



WORLD RELIEF BURUNDI CHILD SURVIVAL PROJECT

RAMBA KIBONDO
“Live Long Child”

FIRST ANNUAL REPORT



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ACRONYMS

ANC	Antenatal Care
BCC	Behavior Change Communication
BPS	Provincial Health Bureau (Bureau Provincial de Santé)
CCM	Community Case Management
CDD	Control of Diarrheal Disease
C-HIS	Community Health Information System
CHW	Community Health Worker
CI	Confidence Interval
C-IMCI	Community-Integrated Management Childhood Illness
COGES	HC drug management committee (Comité de Gestion)
COSA	HC staff management committee (Comité de Santé)
CSHGP	Child Survival & Health Grants Program
CSP	Child Survival Project
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis and Tetanus immunization
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
HC	Health Center
HN-TPO	Health Net-Transcultural Psychosocial Organization
HQ	Headquarters
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide Treated Net
KHD	Kibuye Health District
LLINs	Long-Lasting Insecticide-treated Nets
LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MIPAREC	Ministry for Peace and Reconciliation under the Cross
MMR	Measles, Mumps, Rubella Immunization
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD/Hearth	Positive Deviance/Hearth
PEV	Expanded Program on Immunization
POU	Point-of-Use Water Treatment
TPS	Health Promotion Technician
TT	Tetanus
USAID	United States Agency for International Development
WHO	World Health Organization
WR	World Relief
WRA	Women of Reproductive Age
WRB	World Relief Burundi

Introduction

The World Relief Burundi (WRB) Child Survival Project (CSP) works throughout the four communes of Kibuye Health District (KHD), Gitega Province, Burundi and was initiated in October 2007. The project's goal is to reduce the morbidity and mortality among children under five (U5) and women of reproductive age (WRA) through the implementation of Community-Integrated Management of Childhood Illness (C-IMCI) using the Care Group Model in KHD. The project aims to achieve this goal through three major objectives: 1) Improved linkages between households, communities and the formal health system; 2) Improved availability and access to essential health commodities at the community level; 3) Increased knowledge and adoption of key family practices for child health by child caregivers with support from community leaders and health providers.

The CSP was given the local name, *Ramba Kibondo*, which means "Live Long Child," to reflect both the goal of the project and the hope of the parents of Kibuye for their children. This annual report describes the activities, accomplishments and challenges of the first year of project implementation, specifically from October 2007 to September 2008.

A. Main Accomplishments

Ramba Kibondo has made a great deal of progress in establishing a programmatic foundation for implementation in the next four years. The focus of the first year has been on learning from the communities in the project area, establishing relationships with key stakeholders as well as refining project strategy and systems.

1. Baseline Assessments and Preparation of the Detailed Implementation Plan (DIP): The first major project activity was the design and implementation of the baseline Knowledge, Practice, Coverage (KPC) survey, which was carried out in February 2008. Conducting this household-based survey provided a significant opportunity for the project staff to become familiar with the project area and for community members to become familiar with the project. Following the KPC survey, the project staff also conducted qualitative research to identify the health needs, priorities and resources of the communities in the project area. The Detailed Implementation Plan (DIP) was then completed and submitted in April 2008, presented at the Child Survival and Health Grants Program (CSHGP) DIP Review Meeting in June 2008 and approved in July 2008. The DIP review panel gave very positive feedback on the quality of the DIP and how it illustrated both comprehensive and innovative implementation strategies.

2. Household Census: Conducting a census to identify households with children under the age of five and women of reproductive age is an enormous and time consuming task, but it is essential to building a foundation for implementing the Care Group Model. The project staff conducted a household census throughout the project area from the beginning of April until the middle of June 2008. The census provided an opportunity for building relationship with local leaders, which was critical to the success of the census. The Colline leaders and Nyumbakumi (NK) leaders¹ first informed their communities about the household census. When a promoter arrived in the community the NK leader introduced the promoter to each household in his jurisdiction. The dissemination of information regarding the census was so effective that members of any households that were accidentally overlooked came to the

¹ The Government of Burundi uses an administrative structure that divides geographic regions into progressively smaller areas: Provinces are divided into Communes, Collines, Subcollines and Nyumbakumi (10 household clusters).

promoters and insisted to be included in the census. The results of the household census are included in the “Baseline Data and Assessment Results” section.

3. Volunteer Election and Care Group Formation: The election of 2,710 volunteers and formation of 207 Care Groups represents another major accomplishment of the project. The election of volunteers and formation of Care Groups happened in tandem with the household census. As the promoters conducted the census, groups of 10-15 households (usually the households within one NK) were identified and the mothers from each of these households were called together to elect their volunteer. The promoters reported that mothers were willing to avail themselves for this process, because they knew that this volunteer would be giving them health lessons and this would help to save their children. Many women wanted to be volunteers, but the promoters would provide the women with criteria for being a volunteer—emphasizing that the volunteer must be someone who is trusted and will be available to her neighbors. Often the women would take time to discuss the issue alone and then would come back to the promoter to elect the volunteer. In the Twa² communities there was some reluctance of women to become volunteers—many did not have the confidence to become volunteers, but with encouragement from the promoters they were willing to participate. The CSP now has a total of three Care Groups with all Twa volunteers. Overall, the election process raised awareness about project and ensured that the selection of volunteers was participatory, which has made the recognition of volunteers strong in the community.

4. Implementation of Control of Diarrheal Diseases Intervention: Implementation of the first intervention was a main accomplishment for the CSP. The diarrhea training camp was a great success, because of the significant participation of the project’s MOH partners. The MOH Provincial Director, District Director, District Principal Supervisor, three Supervisors, four TPS, 11 Titulaires and four CHWs all participated in the training camp. The MOH Provincial Director, District Director and District Principal Supervisor all reviewed the diarrhea intervention curriculum and the training camp provided an effective forum for all CSP staff and partners to contribute to the revision of the volunteer curriculum in Kirundi. This process of collaborative curriculum review earned the buy in of these key partners and ensured the harmonization of key messages between the CSP and MOH.

The project’s first intervention was successful in reaching volunteers and households with the key messages related to control of diarrheal diseases. According to project monitoring data, a total of 2,274 Care Group volunteers attended Care Group meetings and a total of 16,729 households received household visits from a Care Group volunteer in September 2008. The project’s first monitoring survey demonstrated that some key indicators of knowledge and practice have significantly improved. For example, the percentage of caregivers who know at least two signs for seeking immediate care when their child is sick improved from the baseline figure of 62.2% [CI 56.4-67.7%] to 90.6% [CI 82.9-95.6%]. Additionally, the percentage of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness improved from the baseline figure of 32.4% [CI 21.8-44.5%] to 68.8% [CI 58.5-77.8%]. See Annex 1: M&E Plan for further details regarding progress of indicators.

5. Lot Quality Assurance Sampling (LQAS) Monitoring Survey: The first monitoring survey was conducted after completion of the diarrhea intervention in October 2008. This event provided a significant capacity building opportunity, which has prepared the CSP team to conduct future monitoring surveys using LQAS. The MCH Specialist trained all CSP staff in LQAS methodology,

² Ethnic minority in Burundi (less than 1% of the total population) that is historically and currently underserved.
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provided technical support during data collection and led the entire team through participatory hand tabulation of the results. The data was also entered into Epi-Info by the M&E Officer and MCH Specialist for the purposes of electronic storage and further data analysis. The same data collection, management and analysis procedures will be used in future monitoring surveys. See Annex 1: M&E Plan for monitoring survey results.

B. Activity Status

Table 1. Activity Status of Project Objectives

Project objectives	Key Activities	Status of Activities	Comments
1. Improved linkages between households, communities and the formal health system.	1.1 Integrate the project C-HIS with the MOH HIS to improve disease surveillance and the quality of local health information	Not yet on target.	Care Group meetings and C-HIS data collection just began in August 2008. Integration of the C-HIS with the MOH HIS has been limited by the low attendance of CHWs at Care Group meetings thus far. CSP staff are focusing efforts on collaboration with the District MOH to encourage CHW attendance at Care Group meetings. The M&E Officer will also submit monthly C-HIS reports to partners starting November 2008.
	1.2 Invite MOH staff to participate in promoter training workshops for child survival project interventions	On target.	The MOH Provincial Director, District Director, District Principal Supervisor, three Supervisors, four TPS, 11 Titulaires and four CHWs attended the Diarrhea Training Camp in June 2008.
	1.3 Mobilize families to participate in antenatal care, MCH weeks, EPI outreach, routine immunization and child health services through a network of Care Group promoters and volunteers	Activities not yet commenced.	Immunization/Vitamin A intervention scheduled to begin February 2009.
	1.4 Increase referrals and counter-referrals between volunteers, community health workers and health centers through coordination of Care Group volunteers and promoters with health center staff	Not yet on target.	It has not been possible to significantly impact referral systems within just two months of Care Group facilitation, but this should improve as CHW attendance at Care Group meetings increases and collaboration with HC staff improves. This objective will be of particular focus during CCM activities in FY10 (pending approval).

Project objectives	Key Activities	Status of Activities	Comments
2. Improved availability and access to essential health commodities at the community level.	2.1 Facilitate increased access to LLINs in the project area in collaboration with public sector funders, Global Fund, DFID and other donors	On target.	Malaria Prevention and Care-seeking intervention scheduled to begin October 2009 (FY10). In July 2008, CSP leadership participated in meetings regarding Global Fund's 2009 Malaria Campaign for Burundi and ITN distributions.
	2.2 In partnership with the MOH, WHO and Unicef, pilot community case management (CCM) of diarrhea and malaria (pending approval) by training and mobilizing selected Care Group volunteers to distribute ORS packets, zinc and effective anti-malarials	Not yet on target.	A total of 5,000 ORS packets were given to the CSP by the Provincial MOH for distribution by promoters and volunteers. If this distribution (scheduled for November 2008) is successful the project may continue to receive a supply for distribution. Zinc has been approved by the National MOH, but supplies have not reached the districts. CCM for diarrhea and malaria has not yet been approved by the MOH.
3. Increased knowledge and adoption of key family practices for child health by child caregivers with support from community leaders and health providers.	3.1 Invite MOH staff to participate in promoter training workshops for child survival project interventions	On target.	The MOH Provincial Director, District Director, District Principal Supervisor, three Supervisors, four TPS, 11 Titulaires and four CHWs attended the Diarrhea Training Camp in June 2008.
	3.2 Train Care Group volunteers in BCC messages every two weeks through Care Group promoters	On target.	Care Group meetings began at the end of July 2008.
	3.3 Saturate communities in the project area with focused BCC messages, reaching every household every two weeks through Care Group volunteers	On target.	Care Group volunteers began visiting households at the end of July 2008.
	3.4 Mobilize religious leaders and community opinion leaders to learn BCC messages and share these messages with their congregations and communities	On target.	A total of 350 religious leaders have been organized into 24 Religious Care Groups, which will meet with a promoter once per month to learn the same BBC messages taught to Care Group volunteers. The Religious Care Group meetings started in September 2008.
	3.5 Sensitize community-based private drug sellers, traditional healers and traditional birth attendants about danger signs and appropriate drug use through community-level meetings led by Care Group promoters	Activities not yet commenced.	Activities planned to begin in FY10, particularly in association with the Malaria intervention scheduled to begin October 2009 (FY10).

Table 2. Activity Status of Technical Intervention Areas

Control of Diarrheal Disease: (20% Level of Effort)
<p>Project Objectives:</p> <ul style="list-style-type: none"> • Increase percent of children 0-23 months with diarrhea who receive ORS or recommended home fluids from 43.7% to 80.0%. • Increase percent of children 0-23 months with diarrhea who are offered continued feeding during illness from 63.4% to 80.0%. • Increase percent of children 0-23 months with diarrhea who are offered increased fluids during illness from 32.4% to 70.0%. • Increase percent of mothers of children 0-23 months who wash their hands with soap at appropriate times from 18.0% to 70.0%. <p>Key Activities: Education to improve hygiene and home treatment of diarrhea using ORT; improved access to ORS and point-of-use water treatment (pending availability); promotion of handwashing stations.</p> <p>Status of Activities: On target.</p> <p>Comments: The Diarrhea intervention was implemented from July-September 2008. Related project objectives are on track, except for continued feeding during illness and handwashing at appropriate times (see Annex 1: M&E Plan). There has been little improvement in the number of covered latrines or handwashing stations and very few households boil their drinking water (see Annex 1: M&E Plan), so Care Group promoters and volunteers will continue to reinforce BBC messages related to these issues. The Provincial MOH gave the project 5,000 ORS packets, which will be distributed by volunteers to caregivers of children with diarrhea beginning in November 2008. Zinc treatment has been approved by the MOH, but has not yet become available at the district level. Point-of-use (POU) water treatment (Sur'eau) is still unavailable in Burundi, so the CSP leadership will continue to advocate for making it available.</p>
Immunization: (10% Level of Effort)
<p>Project Objectives:</p> <ul style="list-style-type: none"> • Increase coverage of DPT1 among children 12-23 months from 62.5% to 80.0%. • Increase coverage of DPT3 among children 12-23 months from 61.0% to 80.0%. • Increase coverage of measles among children 12-23 months from 55.1% to 80.0%. <p>Key Activities: Community mobilization to access EPI services.</p> <p>Activity Status: Activities not yet commenced.</p> <p>Comments: Immunization/Vitamin A intervention scheduled to begin February 2009.</p>
Nutrition: (40% Level of Effort)
<p>Project Objectives:</p> <ul style="list-style-type: none"> • Increase the percent of newborns who were put to the breast within one hour of delivery and did not receive prelacteal foods from 62.0% to 75.0%. • Increase the percent of infants and young children age 6-23 months fed according to minimum appropriate feeding practices from 25.6% to 50.0%. • Achieve sustained adequate or catch-up growth in 60.0% of children who complete the Hearth program. <p>Key Activities: Education of all caregivers to promote optimal infant and child feeding; community-based rehabilitation of malnourished children via the Hearth program.</p> <p>Activity Status: Activities not yet commenced.</p> <p>Comments: Nutrition I intervention scheduled to begin October 2008; Nutrition II intervention (including backyard gardens and PD/Hearth) scheduled to begin April 2009.</p>
Malaria: (30% Level of Effort)
<p>Project Objectives:</p> <ul style="list-style-type: none"> • Increase the percentage of households with a child 0-23 months with an LLIN from 3.0% to 50.0%. • Increase the percentage of children 0-23 months who slept under a treated net the previous night to from 8.0% to 50%. • Increase the percentage of children 0-23 months with fever who receive appropriate antimalarial treatment within 24 hours from 17.1% to 60.0%. • Increase percent of women who slept under an ITN during last pregnancy from 32.7% to 50.0%. <p>Key Activities: Community-wide education to improve malaria prevention and treatment seeking behaviors; improved access to LLINs.</p> <p>Activity Status: Activities not yet commenced.</p> <p>Comments: Malaria Prevention and Care-seeking intervention scheduled to begin October 2009 (FY10).</p>

Cross-cutting: C-IMCI

Project Objectives:

- Increase percent of mothers of children 0-23 months who recognize two or more danger signs of childhood illness from 62.2% to 80.0%.

Key Activities: Community-wide education to improve recognition of danger signs by caregivers, community leaders and health providers.

Activity Status: On target.

Comments: The Diarrhea intervention included key messages related to the recognition of danger signs, which were taught during Care Group meetings for volunteers and religious leaders. See Annex 1: M&E Plan for monitoring data regarding indicator progress.

C. Factors of Impeded Progress

Delayed Procurement of Vehicle and Motorbikes: There were several months of delay in procuring the project vehicle (obtained in April 2008) and motorbikes (obtained in August 2008). It was difficult to coordinate the baseline assessments, project census and implementation activities throughout the project area with little transportation. Once the vehicle was procured, it was still a challenge to take the promoters to their different places of work with one vehicle. The vehicle would transport promoters in two communes one day and then transport promoters in the other two communes the next day. Once the motorbikes were procured, it was still necessary for most CSP staff to learn how to drive the motorbikes. Over half can now confidently drive the motorbikes and the rest have hired drivers to assist them while they are still learning, so the hindrance of transportation has been largely overcome.

Delayed Hiring of Supervisors and Promoters: The project requires a total of four supervisors to be responsible for each of the four Communes in the project area as described in the DIP. The hiring of supervisors was delayed until August 2008 and at that time only two were hired. Currently, the project is functioning with only two supervisors, which is not allowing for adequate supervision of the promoters. The Training Officer and M&E Officer continue striving to fulfill the duties of two supervisors, in addition to their regular responsibilities, but the lack of adequate supervision is impacting the quality of Care Group facilitation and monitoring. The CSP leadership team has recommended one promoter to become a supervisor and the WRB Country Office has committed to resuming recruitment for a fourth supervisor. It is anticipated that these positions will be filled in November 2008.

After the completion of Care Group formation in June 2008, it was determined that 23 promoters would be necessary to reach all 207 Care Groups. However, the project has been functioning with 22 promoters or less (due to promoter resignations), so supervisors have been filling in for promoters that are absent. The CSP leadership team submitted a request to hire an additional promoter and a hiring selection process was conducted by the WRB Country Office in October 2008, so it is anticipated that two new promoters (one to replace the promoter being moved to a supervisor position and one additional promoter to make a total of 23) will be starting work in November 2008.

Resignation of Project Manager: The Project Manager resigned in July 2008, which has had a number of impacts on the continuity and progress of project implementation. As would be expected, the loss of a key member of the CSP leadership team impacted CSP team morale and relationships with project partners. Over the past few months the Training Officer has been functioning as the Interim Project Manager, but it has been difficult for both remaining members of the CSP leadership team (Training Officer and M&E Officer) to manage their regular activities as well as take on additional responsibilities in the absence of a Project Manager. Duties related to field implementation and

supervision have taken a priority, while maintaining regular contact with partnering administrative, MOH and NGO agencies has been a challenge. The WRB Country Office has recently identified and hired a new Project Manager, who will begin work on November 10, 2008 (pending USAID approval).

Lack of Communication with WR HQ Technical Unit: There has been a hindrance of communication between the CSP staff and the WR HQ Technical Unit, which has significantly limited the technical oversight of the project. This situation has resulted in the diarrhea intervention curriculum for Care Group volunteers being printed and implemented without any input from the Technical Unit and data collection forms for the Community-Health Information System (C-HIS) being revised and implemented without review by the Technical Unit. Additionally, the Technical Unit did not receive all bimonthly or quarterly reports produced by the CSP. The MCH Specialist spent six weeks (September-November 2008) in the project area with CSP staff, so that technical input could be caught up in the most critical areas. The WRB Country Office has stated that timely communication between the CSP staff and Technical Unit will be improved and supported, so it is hoped that appropriate technical oversight of the CSP will be possible in the coming year.

D. Technical Assistance Needs

There will be a number of specific technical assistance needs in the coming year, which will be fulfilled by the WR HQ Technical Unit and consultants:

Technical Orientation of New Project Manager: It will be necessary for the new Project Manager to be oriented to the Care Group methodology and the technical aspects of the CSP's implementation strategy as soon as possible. The Project Manager will be expected to review the DIP and participate in conference calls with the WR HQ Technical Unit in November 2008. Close communication between the Project Manager and Technical Unit regarding project implementation and progress will be particularly necessary over the first few months of FY09.

Integration of Adult Education Methodology: The Burundi CSP promoters need to learn how to use culturally appropriate participatory teaching methods such as dialogue, story, song, drama and pictures for successful Care Group facilitation. The WR HQ Technical Unit and WRB Country Office will pursue opportunities to provide further technical support and training in these areas within the first quarter of FY09. One option to be explored would be for the former Deputy Project Manager from the first WR CSP in Rwanda to visit Burundi and lead training in adult participatory education techniques for Care Groups.

Positive Deviance/Hearth Training: PD/Hearth will be introduced by the project in the fourth quarter of FY09. In neighboring Rwanda, the WR Umucyo CSP had a successful experience with PD/Hearth following training provided by Drs. Warren and Gretchen Berggren at a regional workshop organized by WR with partial support from CORE. In order to transfer the benefits of knowledge and experience gained in Rwanda, WR will arrange for the Project Manager of the first WR CSP in Rwanda to train the Burundi CSP staff in PD/Hearth. The training will take place in the second or third quarter of FY09, depending on the consultant's availability.

Conflict Resolution Training: All CSP program staff will participate in conflict resolution training with a local expert trainer from Ministry for Peace and Reconciliation under the Cross (MIPAREC), a Gitega-based Community-Based Organization (CBO) with expertise in curriculum development for peace and reconciliation. As described in the DIP, WR has a good relationship with MIPAREC, so a

mutually convenient time for this training will be arranged between the two organizations for the first quarter of FY09.

E. Substantial Changes to Project Description

There have been no substantial changes to the project description from the DIP that would require a change to the Cooperative Agreement.

F. Progress toward Sustainability

The sustainability plan for this project primarily relies on the integration of the Care Group structure within the existing formal health system. This integration must involve both MOH staff and CHWs taking an active role in Care Group facilitation and the institutionalization of the C-HIS, so the CSP is tracking indicators related to these elements of sustainability (see Annex 1: M&E Plan).

The CSP has linked promoters and supervisors to specific Health Centers (HCs) to facilitate the process of Care Group and health system integration. Promoter responsibility areas were created within HC catchments, so that each promoter serves Care Groups within one HC catchment area. Most of the promoters are currently living in HC staff accommodations at the HC associated with her responsibility area, which has naturally resulted in frequent communication between promoters and HC staff. Supervisors are responsible for maintaining coordination with all the HCs within her Supervision Area (SA) by participating in COSA meetings and providing CSP updates to HC staff. The HCs have offered meeting space for supervisors to hold commune level staff meetings with promoters.

The most essential link between the Care Group structure and formal health system must be made through the participation of CHWs in Care Group meetings. The CSP aims for the Care Group volunteers to extend the reach of CHWs in the community to the household level, which is a concept that has been embraced by the MOH, but the attendance of CHWs at Care Groups meetings has been limited to date (see Annex 1. M&E Plan). However, it should also be noted that 31 of the elected Care Group volunteers are also CHWs. Regular attendance of CHWs at Care Group meetings is key to the institutionalization of the C-HIS, because CHWs can report this information to their supervising COSA as described in the DIP. The CSP leadership team is focusing efforts on improving collaboration with the District MOH to encourage CHW attendance at Care Group meetings.

G. Specific Information Requested

No specific information was requested for response in the first Annual Report during the DIP consultation for this project.

H. Baseline Data and Assessment Results

A household census was conducted throughout the project area after the submission of the DIP. This census was necessary for establishing the actual number of households with women of reproductive age and children under the age of five, so that the necessary number of Care Group volunteers could be accurately determined. The process for conducting this census in the community is described in the “Main Accomplishments” section.

The household census found that there were a total of 22,856 households with women of reproductive age and children under the age of five in the project area. The census did not count all women of reproductive age in these households, but rather recorded only the female heads of households (meaning that the woman is the single head of her household, wife of the male head of her household or other female child caregiver in the case of a widowed male head of household). The project staff made this decision to simplify the data collection process, because identifying the number of households to be reached was determined to be of greatest importance. However, the project will still strive to reach all women of reproductive age through the Care Group structure, since all women of reproductive age in a household will be encouraged to participate in the household visits by volunteers. The census did count the total number of children under the age of five in all households. This census methodology should be kept in mind when comparing the results of the census with the population estimates gathered from government records and reported in the DIP. A breakdown of census results in comparison to estimates based on national statistics is included in Annex 2: Household Census Results.

I. Challenges and Updates to Project Management System

Financial Systems: Over the past year the financial systems in place have not allowed for the Project Manager to review expenses charged to the project or track spending relative to the budget. The WRB Country Office states that a new financial system is being installed in October 2008, so there will be improved financial services in the new fiscal year. It is expected that the Project Manager will be able to receive monthly financial reports in the coming year.

Logistical Systems: There were several months of delay in procuring the CSP vehicle and motorbikes, which made the first year of implementation activities difficult for CSP staff. Additionally, there have been several months of delay in making arrangements for the purchase of fuel in Gitega City (30 minutes from the CSP Office), so the CSP has been primarily limited by the amounts that can be transported from Bujumbura. The WRB Country Office states that a contract will be signed with a selected petrol provider in October 2008 and that a CSP bank account will be established in Gitega City to ease the purchasing process in November 2008.

Human Resources: There has been significant staff turnover and delays in staff recruitment for the CSP. As described in the “Factors of Impeded Progress” section, staff recruitment has been resumed and all positions are expected to be filled in November 2008.

Communication Systems: There has been a hindrance of communication between the CSP staff and the WR HQ Technical Unit, which has significantly limited the technical oversight of the project. This issue has been described in the “Factors of Impeded Progress” section.

J. Local Partner Organization Collaboration and Capacity Building

The CSP has developed strong collaborative relationships with administrative authorities and local leaders. Commune administrators have offered space for CSP staff to hold meetings and have been willing to address any problems in the community by calling together Colline leaders to further explain and support the work of the CSP. The involvement of NK leaders was essential to completing the census. The NK leaders have also been active in participating in Care Group meetings and in mobilizing volunteers to attend. Over 25% of Care Groups had a village leader in attendance during meetings in August and September. Finally, over 350 local religious leaders have been organized into

24 Care Groups that will meet once per month to learn the same key messages as Care Group volunteers, so they can share these health messages with their faith communities.

The CSP has continued to explore opportunities for further collaboration with the MOH and Healthnet-TPO. The Provincial MOH recently gave 5,000 ORS packets to the CSP, which will be distributed in November 2008. If this distribution through Care Group volunteers is successful, there will be opportunities to receive more supplies in the future. The Provincial MOH Director expressed the difficulty of transporting ORS to HCs in Kibuye Health District, so the CSP offered to transport ORS to HCs during regular working activities. Healthnet-TPO recently commenced a demonstration garden project at two HCs in Kibuye Health District. As the CSP develops plans for the backyard gardens component of the Nutrition II intervention, CSP staff will visit Healthnet-TPO's demonstration gardens, meet with their project staff and identify points of synergy.

In September 2008, Care Group promoters and volunteers recognized that there was an outbreak of dysentery and cholera in Buraza Commune. Provincial and District MOH authorities were informed, which resulted in an MOH intervention that included delivery of medicine and ORS packets to the effected communities. Additionally, Care Group promoters were able to work with Nyumbakumi leaders to mobilize community members to build latrines. This level of responsiveness by the CSP staff, local health authorities and community leaders clearly demonstrates effective collaboration.

K. Mission Collaboration

Burundi is classified as a USAID Limited Presence Country with oversight from USAID/East Africa, so WR maintains communication with personnel both from USAID/Burundi and USAID/East Africa. Melanie Morrow, WR Director of Maternal & Child Health Programs, met with Jim Anderson, USAID/Burundi Country Representative and Alice Nibitanga, Program Development Specialist, during the DIP development process in February 2008. They were very supportive in sharing information regarding USAID/Burundi and its partner activities, including the new Maternal and Child Health Project implemented by Pathfinder and Management Sciences for Health. World Relief submitted the project's DIP to both Jim Anderson and to Stephanie Lazar, Program Manager Burundi, USAID/East Africa. In June 2008, USAID/Burundi hired a new Foreign Service National, Dr. Donatien Ntakarutimana, who is responsible for monitoring and support of USAID/Burundi's health programming. WR has been directed to commence regular communication with Dr. Donatien Ntakarutimana as the primary point of contact at USAID/Burundi for health programming.

The CSP has received two site visits from USAID/Burundi during its first year of implementation. At the end of May 2008, Jim Anderson, USAID/Burundi Country Representative, visited the project with a team of USAID colleagues. The Project Manager was able to provide an update on CSP start-up activities, including the process of working with local leaders to conduct the household census throughout the project area. On July 23, 2008 the CSP received another visit from USAID, which included Judy Manning, USAID Health Development Officer and Dr. Donatien Ntakarutimana, USAID/Burundi Program Development Specialist (Health). Care Group formation had recently been completed and the Care Groups were just beginning to hold biweekly meetings, so the visitors from USAID were able to observe a Care Group meeting in addition to receiving an update on project implementation from CSP staff.

L. Other Relevant Aspects

All relevant aspects of the project have been discussed in the preceding sections.

Annex 1: Monitoring & Evaluation Plan

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
CONTROL OF DIARRHEAL DISEASES/WATER & SANITATION							
IR3	Increase percent of children with diarrhea who receive ORS or recommended home fluids from 43.7% to 70.0%.	<u>RC12: ORT</u> : Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	KPC/Baseline & Final Monitoring Survey /Biannual	43.7% <i>Confidence Interval: 31.9-56.0%</i>	74.0% <i>Confidence Interval: 64.0-82.4%</i>	80.0%	Train volunteers and caregivers in ORT principles and use of ORS or recommended home fluids (including breast milk) for prevention of dehydration in children with diarrhea. To increase access to ORS, volunteers will distribute ORS packets to families of sick children in their communities (pending approval).
IR2	<i>For monitoring purposes, if volunteers are approved to distribute ORS packets.</i>	<u>Community ORS Distribution</u> : Number of ORS packets distributed by volunteers within Kibuye Health District each month.	Care Group Registries & Monthly Project Reports/Monthly	N/A	0 <i>*ORS packet distribution anticipated to begin in November 2008</i>	N/A	
IR2	<i>For monitoring purposes.</i>	<u>Health Center ORS Stock</u> : Percent of Health Centers without ORS stockouts each month.	Health Center Registries & Monthly Project Reports/Monthly	N/A	90.9% <i>*10/11 Health Centers with no stockouts in October 2008</i>	N/A	
IR3	Increase percent of children with diarrhea who are offered increased fluids during illness from 32.4% to 70.0%	<u>Key Indicator: Increased fluid intake during diarrheal episode</u> : Percentage of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	KPC/Baseline & Final Monitoring Survey/ Biannual	32.4% <i>Confidence Interval: 21.8-44.5%</i>	68.8% <i>Confidence Interval: 58.5-77.8%</i>	70.0%	Train volunteers and caregivers in the importance of increased fluid intake during diarrheal episode.
IR3	Increase percent of children with diarrhea who are offered continued feeding during illness from 63.4% to 80.0%	<u>Key Indicator: Continued feeding during a diarrheal episode</u> : Percentage of children 0-23 months with diarrhea in the last 2 weeks who were offered the same amount or more food during the illness	KPC/Baseline & Final Monitoring Survey / Biannual	63.4% <i>Confidence Interval: 51.1-74.5%</i>	58.3% <i>Confidence Interval: 47.8-68.3%</i>	80.0%	Train volunteers and caregivers in the importance of continued feeding during diarrheal episode.

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR2	<i>Zinc not yet available in Kibuye Health District. Target will be set if/when zinc becomes available.</i>	<u>Key Indicator: Zinc:</u> Percentage of children age 0-23 months with diarrhea in last two weeks who were treated with zinc supplements.	KPC/Baseline & Final Monitoring Survey / Biannual	N/A	N/A	N/A	Zinc for treatment of diarrhea in children has been approved by the national MOH, but has not yet been rolled out. CSP will advocate for the approval of community based distribution of zinc in national level C-IMCI meetings and in communications with MOH policy-makers.
IR2	<i>For monitoring purposes, if zinc becomes available in Kibuye Health District.</i>	<u>Community Zinc Distribution:</u> Number of zinc treatment courses distributed by volunteers within Kibuye Health District each month.	Care Group Registries & Monthly Project Reports/Monthly	N/A	N/A	N/A	If zinc is made available, the project will: (a) Sensitize caregivers to benefits of zinc treatment for children with diarrhea and train volunteers to follow up on zinc regimen during home visits; (b) coordinate with sector leaders, HC <i>titulaires</i> , and COGEs to ensure prompt implementation of treatment protocol and inclusion of zinc in drug supply monitoring mechanisms; and (c) train and equip community health workers to provide zinc treatment, to increase access at the community level (pending approval).
IR2	<i>For monitoring purposes if zinc becomes available in Kibuye Health District.</i>	<u>Health Center Zinc Stock:</u> Percent of Health Centers without zinc stockouts every month.	Health Center Registries & Monthly Project Reports/Monthly	N/A	N/A	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR3	Increase percent of mothers of children 0-23 months who wash their hands with soap at appropriate times from 18.0% to 70.0%.	<u>Appropriate hand washing practices:</u> Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing and who washed their hands with the cleanser after defecation and at one other appropriate time.	KPC/Baseline & Final Monitoring Survey/Biannual	18.0% <i>Confidence Interval: 13.8-22.8%</i>	35.4% <i>Confidence Interval: 25.9-45.8%</i>	70.0%	Train volunteers to help households to establish hand washing stations. Reinforce BCC messages on hand washing through community opinion leaders.
IR2	<i>For monitoring purposes.</i>	<u>RC 15: Soap at the place for hand washing:</u> Percent of mothers of children ages 0-23 months who live in a household with soap at the place for handwashing.	KPC/Baseline & Final Monitoring Survey/Biannual	53.7%	75.0%	N/A	Social marketing of soap by community-based agents.
IR3	<i>For monitoring purposes.</i>	<u>Key Indicator: Safe feces disposal:</u> Percentage of mothers of children 0-23 months who disposed of the youngest child's feces safely the last time s/he passed a stool. <i>Note: safe disposal includes dropped into toilet facility; water discarded into a toilet facility (except composting toilet); water discarded into sink or tub connected to drainage system (sewer, septic tank, or pit).</i>	KPC/Baseline & Final Monitoring Survey/Biannual	58.2%	61.5%	N/A	Train volunteers and caregivers in safe disposal of child's feces.
IR3	<i>For monitoring purposes.</i>	<u>Latrines:</u> Percentage of mothers of children 0-23 months who have a covered latrine or toilet connected to a drainage system.	KPC/Baseline & Final Monitoring Survey/Biannual	9.0%	9.4%	N/A	Mobilize households for latrine utilization and maintenance.
IR2	<i>Point-of-use water treatment (Sur'eau) is not currently available in Burundi. Target will be set if/when point-of-use water treatment product becomes available.</i>	<u>RC14: Point of Use (POU):</u> Percentage of households of children age 0-23 months that treat water effectively (includes boiling, chlorination, solar disinfection, and filtration).	KPC/Baseline & Final Monitoring Survey/Biannual	1.7%	17.7%	N/A	Train volunteers and caregivers in safe transport and storage of drinking water. Introduce point-of-use water treatment and reinforce boiling as an

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR2	<i>For monitoring purposes, if Sur'eau becomes available in Burundi.</i>	<u>Community Sur'eau Distribution:</u> Number of Sur'eau units distributed by volunteers within Kibuye Health District each month.	Care Group Registries & Promoter Reports/Monthly	N/A	N/A	N/A	effective water treatment strategy. Social marketing of Sur'Eau by community-based agents (pending availability).
	<i>Disease Burden Monitoring:</i>	<u>Two-week period prevalence of diarrhea:</u> Percentage of children age 0-23 months who had diarrhea at any time in prior 2 weeks.	KPC/Baseline & Final Monitoring Survey/Biannual	23.7%	53.1%	N/A	Conduct biannual monitoring surveys for project health information system.
NUTRITION							
IR3	Increase the percent of newborns who were put to the breast within one hour of delivery and did not receive prelacteal foods from 62.0% to 75.0%.	<u>Key Indicator: Immediate and exclusive breastfeeding of newborns:</u> Percentage of newborns who were put to the breast within one hour of delivery and did not receive prelacteal foods.	KPC/Baseline & Final Monitoring Survey/Biannual	62.0%	Anticipated January 2009	75.0%	Train volunteers to encourage immediate breastfeeding and discourage prelacteal foods. Sensitize TBAs, grandmothers, and other birth companions.
IR3	<i>For monitoring purposes.</i>	<u>RC4: Exclusive breastfeeding:</u> Percentage of children 0-5 months who were exclusively breastfed during the last 24 hours	KPC/Baseline & Final Monitoring Survey/Biannual	86.4%	Anticipated January 2009	N/A	Train volunteers to encourage immediate breastfeeding and discourage prelacteal foods. Sensitize TBAs, grandmothers, and other birth companions.
IR3	Increase the percent of infants and young children age 6-23 months fed according to minimum appropriate feeding practices from 25.6% to 50.0%.	<u>RC5: Infant and young child feeding:</u> Percentage of infants and young children age 6-23 months fed according to minimum appropriate feeding practices	KPC/Baseline & Final Monitoring Survey /Biannual	25.6%	Anticipated January 2009	50%	Train volunteers and caregivers on importance of appropriate and adequate complementary feeding; importance of dietary variety; Vitamin A-rich foods; protein, etc. Promote kitchen gardens.

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR3	Achieve sustained adequate or catch-up growth in 60.0% of children who complete the Hearth program.	<u>Hearth</u> : Percent of children who completed the Hearth program achieve sustained adequate (200-600 grams) or catch-up (over 700 grams) growth for at least 2 months after Hearth.	Registers maintained by promoters and specially trained volunteers for each cycle of Hearth.	N/A	Anticipated January 2009	60.0%	Promoters and volunteers conduct community based Hearth sessions for underweight children.
IR3	<i>For monitoring purposes.</i>	<u>Dietary diversity of foods consumed by young children</u> : Mean number of food groups eaten in the last 24 hours by children age 6-23 months	KPC/Baseline & Final Monitoring Survey/ Biannual	3.2	Anticipated January 2009	N/A	Train volunteers and caregivers on importance of importance of dietary variety; Vitamin A-rich foods; protein, etc. Promote kitchen gardens.
IR1	<i>For monitoring purposes.</i>	<u>RC6: Vitamin A supplementation in the last 6 months</u> : Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (care verified or mother's recall).	KPC/Baseline & Final Monitoring Survey/Biannual	81.7%	Anticipated January 2009	N/A	Train volunteers and caregivers on importance of Vitamin A; mobilize community to access Vitamin A from health centers and national campaigns
	<i>Disease Burden Monitoring:</i>	<u>RC16: Underweight</u> : Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/HCHS reference population).	Anthropometry during KPC/Baseline & Final; Monitoring Survey/Biannual	16.4%	Anticipated January 2009	N/A	Conduct biannual monitoring surveys for project health information system.
MALARIA							
IR2	Increase the percentage of households with a child 0-23 months with an LLIN from 3.0% to 50.0%.	<u>Ownership of long lasting insecticide-treated bed net</u> : Percentage of households of children 0-23 months that own at least one long lasting insecticide-treated bed net (LLIN).	KPC/Baseline & Final Monitoring Survey/Biannual	3.0%	Anticipated July 2009	50.0%	Coordinate with the MOH to assist in community based distribution of LLINs procured through DFID, Global Fund and other mechanisms.
	<i>For monitoring purposes.</i>	Number of LLINs distributed by volunteers (pending availability).	Promoter distribution records/Monthly	N/A	Anticipated July 2009	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR2 IR3	Increase the percentage of children 0-23 months who slept under an LLIN or ITN the previous night to from 8.0% to 50%.	<u>RC11: Child sleeps under an insecticide-treated bed net:</u> Percentage of children age 0-23 months who slept under an insecticide-treated bed net the previous night (LLIN or ITN treated with the past six months).	KPC/Baseline & Final Monitoring Survey /Biannual	8.0%	Anticipated July 2009	50.0%	Train volunteers and community leaders to encourage mothers and children under five to sleep under insecticide-treated bed nets every night.
IR2 IR3	Increase the percentage of children 0-23 months with fever who receive appropriate antimalarial treatment within 24 hours from 17.1% to 60.0%.	<u>RC10: Child with fever receives appropriate antimalarial treatment:</u> Percentage of children 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began.	KPC/Baseline & Final Monitoring Survey /Biannual	17.1%	Anticipated July 2009	60.0%	Train volunteers and caregivers to recognize fever as presumptive diagnosis of malaria in children and to seek care from trained provider within 24 hours of onset of fever. Pending approval, train community-based distributors to provide effective anti-malarials for home-based management of fever (suspected malaria) in children 6-23 months. Sensitize traditional healers, pastors, and other community leaders for prompt referral of children with fever.
	<i>For monitoring purposes.</i>	Number of antimalarial treatment courses distributed by volunteers (pending approval).	Volunteer distributor registries and promoter reports/Monthly	N/A	N/A	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR2 IR3	Increase percent of women who slept under an ITN during last pregnancy from 32.7% to 50.0%.	<u>Key Indicator: ITN use by mothers during pregnancy:</u> Percentage of mothers of children 0-23 months who slept under an ITN during their pregnancy with the youngest child.	KPC/Baseline & Final Monitoring Survey /Biannual	32.7%	Anticipated July 2009	50.0%	Encourage pregnant women to sleep under insecticide-treated bednets every night. Establish a voucher system to enable pregnant women to obtain a free net from a community-based distributor based on health worker referral at ANC visit.
IR3	<i>For monitoring purposes. Target will be set if/when IPT is approved.</i>	<u>Key Indicator: IPT:</u> Percentage of mothers of children 0-23 months who took effective antimalarials during the pregnancy with the youngest child	KPC/Baseline & Final Monitoring Survey/Biannual	N/A	N/A	N/A	IPT is not currently available for pregnant women. WHO is advocating for policy change to allow IPT in Burundi. If policy changes and drugs are available, the CSP will integrate IPT into malaria prevention messages for pregnant women and reinforce importance of early ANC.
	<i>Disease Burden Monitoring:</i>	<u>Two-week period prevalence of fever:</u> Proportion of children age 0-23 months with a report of fever in the last 2 weeks	KPC/Baseline & Final Monitoring survey/Biannual	37.0%	Anticipated July 2009	N/A	Conduct biannual monitoring surveys for project health information system.
IMMUNIZATION							
IR1	Increase coverage of DPT1 among children 12-23 months from 62.5% to 80.0%.	<u>Access to Immunization Services:</u> Percentage of children 12-23 months who received DPT1 according to the vaccination card by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	62.5%	Anticipated April 2009	80.0%	Partner with health sector leaders and health center staff to coordinate Maternal and Child Health Weeks for

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR1	<i>For monitoring purposes.</i>	<u>RC8: Access to Immunization Services:</u> Percentage of children 12-23 months who received DPT1 according to the vaccination card or mother's recall by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	94.9%	Anticipated April 2009	N/A	immunization outreach. Community mobilization to increase participation in MCH Weeks. Health workers to check immunization cards for all children who present at HC for well child, sick child, or sibling visits; recover defaulters.
IR1	Increase coverage of DPT3 among children 12-23 months from 61.0% to 80.0%.	<u>Health System Performance regarding Immunization Services:</u> Percentage of children 12-23 months who received DPT3 according to the vaccination card or health booklet by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	61.0%	Anticipated April 2009	80.0%	
IR1	<i>For monitoring purposes.</i>	<u>RC9: Health System Performance regarding Immunization Services:</u> Percentage of children 12-23 months who received DPT3 according to the vaccination card or mother's recall by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	73.5%	Anticipated April 2009	N/A	
IR1	Increase coverage of measles among children 12-23 months from 55.1% to 80.0%.	<u>Measles vaccination:</u> Percentage of children age 12-23 months who received a measles vaccination according to the vaccination card or health booklet by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	55.1%	Anticipated April 2009	80.0%	
IR1	<i>For monitoring purposes.</i>	<u>RC7: Measles vaccination:</u> Percentage of children age 12-23 months who received a measles vaccination according to the vaccination card or mother's recall by the time of the survey.	KPC/Baseline & Final Monitoring Surveys/Biannual	89.0%	Anticipated April 2009	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR1	<i>For monitoring purposes.</i>	<u>Key Indicator: Possession of a child vaccination card or health booklet – Ever had:</u> Percent of mothers of children 0-23 months who were ever given a vaccination card or health book for their youngest child 0-23 months.	KPC/Baseline & Final Monitoring Surveys/Biannual	94.0%	Anticipated April 2009	N/A	Communicate existing shortage of health cards at health center level to sector and provincial level leadership. Train volunteers and mothers in the importance of storing immunization cards in a safe place, protected from the elements.
IR1	<i>For monitoring purposes.</i>	<u>Key Indicator: Possession of a child vaccination card or health booklet – Currently have:</u> Percent of mothers of children 0-23 months who currently possess a vaccination card or health book for their youngest child 0-23 months.	KPC/Baseline & Final Monitoring survey/Biannual	73.3%	Anticipated April 2009	N/A	
IR1	<i>For monitoring purposes.</i>	<u>Key Indicators: Antigen and dose specific coverage:</u> Percent of children 12-23 months who received each antigen and dose that is part of the national immunization schedule by the time of the survey as verified by vaccination card or health booklet.	KPC/Baseline & Final Monitoring survey/Biannual <i>Specific targets are set for DPT1, DPT3 & measles as stated above. Other antigens will be tracked for monitoring purposes.</i>				Partner with health sector leaders and health center staff to coordinate Maternal and Child Health Weeks for immunization outreach Community mobilization to increase participation in MCH Weeks Encourage health workers to check immunization health cards for all children who present at HC for well child, sick child, or
		BCG		72.0%	Anticipated April 2009	N/A	
		Polio0		69.7%	Anticipated April 2009	N/A	
		Polio1		65.3%	Anticipated April 2009	N/A	
		Polio2		61.7%	Anticipated April 2009	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
		Polio3		56.0%	Anticipated April 2009	N/A	sibling visits and to provide vaccines as needed to bring children up-to-date with immunization schedule.
		Measles		55.1%	Anticipated April 2009	80.0%	
		Pentavalent I (DPT1, Hib, and HepB)		62.5%	Anticipated April 2009	80.0%	
		Pentavalent 2 (DPT2, Hib, and HepB)		63.0%	Anticipated April 2009	N/A	
		Pentavalent 3 (DPT3, Hib, and HepB)		61.0%	Anticipated April 2009	80.0%	
IR1	<i>For monitoring purposes.</i>	<u>Drop-Out Rate:</u> (DPT1-DPT3) / DPT1: (Percentage of children age 12-23 months who received DPT1 by 12 months according to vaccination card or health booklet - Percentage of children age 12-23 months who received DPT3 by 12 months according to vaccination card or health booklet) / Percentage of children age 12-23 months who received DPT1 by time of survey according to vaccination card or health booklet.	KPC/Baseline & Final Monitoring survey/Biannual	2.5%	Anticipated April 2009	N/A	
C-IMCI							
IR1 IR3	Increase the percent of mothers who recognize two or more danger signs of childhood illness from 62.2% to 80.0%.	<u>Danger signs:</u> Percentage of mothers of children age 0-23 months who know at least two signs for seeking immediate care when their child is sick.	KPC/Baseline & Final Monitoring survey/Biannual	62.2%	90.6%	80.0%	Train volunteers and caregivers to recognize danger signs of child illness that require immediate care seeking.
				<i>Confidence Interval: 56.4-67.7%</i>	<i>Confidence Interval: 82.9-95.6%</i>		
CAPACITY BUILDING & SUSTAINABILITY							
IR1 IR3	Mobilization of Community Volunteers through the Care Group	<u>Care Group Attendance:</u> Number and percent of Care Groups with at least 70% volunteer attendance per month.	Promoter & Supervisor Reports/Monthly	N/A	133/207= 64.2% (Sept 2008)	70%	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
	Structure.	<u>Volunteer Attrition:</u> Percent of volunteers who drop out for reasons other than death or movement out of the area per year (beginning year 2).	Promoter & Supervisor Reports/Annual	N/A	*During Year One a total of 93 volunteers (out of 2,701) dropped out and 74 of these volunteers were replaced (as of October 2008).	<10%	
		<u>Care Group Performance:</u> Number and percent of Care Groups averaging 70% or above on verbal tests of intervention knowledge.	Promoter & Supervisor Checklists/Once after each intervention	N/A	*Data collection will begin in Nov 2008	70%	
		<u>Pastoral Groups:</u> Number and percent of pastoral groups that meet per month.	Supervisor Monthly Reports/Monthly	N/A	18/24= 75.0% (Sept 2008)	70%	
IR1	Integration of Care Group Model with Existing Ministry of Health C-IMCI Structure	<u>CHW Integration:</u> Number and percent of Care Groups with a CHW in attendance in at least one meeting per month.	Promoter & Supervisor Reports/Monthly	N/A	7/207= 3.4% (Aug 2008) 12/207= 5.8% (Sept 2008)	70%	
		<u>TPS Integration:</u> Number and percent of TPS active in Care Group supervision per month.	Promoter & Supervisor Reports/Monthly	N/A	*Data collection will begin in Nov 2008	70%	
IR1	Institutionalization of Project Health Information System with District Health Information System	<u>Institutionalization of C-HIS:</u> Number and percent of health facilities involved in management of C-HIS per month.	Supervisor Monthly Reports/Monthly	N/A	0%	80%	
		<u>Institutionalization of C-IMCI:</u> Number and percent of COSAs involved in management of C-HIS per month.	Supervisor Monthly Reports/Monthly	N/A	0%	80%	
		<u>Institutionalization of C-IMCI:</u> Number and percent of COSAs with current action plans for community health.	Supervisor Monthly Reports/Monthly	N/A	10/11=90.9%	80%	

Annex 2: Household Census Results

Commune	Households	Women of Reproductive Age	Children Under Five Years of Age	Children Under Five Years of Age				
				0-11 Months	12-23 Months	24-35 Months	36-47 Months	48-59 Months
Bukirasazi	3,777	3,777*	5,274	1,141	1,120	1,064	1,039	910
Buraza	6,032	6,032*	8,441	1,940	1,664	1,452	1,590	1,795
Itaba	6,301	6,301*	8,533	1,951	1,725	1,699	1,702	1,456
Makebuko	6,746	6,746*	8,773	2,167	1,813	1,671	1,613	1,509
TOTAL	22,856	22,856*	31,021	7,199	6,322	5,886	5,944	5,670
NATIONAL ESTIMATES	N/A	38,176	24,376	6,688	6,688	11,000		

**Indicates number of households with one or more women of reproductive age; actual number of women (when more than one is in the same household) was not recorded during the household census.*

The number of women of reproductive age counted during the census (22,856) is not comparable to the estimate based on national statistics (38,176), since the census did not count all women of reproductive age, but rather the number of households with women of reproductive age. The number of children under the age of five counted during the census (31,021) is comparable to the estimate based on national statistics (24,376), since the census did endeavor to count all children under the age of five.

Annex 3: Workplan

Result	Major Activities	Year 2 (2008-2009)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Introduction of Child Survival Interventions													
	Nutrition I	X	X	X	X	X	X	X	X	X	X	X	X	All CSP Staff
	Immunization/Vitamin A					X	X	X	X	X	X	X	X	All CSP Staff
	Nutrition II							X	X	X	X	X	X	All CSP Staff
	Backyard Gardens							X	X	X	X	X	X	All CSP Staff
	PD/Hearth									X	X	X	X	All CSP Staff
	Curriculum Development													
	Develop Curriculum for Nutrition I	X												Training Officer, Project Manager, MCH Specialist
	Develop Curriculum for Immunization				X									Training Officer, Project Manager, MCH Specialist
	Develop Curriculum for Nutrition II						X							Training Officer, Project Manager, MCH Specialist
	Develop Curriculum for Backyard Gardens						X							Training Officer, Project Manager, MCH Specialist
	Develop Curriculum for PD/Hearth								X					Training Officer, Project Manager, MCH Specialist
	Develop Curriculum for Malaria Prevention and Care-seeking (Implementation beginning in FY10)												X	Training Officer, Project Manager, MCH Specialist
	Training Sessions													
	Survey Training/Refreshers	X												M&E Officer, MCH Specialist
	Supervision Seminar for CSP Supervisors		X											Training Officer, M&E Officer, Project Manager
	Nutrition I Training Camp	X												Training Officer, M&E Officer, Project Manager
	Immunization /Vitamin A Training Camp				X									Training Officer, M&E Officer, Project Manager
	Nutrition II Training Camp						X							Training Officer, M&E Officer, Project Manager

Result	Major Activities	Year 2 (2008-2009)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Backyard Gardens Training Camp						X							Training Officer, M&E Officer, Project Manager
	Conflict Resolution Training			X										Consultant (Exact month depends on consultant availability)
	PD/Hearth Training Camp				X									Consultant (Exact month depends on consultant availability)
	Management of Project Personnel													
	Recruit and hire replacement Project Manager	X												WRB Country Office
	Recruit and hire remaining promoters	X												WRB Country Office
	Recruit and hire remaining supervisors	X	X											WRB Country Office
	CSP Leadership Quarterly Planning	X			X			X			X			Project Manager, Training Officer, M&E Officer
	Training of Care Groups	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors, Promoters
	Training of Pastoral Care Groups	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors, Promoters
	Supervisors and Promoters Submit Weekly Work Plan	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors, Promoters
	Promoters Conduct Household Visits	X	X	X	X	X	X	X	X	X	X	X	X	Promoters
	Supervisors Conduct Household Visits	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors
	Supervisors Conduct Care Group Visits	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors
	Distribute Annual Incentives to Volunteers		X											All CSP Staff
	Meetings and Reporting													
	Quarterly Review/Planning Meetings with MOH and HN-TPO	X			X			X			X			Project Manager, Training Officer, M&E Officer
	Monthly Meetings with COSAs	X	X	X	X	X	X	X	X	X	X	X	X	Supervisors, Promoters

Result	Major Activities	Year 2 (2008-2009)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Biweekly Meetings with Supervisors & Promoters	X	X	X	X	X	X	X	X	X	X	X	X	Project Manager, Training Officer, M&E Officer, Supervisors, Promoters
	Monthly C-HIS Reporting for Partners	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer
	Biweekly Reporting	X	X	X	X	X	X	X	X	X	X	X	X	Project Manager, Training Officer, M&E Officer
	Monthly Reporting	X	X	X	X	X	X	X	X	X	X	X	X	Project Manager, Training Officer, M&E Officer
	Annual Reporting	X												Project Manager, Training Officer, M&E Officer, MCH Specialist
	Monitoring & Evaluation: Health Information System Monitoring Surveys													
	Diarrhea Intervention Monitoring Survey	X												M&E Officer, Supervisors, Promoters, MCH Specialist
	Nutrition I Intervention Monitoring Survey				X									M&E Officer, Supervisors, Promoters, MCH Specialist
	Immunization/Vitamin A Intervention Monitoring Survey							X						M&E Officer, Supervisors, Promoters, MCH Specialist
	Nutrition II Monitoring Survey											X		M&E Officer, Supervisors, Promoters, MCH Specialist
	Monitoring & Evaluation: Community-Health Information System													
	Care Group Activity Indicators Data Collection	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer, Supervisors, Promoters
	Care Group Vital Health Events Data Collection	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer, Supervisors, Promoters
	Community Meeting Notes Submission	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer, Supervisors, Promoters
	Household Visit Data Collection	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer, Supervisors, Promoters
	Care Group Visit Data Collection	X	X	X	X	X	X	X	X	X	X	X	X	M&E Officer, Supervisors

Result	Major Activities	Year 2 (2008-2009)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Technical Assistance Trips													
	Headquarters Maternal and Child Health Specialist Visit	X											X	MCH Specialist
	Conflict Resolution Trainer			X										Consultant (Exact month depends on consultant availability)
	PH/Hearth Trainer				X									Consultant (Exact month depends on consultant availability)

Note: The only major change to the workplan for year two from the DIP workplan is the implementation order of the Immunization and Nutrition II interventions. The Immunization intervention will be implemented before the Nutrition II intervention, in order to allow for more preparation time for PD/Hearth activities (including the scheduling of a consultant to lead the PD/Hearth Training Camp). Additionally, the Conflict Resolution Training has been moved to the workplan for year two, because this training was not accomplished in year one.

Annex 4: Budget

Annex 5: Papers or Presentations

The following presentation was given by Chantal Inamahoro (Project Manager) and Alyssa Davis (Maternal and Child Health Specialist) at the Child Survival and Health Grants Program Detailed Implementation Plan (DIP) Review Meeting on June 6, 2008 in Washington, DC:

World Relief Burundi Child Survival Project



Kibuye Health District, Gitega Province, Burundi
October 1, 2007-September 31, 2012
Detailed Implementation Plan Review



Project Site Background



- Total Project Area Population: 169,747*
- Women of reproductive age: 38,176¹
- Children under five years of age: 24,376¹
- Infant mortality rate: 166 per 1,000
- Children under five mortality rate: 231 per 1,000
- Local Partners: The Burundi MOH, Kibuye Hospital and 11 Health Centers, Free Methodist Church (Kibuye Hospital Administrator), and Healthnet-TPC (Performance Based Financing Organization)
- Political context: Transitioning from disaster relief to rehabilitation and development, following years of civil war and conflict.

* Reflects estimates

Top Causes of Mortality and Morbidity



- Malaria accounts for almost half of child deaths in health facilities nationwide (Burundian Ministry of Health)
- Malnutrition is the second leading cause of death (Burundian Ministry of Health)
- Forty-one percent of rural children under five years are underweight (World Food Program)
- Project Baseline KPC survey found nearly one-fifth of children under-five years had diarrhea in the past two weeks
- Project Baseline KPC survey found just 55.1% measles vaccination coverage as documented by immunization card

World Relief Burundi Child Survival Project Results Framework

Goal: **Implement CMCB using the Care Group Model in Kibuye Health District.**

Strategic Objective: **To reduce morbidity and mortality among children under five and women of reproductive age in Kibuye Health District.**

Results/ Objectives	Activities/ Strategies
1. Improved coverage of malaria prevention and treatment services	1.1. Engage the community to identify and address barriers to malaria prevention and treatment services 1.2. Increase community participation in malaria prevention and treatment services 1.3. Increase malaria prevention and treatment services coverage in the community 1.4. Increase community awareness of malaria prevention and treatment services
2. Improved community awareness of malnutrition and its consequences	2.1. Increase community awareness of malnutrition and its consequences through community-based education and training 2.2. Increase community awareness of malnutrition and its consequences through community-based education and training
3. Increased knowledge and adoption of the Care Group Model for child health and nutrition	3.1. Increase knowledge and adoption of the Care Group Model for child health and nutrition through community-based education and training 3.2. Increase knowledge and adoption of the Care Group Model for child health and nutrition through community-based education and training

HOUSEHOLD & COMMUNITY (H&C) AN IMPLEMENTATION FRAMEWORK



Element 1: Improving the knowledge, attitudes, health practices, and the community they care for

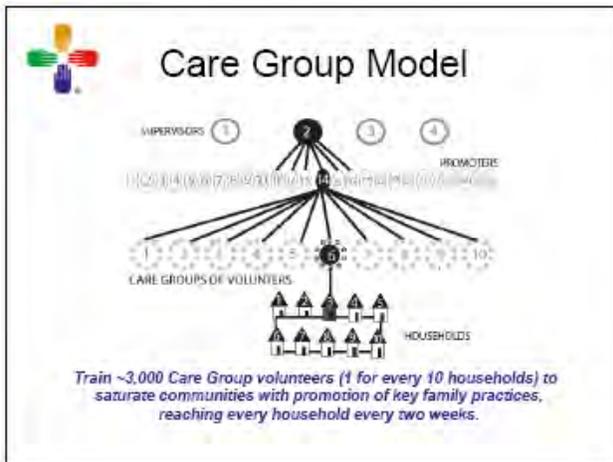
Element 2: Increase appropriate and accessible health care and information from community-based providers

Element 3: Integrating prevention of the family practices related to child health & nutrition

Intervention Areas

- **Nutrition: (40%)** Education of all caretakers to promote optimal infant and child feeding; community-based rehabilitation of malnourished children via the Health program.
- **Malaria: (30%)** Community-wide education to improve malaria prevention and treatment seeking behaviors; improved access to LLINs and anti-malarial treatment.
- **Control of Diarrheal Disease: (20%)** Education to improve hygiene and home treatment of diarrhea using ORT; improved access to ORS, point-of-use water treatment (as available) and hand washing stations.
- **Immunization: (10%)** Community mobilization to access EPI services.

Levels of effort, strategies and implementation timelines are based on disease burden and potential for impact considering the context of policy and resources.



Project Progress: Stakeholder Meetings

National Level

- Minister of Health (1)
- National Director of Malaria and Malnutrition (1)
- National Director of Immunization (1)
- National Director of Reproductive Health (1)
- National Director of Information, Education, Communication (1)
- Chairperson of IMCI within Department of Health Services and Programs (1)

Commune Level

- Buraza**
 - Community Health Workers (45)
 - COISA Presidents and Vice Presidents (4)
- Bukirasazi**
 - Community Health Workers (36)
 - COISA Presidents and Vice Presidents (6)
- Itaba**
 - Community Health Workers (43)
 - COISA Presidents and Vice Presidents (6)
- Makebuko**
 - Community Health Workers (55)
 - COISA Presidents and Vice Presidents (8)

Provincial and District Level

- Provincial Medical Director (1); District Medical Director (1)
- Commune Administrators (4)
- District Supervisors (3)
- TPS Coordinator (1)
- TPS (4)
- Health Center Chiefs (11)
- Healthnet-TPO Communicator (1)
- Health System Information Coordinator (1)

Project Progress: Stakeholder Meetings

Local Religious Institutions

- Kibuye District Level Meeting:** Church Leaders (33) representing all denominations across Kibuye Health District
- Commune Level Meetings:**
 - Buraza (6 Church Leaders);
 - Bukirasazi (6 Church Leaders);
 - Itaba (4 Church Leaders);
 - Makebuko (4 Church Leaders)

International Organizations

- WHO
- Healthnet TPO
- Pathfinder
- CARE
- ODAG
- GTZ

Project Progress: Census and Volunteer Selection

- Promoters are each assigned to 8-12 Subcollines within the project area.
- With the help of Nyumba Kumi leaders, promoters identify all households with children under the age of five or women of reproductive age within the Nyumba Kumi.
- Among the women of these households the members elect one woman to be the Care Group Volunteer.

Government Structure: Commune → Colline → Subcolline → Nyumba Kumi

Volunteer Motivation and Retention

Motivation:

- Internal motivation of helping their community
- Observing the impact of their work in the community and through surveillance (DHS)
- Recognition of community members and leaders for their work
- Receiving the training, supervision and feedback
- Small yearly recognition gift (i.e. t-shirt, igtenge, etc)

Replacement:

- The members of the Nyumba Kumi will elect a new volunteer from the women who have already been receiving household visits, so they will have appropriate background knowledge and will continue to catch up during Care Group meetings

Evidence:

- Yearly drop out rates of less than 2% (WR Mozambique, Vumonga I)
- Over life of project drop out rate of less than 3% (WR Rwanda, Umucyo Project)
- Twenty months after the end of project, over 83% of volunteers were still active in their communities (WR Mozambique, Vumonga I)

Innovations

Within the Burundian Context:

- Demonstrate C-IMCI implementation through the Care Group Model
- Pilot Community Case Management
- Demonstrate synergy with Performance Based Financing
- Strengthen civil society in post-conflict Burundi through community based mobilization for child health



Equity

Guiding Principal:

- Census based approach of the Care Group Model insures that all households are reached—even the most vulnerable populations

Project Example:

- Twa are a historically oppressed ethnic minority in Burundi (representing 1% of the total population)
- Marginalization of Twa communities leads to reduced access and utilization of social services
- Twa communities have been reached by promoters for the census and volunteer selection process



Sustainability

- Reaching the household level is too large a task for the current MOH system of Community Health Workers, but with Care Group networks a sustainable system is possible
- Project staff (Promoters, Supervisors) will work with the MOH Chiefs of Health Centers, TPS, Supervisors, Community Health Workers, so even when the projects ends these members of the health system will be able to move forward
- Care Groups will be linked with MOH Community Health Workers in preparation for this relationship to remain after the life of the project
- Working with the key stakeholders of the health system, local government and community based institutions (religious leaders and communities) is a multisectoral approach, which provides a foundation for sustainability



MURAKOZE CANE!



Annex 6: Results Highlight

The Burundian Ministry of Health (MOH) is currently piloting a Community-Integrated Management of Childhood Illness (C-IMCI) strategy, but has encountered the common challenge of effectively reaching the household level for community-wide behavior change. Over the next four years, World Relief aims to influence national health policy and strategy in Burundi by demonstrating that the Care Group Model is an effective approach for implementation of C-IMCI. World Relief Burundi's Child Survival Project, *Ramba Kibondo* ("Live Long Child"), is the first to implement the Care Group Model in Burundi. Documenting the success of the Care Group Model in this project will provide leverage for influencing community health in Burundi and will contribute to the evidence base for this promising practice.

The first year of *Ramba Kibondo*'s implementation has already produced results that the Care Group Model will be able to address the Burundian MOH's challenge of implementing C-IMCI at the household level. The project has already been able to recruit 2,701 Care Group volunteers in Kibuye Health District, resulting in one volunteer for every 10-15 households. Prior to recruitment of Care Group volunteers, there were 166 community health workers (CHWs), which resulted in only one CHW for approximately every 150 households. A total of 2,274 Care Group volunteers have been motivated to attend Care Group meetings, where they have learned behavior change communication messages related to the control of diarrheal diseases (September 2008). A total of 16,729 households have received household visits from a Care Group volunteer, where they have learned the same behavior change communication messages (September 2008). Already the Care Group structure has mobilized the most extensive network of community health educators in Kibuye Health District, who are able to reach more households in a two week period than has ever before been possible.

The effectiveness of the Care Group Model in mobilizing an extensive network of community health educators to reach individual households in the community has also been demonstrated through *Ramba Kibondo*'s Community-Health Information System (C-HIS). Care Group volunteers started reporting on vital health events (pregnancies, births, maternal deaths and under five deaths) in August 2008, which has made community-based health information available to community members, community leaders and MOH authorities for the first time in Kibuye Health District. The significance of tracking and acting on household level health information became especially apparent in September 2008. While conducting household visits, Care Group promoters and volunteers recognized that there was an outbreak of dysentery and cholera in Buraza Commune. Provincial and District MOH authorities were informed, which resulted in an MOH intervention that included delivery of medicine and ORS packets to the effected communities. Additionally, the Care Group promoters were able to work with Nyumbakumi (10 household cluster) leaders to mobilize community members to build latrines. Regular contact with households through the Care Group network of promoters and volunteers made this level of responsiveness by local health authorities and community leaders possible.

The *Ramba Kibono* CSP has already begun to create essential linkages between households, communities and the formal health system through the Care Group Model. Further documentation of this success will provide leverage for influencing C-IMCI implementation strategy in Burundi and increased evidence for the promising practice of the Care Group Model.

Annex 7: Social Behavior Change Strategy

The complete social behavior change strategy was included in the Detailed Implementation Plan (pages 43-85).

Annex 8: Child Survival and Health Grants Program (CSHGP) Data Form

Child Survival and Health Grants Program Project Summary

Oct-30-2008

World Relief Corporation (Burundi)

General Project Information:

Cooperative Agreement Number: GHN-A-00-07-00011
Project Grant Cycle: 23
Project Dates: (10/1/2007 - 9/30/2012)
Project Type: Standard

WRC Headquarters Technical Backstop: Alyssa Davis
Field Program Manager: Chantal Inamahoro
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: Stephanie Lazar

Field Program Manager Information:

Name: Chantal Inamahoro
Address:

Phone:
Fax:
E-mail:

Funding Information:

USAID Funding:(US \$): \$1,500,000 PVO match:(US \$) \$520,609

Project Information:

Description:

The program goals are (1) To reduce morbidity and mortality among children under five and women of reproductive age. (2) To strengthen links from household to health system, empowering communities to act on local data to improve their health. (3) To build civil society in post-conflict Burundi, bring people together with a shared vision for the future of their children. (4) To model sustainable C-IMCI implementation strategies for national scale in Burundi.

Key strategies include implementation of the Care Group Model in Kibuye Health District and integration with MOH to introduce the C-IMCI in Burundi; modeling intensive community mobilization for C-IMCI roll-out and scale-up; piloting community-case management of malaria and diarrhea in Burundi; synergy with performance-based financing; and building civil society through mobilization for child health.

Location:

Kibuye Health District in southeastern Gitega Province in central Burundi.

Project Partners	Partner Type	Subgrant Amount
Ministry of Health	Collaborating Partner	
HealthNet TPO	Collaborating Partner	

General Strategies Planned:

Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	PVOs/NGOs (Incl. US)	(None Selected)	National MOH Dist. Health System Health Facility Staff	Other CBOs CHWs

Interventions/Program Components:

Immunizations (10 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Vitamin A
- Surveillance
- New Vaccines
- Mobilization
- Media Campaigns

Nutrition (25 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- IFA
- Gardens
- Comp. Feed. from 6 mos.
- Weigh
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition

Vitamin A (5 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Supplementation
- Integrated with EPI
- Gardens
- (IMCI Integration)
- (CHW Training)
- (HF Training)
- (IMCI Integration)
- (CHW Training)
- (HF Training)

Control of Diarrheal Diseases (20 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mgmt./Counseling
- Zinc

Malaria (30 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Access to providers and drugs
- ITN (Bednets)
- Care Seeking, Recog., Compliance
- (IMCI Integration)
- (CHW Training)
- (HF Training)
- (IMCI Integration)
- (CHW Training)
- (HF Training)

Breastfeeding (10 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Promote Excl. BF to 6 Months
- Peer support
- (IMCI Integration)
- (CHW Training)
- (HF Training)
- (IMCI Integration)
- (CHW Training)
- (HF Training)
- (IMCI Integration)
- (CHW Training)
- (HF Training)

Target Beneficiaries:

Infants < 12 months:	8,888
Children 12-23 months:	8,888
Children 0-23 months:	13,376
Children 24-58 months:	11,000
Children 0-69 Months	24,376
Women 15-49 years:	88,176
Population of Target Area:	188,747

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0%	0.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	157	300	52.3%	9.9
Percentage of children age 0-23 months whose births were attended by skilled personnel	181	300	60.3%	10.4
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child	98	300	32.7%	8.4
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	70	81	86.4%	21.6
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	179	219	81.7%	13.0
Percentage of children age 12-23 months who received a measles vaccination	121	136	89.0%	16.7
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	129	136	94.9%	16.8
Percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	100	136	73.5%	16.2
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	19	111	17.1%	10.4
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	31	71	43.7%	19.2
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks	54	102	52.9%	17.1

...to the nearest appropriate health provider.				
Percentage of households of children age 0-23 months that treat water effectively.	5	300	1.7%	2.1
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview.	161	300	53.7%	10.0
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malarial risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	24	300	8.0%	4.4
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	49	299	16.4%	6.2
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	56	219	25.6%	8.8

Comments for Rapid Catch Indicators

Please Note: In Burundi the government considers women of reproductive age to be 15-45 not 15-49. Therefore, WRA figure in beneficiaries is for women 15-44 years old.

Note:
 Rapid Catch #1: Child Spacing is not a 2007 Rapid Catch Indicator.
 Rapid Catch #15: The 2007 Rapid Catch Indicator for hand washing only asks about soap, not combined with hand washing practice. Numbers reported here are consistent with the 2007 Rapid Catch so only reflect possession of soap.