working within the perimeters of government policy and strategy and our input has been greatly valued. The program has looked to other sources to overcome budget challenges and have secured the support of the MSH for the TOT, PNLIP, and UNICEF for additional funding for printing of training tools and CHW registers. The three PVOs have also sourced additional funds from CIDA and their own private donors.

**Availability of Coartem and CHW kits** The issue in Year One as to who was going to provide the kits to the CHWs post training has been resolved by the program. PMI, with the intercession of the Rwanda mission, provided additional funding to John Snow International-DELIVER project to procure all the working materials and tool contents (excluding drugs) in the CHW kits for the six districts. Regarding Coartem, however, there are still stock-outs, primarily due to medication packaging delays. When this delay occurs, the program contacts PNLIP, who contacts PSI, and the problem is typically resolved quickly.

**Policy decision on management of fever in Nyaraguru and Nyamagabe Districts** With the roll-out of the community IMCI intervention into the remaining two districts, the protocol for CCM for children with fever urgently needs to be addressed. While these districts are categorized as hypo-endemic, baseline assessments as well as health service records suggest the burden of fever and potentially malaria may be more intense. This year we analyzed HC records for confirmed and presumed malaria cases for the two districts and shared findings with PNLIP. Discussions are underway regarding the potential use of rapid diagnostic tests. We are seeking technical support from the PMI team on this matter.

Figure 1 Annual Reported HC Malaria cases per habitant by Health Center in Nyamagabe and Nyaraguru, Rwanda 2006 and 2007



**Annual Performance Review Preliminary Results** Initial results showed the following: CHWs have difficulties in estimating the 24 hour calculation after onset of fever and calculating the ages of the child in months and years; registers have narrow spaces for filling-in information and are hard to read; 75% of CHWs were supervised at least once after they had undergone HBM training; stock-outs were reported of red blisters (Coartem) and there was a shortage of registers; CHW meetings were not happening due to lack of communication, with no feedback during meetings; lack of transport; kit items were not complete; and assistance was requested for CHW cooperatives. On a positive note, mothers and caregivers interviewed were very satisfied with the services of the CHWs; fully aware of the CHWs' work and grateful for the impact on the community especially for children's health. Program staff is using these results to systematically address these issues raised with the concerned health authorities to improve performance.

**Sharing of MoH data with NGOs** A circular from the Minister of Health dated June 11, 2008, was disseminated and addressed to all health management directors and hospital directors not to disclose health data to foreigners. This has created problems for our M&E officers in the field. Among the 6 program districts, Ngoma and Bushenge Hospital zone (Nyamasheke district) have been most affected by this restriction. In the joint annual review meeting with the district partners, the Directors of Health in these two districts acknowledged the problem and volunteered to discuss this matter with the concerned Hospital Directors. The program also approached USAID/PMI to raise this issue in the next implementing partners' quarterly meeting.

**Implementation of Performance Based Financing** CHW motivation has always been an issue raised during reviews and evaluations, especially now with the increased workload due to the additional community health interventions. Currently there is a government grant for a three year community performance based financing project in Rwanda, funded by the World Bank and Global Fund. By the end of 2008, community health activities will be one of the recipients of these grants through the MoH Community Health Desk, therefore implementation plans and budgets are being finalized with key inputs from the program.

#### **D. Technical Assistance Requirements**

The planned technical assistance needs for Year Two were achieved and included:

- Visiting CCM Research Team and IRC technical advisor reviewed monitoring system and refinement of PDA training.
- Three-day BEHAVE framework for BCC facilitated by WR MCH Director, EIP staff, and district partners to refine social behavior change strategy. This led to an updated BEHAVE frameworks (diarrhea) and BCC key messages elaborated (diarrhea).
- Technical visit of Concern US & IRC backstop advisors from USA; performance assessment meetings & conceptual approach presented to integrate nutrition into EIP. A district scorecard was developed to determine staff performance.
- IRC technical backstop visit focused on the consolidation of M&E indicators and the orientation of the new M&E officer.
- Concern's Health Program Officer supported management of program data in preparation of annual report and the staff Annual Review workshop.
- IRC's Health Advisor from Uganda assisted with the conceptualization of the nutrition plan.
- Concern Nutrition Advisor from Headquarters provided technical input to the team on finalizing the operational strategies/guidelines for integrating CMAM activities into the program and ensured that the integration strategies/guidelines are CMAM focused and aligned with the activities, conducted site visits of the potential nutrition areas to observe/assess the health facilities in terms of infrastructure and staff's capacities, finalized the draft on integration plan.
- IRC's volunteer intern facilitated and built the capacity of the team in giving the nutrition plan a heads up; consolidated the CMAM protocol including M&E tools and made an assessment of the survey areas and drafted questionnaires.

In keeping with the DIP, there is a range of technical assistance required for Year Three that will be sourced by the backstops from the three PVOs:

- **Financial monitoring review and support (CW)** The support visit planned by the Concern US Finance Director in Quarter 2 is to assist with the mid-term program budget analysis of spending rates, strengthening of financial management systems and, with the program team of the three PVOs, review the status of the grant for the last two years of implementation.
- **Preparations for the mid-term survey (IRC)** A support visit is planned by the IRC technical backstop to assist in conducting the KPC survey for the mid-term evaluation. The visit is planned for the second quarter of 2009.
- **Mid-term evaluation (CW, IRC, WR)** An external consultant and the three technical advisors, one from each partner agency, will give support to the evaluation and the External Consultant and analysis of the mid-term evaluation. The evaluation is planned for June 2009. The midterm review will pay particular attention to the comparison of the community mobilization models and options for adapting the care group methodology, assessing the implementation of the quality assurance and program monitoring strategies, and the CHW supervision.
- **Integration of Nutrition into the program (CW)** A Nutrition Advisor will provide technical support in Year Three to assist with the early stages of the integration, the baseline survey, and CMAM training for program staff.

### **E. Substantial Changes**

There are no significant changes that will require a modification to the Cooperative Agreement. However, there are two substantial programmatic changes to note:

**1. Integration of C-IMCI into Community Health CHW Package** In the DIP, CCM of malaria was to be integrated with pneumonia and diarrhea as one package for CHW training. However, because of the delay in pneumonia and diarrhea training modules, all CHWs first received training on malaria and then on the integrated package with diarrhea, pneumonia, malnutrition plus the other community health services’ modules. With the new Community Health CHW package, the number of training days increased from three to eight and the registers and tools increased significantly (both increases exceed what the program budgeted for in the DIP). The program’s Team Leader worked with other stakeholder to address these financial challenges. MSH contributed approximately \$50,000 to fund the Training of Trainers and UNICEF/PNILP/PMI are funding an estimated \$120,000 for the printing of tools and registers. As previously mentioned, the integrated training already commenced in Kirehe district, to be followed by Gisagara, Nyamasheke, and Ngoma district, and finally the two districts of Nyaruguru and Nyamagabe.

**2. Integration of Nutrition into the Program** As mentioned in the Main Accomplishments section, the program is integrating a nutrition component into the program. Given the preliminary baseline findings from the six program districts—using mid-upper arm circumference (MUAC), 2% measured MUAC<110mm and 9% measured MUAC>110mm and <125mm, with Nyamagabe and Nyaruguru being the worst affected<sup>4</sup>—and the positive results of the three PVOs’ nutrition interventions, the program conceptualized the scale up of these interventions to other districts and their integration into the Community Health protocols.

**MUAC Results for children 6-23 months in EIP Districts, Jan-March 2007**

<b>Category</b>	<b>Result</b>	<b>Confidence Interval</b>
MUAC ≤ 110mm	2.4% (10/424)	(1.0% - 3.8%)
MUAC 111-125mm	9.4% (40/424)	(6.6%-12.2%)
MUAC >125mm	88.2% (374/424)	(85.1% - 91.3%)

<sup>4</sup> In the recent national MCH week campaign, children 6-59 months were screened for their nutritional status using the MUAC tape. The MUAC measure showed 5.6% for moderate (between >110mm and 125mm) and 1.8% for severe (<110mm), with the highest rates in Nyamagabe District.

Community-based Therapeutic Care (CTC) is an innovative 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 at in-patient facilities using standard WHO malnutrition treatment protocols. The CHWs will be trained on screening and referral of children using MUAC tape. After the training the CHWs will be expected to screen all sick children that they come across and regular community based screen to identify and refer the malnutrition cases (refer to Annex IX Draft Integration of Nutrition).

### **F. Sustainability Plan**

The program maximized district level planning to reinforce partnership and resource mobilization through participatory approach. Program staff at the district level strengthened coordination with and amongst the district, sector (health center), cellule and village levels through consultations and orientation meetings to ensure ownership between health systems and family and communities. The program will continue to provide support on transfer of skills to district counterpart (supervisors) for close supportive supervision and monitoring and build within the existing support supervision system at different levels of the health district system. In addition, the program’s sustainability plan aims to instill into the Care Group members positive family and community practices using the BCC messages that were recently developed during the formative and qualitative research projects (refer to Annex X).

With the government and donor commitments to reinforce the capacity of the Community Health Desk of the MoH and also to roll out the Community Health CHW training plan throughout the country, the C-IMCI commodities will be made available to CAMERWA and through the national essential drugs program. Funds for community PBF from World Bank /GF will also be channeled to the Community Health Desk for community health activities which will encourage the retention of CHWs. Presently, the program is starting dialogue with MoH regarding the national health care financing scheme ‘*Mutuelle*’ at all levels for the integration of CCM into the scheme.

The establishment of a **District Score Card** was recommended by the DIP reviewers to promote focus on critical standards that need to be maintained by the Districts with support from the central level. The scorecard provides an overarching view regarding district CIMCI performance that can be used by decision makers as well as community to rapidly assess progress across critical operational elements and facilitate change and trigger quality improvement. The tool aims to foster local health planning and facilitate benchmark setting. The scorecard is identical for all districts and therefore results comparable to promote learning and exchange for problem solving. It is a mechanism for communication and coordination. The initial version of the

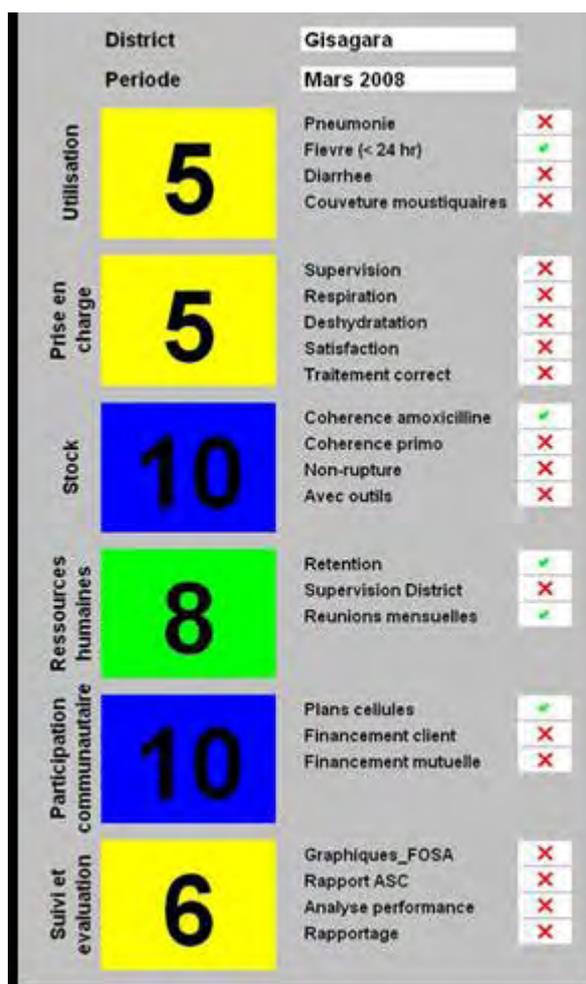


Figure 2: District CIMCI Scorecard

scorecard was developed by the program team on March 13-14 by defining six core components and 3-4 most critical standards within them. The standards are based on the then national CIMCI guidelines and parameters established in the DIP.

We determined that it was best to fold in the developing sustainability goals, components and measurements into the district scorecard to streamline measurement systems and processes and because ultimately sustainability implies that the district and its health centers and communities are leading and covering the CIMCI needs of the population. The Program is working with our district and community counterparts to include the supporting socio-ecological environment component into the tool as it is further developed and tested.

**G. First Annual Report Responses**

No specific information was requested for response from the CSHGP’s review of previous Annual Report.

**H. EIP Projects’ Scale Up Strategy**

Please refer to the Program DIP on pp. 65-67 regarding the program’s scale-up strategy. The core elements and how we have made progress towards them include:

**1. Replicability** By ensuring that the program is delivered through existing structures, generalizable conditions, national strategies, what is developed and effective in the project districts, should be applicable to the remaining 80% of the country. In Year Two, our commitment to this element was the holding back of the training of CHWs until the Community Health Training Package was finalized.

**2. Scale-up community treatments** Another dimension of scale-up is the reach to 175% more children than our original individual grants and the expansion of diseases and conditions that are treated at the community level. While caretakers are still slow to seek treatment for child diarrhea in the districts where it is available, malaria and pneumonia treatments are picking up.

	<b>Year One (Oct 1, 2006 – Sept 30, 2007)</b>	<b>Year Two (Oct 1, 2007 – Sept 30, 2008)</b>	<b>% Change</b>
<b>Community treatment for malaria (CoArtem®)</b>	73,357 (in 4 districts)	108,547 (in 4 districts)	48%
<b>Community treatment for diarrhea (with ORS + zinc)</b>	4,513 (in 2 districts)	4,068 (in 2 districts)	-10 %
<b>Community treatment for pneumonia (amoxicillin)</b>	0	923 (in one district)	100%

**3. Contributing to common national standards and tools to facilitate uptake of project experiences** Through continuing partnership and close coordination with the technical working groups at the national level (Community Health, Malaria and IMCI), the program shared the most recent information of the CCM implementation within the regions and shared program experiences at meetings and conferences. The program has also established a partnership with the Community Health, IMCI and Malaria TWG to support their leadership to continue to influence scale up of HBM into non-endemic areas. Care was taken to ensure review of the integrated plan for managing acute malnutrition by engaging the nutrition, community health and IMCI desks in the refinement and harmonization of the protocols. This process took place from May-August 2008.

**4. Streamlining community mobilization approaches** The two community mobilization models (CHW binomes and Care Groups) are functional in all 6 districts and project staff and district partners closely reviewing the components of the different models and looking at how to replicate elements within their existing resources. The midterm review in year three will formally review the

two approaches and make recommendations for streamlining. Districts are already showing some interest and initiative to expand the care groups.

## **I. Management Issues**

The overall program is managed from the Kabeho Mwana 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.

**Financial Management Systems** The Finance Managers meet every other month (vs. every month during Year One) and this has ensured regular discussion of the key issues, ongoing problem-solving and clear documentation of all decisions taken and agreements reached. While financial management systems have continued to develop and quarterly financial reporting by all PVOs has improved, there were some notable challenges in Year Two.

Per the DIP, the program established a cash forecasting process for the consortium, which at times has been difficult to maintain. For instance, some expenditures are unplanned and therefore cause delays in processing for payment. The transfer of funds to the districts are sometimes delayed. These delays have been raised with the CDs and Finance managers and the program is working to resolve this issue.

**Human Resources** The Kabeho Mwana Team Leader and the managers have done extraordinary work on team building with the staff. This has helped with the sense of program identity and bringing the team together despite various challenges in Year Two. The program held quarterly meetings for all six districts, attended by all program managers, officers, district counterparts (homologues) and occasionally the Directors of Health and Medical Directors. The agenda covers progress to date of activities, review of data collected during the past months, new updates from MoH at the national and district level, finding solutions to constraints and planning for the next three months.

As noted during the Annual Review workshop discussions with Kabeho Mwana staff, staff satisfaction, motivation and commitment to the program are strong. The team feels supported and that senior management is responsive. However, the program continues to encounter some discrepancies between consortium partners. For instance, there are some inconsistencies regarding salaries and basic allowances for the program despite efforts made to harmonize due to match/non-federal budget constraints. The Team Leaders, CDs, and Finance Managers are actively working to resolve this issue and better harmonize salaries and benefits.

**Communications** Working in relatively remote areas, at times the program experienced problems with access to internet due to the telephone companies' insufficient cell sites in the district. Within the consortium, the communication cost allocated per month to each officer is currently not harmonized. IRC has reduced its communication expenses for the officers for a three month period; however once funding is secured IRC plans to return to its original allocation so that this will be harmonized again.

**Staff/Team Development** The PVO partners carried out staff appraisals/performance management reviews and identified career development plans. The main trainings and workshops attended in Year Two were:

- Administration assistant for the program office in Kigali is currently supported on her Administration course for the first year.
- One M&E officer attended the one-week C-IMCI learning workshop in Madagascar.

- QA Officers attended the Partnership workshop and Disaster Risk Reduction organized by Concern Worldwide in Rwanda.

In addition, during the annual review workshop, the staff noted a range of staff development requests including continued training on QA, leadership and management skills, PDA capacity and communication in English. With the Technical Backstops' input, the program is exploring ways to meet these staff development requests and build these into the work plan and TA visits. Lastly, with the forthcoming World Bank funded community-PBF, the program will be working with MSH to ensure the on-line tracking of PBF indicators and payment for community health activities. Program staff will need to be trained on data collection and transfer skills to health facility staff.

**Relationships with local program partners** The program is becoming a key implementer at the national level, dialoguing with decision making and contributing to strategic planning with the IMCI, Community Health and the NMCP HBMF working groups. Overall, the relationship at the district level has been positive, each complementing each other, except in one district, where the issue of the PBF contract of CHW supervision has not yet been resolved and health center/community data has not been made accessible to the program staff (this issue has been raised with the MoH at the national level). The delay in the roll-out of the CHW training has somewhat strained the relationship with the districts especially in the two new districts of Nyaruguru and Nyamagabe. To minimize this setback, the program communicated more often with the district partners on the progress of the Community Health strategy and involved them in national level meetings.

The Program Advisory Committee (PAC) as described in the DIP and its role as a guiding body to review performance against plans and how it will be used to advocate for replication of C-IMCI across the country has not been launched as planned. However, the program regularly engaged the technical support and sought advice from the IMCI, Malaria and Community Health technical working group in developing plans and has also played a key role during review process of PMI, USAID and the MoH. The plan is to launch the PAC in Year Three. Members have already been identified and the TOR is in draft form to be shared with prospective members.

### **J. Local Partner Organization and Capacity Building**

Kabeho Mwana supported the district health authorities and provided training to build the technical knowledge and training skills of district health authorities, HC staff, and CHW Supervisors to train and supervise CHWs in effective behavior change activities, through the COSAs, CDC members and local leaders. At the same time health centers and the program facilitated the forming of CHW associations to become cooperatives and play leadership roles in community health. Health facility staff were trained on supportive supervision through performance contracting and reinforcement of the relationship between the formal health system and the informal cadre of CHWs and other community volunteers. In addition, the monthly meetings of CHWs with the health staff of the health centers provided a forum for continuing training, data analysis and reporting. The program will continue to build the capacity of the District health team and support them in their request to strengthen data management capacity, including PDA and Excel skills.

### **K. Mission Collaboration**

In Year Two the Kabeho Mwana team appreciated and relied upon a good working relationship with the USAID Mission in Rwanda. The Mission has been very supportive of the program and flexible to accept all changes that have been suggested. The majority of the program's direct interaction with the Mission was with the PMI team, although good working relationships were maintained on multiple levels with the Mission's health team in spite of several personnel changes

within that team.<sup>5</sup> The Mission continued to provide support to program activities, including the official launching day of Kabeho Mwana in June 2008. Whenever possible, the program team has also worked to support and facilitate the work of the Mission. Staff regularly attended quarterly USAID meetings, any PMI partner meetings, and the Team Leader participated in the three-day USG health partners retreat in March. Since October 2007 EIP has hosted four visits to program field sites from USAID and PMI delegations.

Previously the program's activity manager was from the Mission's MCH team, but the Mission has indicated that because of Kabeho Mwana's close working relationship with PMI, the activity manager will from this point forward be a member of that team.

The Mission was proactive when the MoH proposed changes related to the revised National Community Health policy, requesting a presentation from the Community Health Desk, and offering support through means such as participation in the community health technical working groups. As Kabeho Mwana adjusted the program to the changes in policy and strategy, the Mission gave its approval.

Kabeho Mwana staff sit on several task forces and technical working groups in which Mission health staff also have membership, including the IMCI task force, and the malaria/HBM working group. The Team Leader, managers, and representatives from each of the consortium's partners were all invited to participate in the community health desk's development of a treatment protocol for malnutrition. Moreover, the planning process for the PMI Malaria Operational Plan (MOP) took place in July, including a visit from a large delegation from Washington. Kabeho Mwana participated in many of the meetings for partners during the visit and contributed to the draft MOP for July 2008 – June 2009. USAID/PMI also commissioned an evaluation of HBM this year, carried out by MSH and BASICS.<sup>6</sup>

For the coming year program staff have identified several steps in order to build upon and improve working relationships with the Mission. The new Senior Health Advisor recently initiated a series of regular meetings of USAID partners working in maternal/child/reproductive health, and Kabeho Mwana will continue to participate. Program staff will also arrange for more frequent meetings with the Senior Health advisor in order to ensure that she has familiarity with the program and will make sure that any new Mission staff with connections to the program are fully briefed upon their arrival.

#### **L. Other Relevant Issues**

Relevant issues were addressed throughout the Annual Report. However, the Annexes provide additional information regarding Kabeho Mwana program activities during Year Two.

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<sup>5</sup> There were several personnel changes on the health and PMI teams in 2008. The health team leader and health advisor left Rwanda for other positions, leaving either vacant positions or interims personnel. A new Senior Health Advisor, as well as two new PMI advisors (CDC and USAID), were introduced to USG partners in April.

<sup>6</sup> Two program districts were included in the evaluation (Nyamasheke and Kirehe), and EIP participated in the evaluation and restitution meetings. EIP is a key implementing partner of HBM, and often used as the showcase example whenever presentations are made about HBM in Rwanda.