



WORLD RELIEF BURUNDI CHILD SURVIVAL PROJECT

RAMBA KIBONDO
“Live Long Child”

SECOND 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 second year of project implementation, specifically from October 2008 through September 2009.

A. Main Accomplishments

Ramba Kibondo has completed its second year of project implementation, which has included the first full year of Care Group mobilization and covered the Nutrition I, Immunization and Nutrition II interventions. As of September 2009, the project includes 208 Care Groups comprised of 2,732 Care Group volunteers along with 24 Pastoral Care Groups comprised of 329 religious leaders or representatives. The focus of the second year has been on learning how activities must be synchronized for optimal project functionality and striving to establish an environment that is conducive to effective teamwork.

Infant and Young Child Feeding Indicator: There has been a significant improvement in one of the project's behavior change objectives, namely the objective to 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%. The project's Nutrition I intervention monitoring survey (January 2009) documented an increase in this indicator from 25.6% [CI 14.7-36.5%] to 72.0% [CI 52.5-91.5%], which demonstrates a dramatic increase in the percentage of children being fed according to minimum appropriate feeding practices and is statically significant based on 95% confidence intervals. This Rapid Catch 2007 indicator takes into consideration both food diversity and feeding frequency and thus represents two critical dimensions of infant and young child feeding practices. It should also be noted that the monitoring indicator related specifically to the dietary diversity of foods consumed by young children improved with the mean number of food groups eaten in the last 24 hours by children age 6-23 months increasing from 3.2 to 4.7 (January 2009). The behavior change communication curriculum developed by the project and Care Group training activities during the Nutrition I intervention contributed to this result. An additional Nutrition II monitoring survey would need to be conducted after the completion of PD/Hearth implementation, in order to see if PD/Hearth activities will also contribute to improvements in infant and young child feeding.

While the percentage of newborns who were put to the breast within one hour of delivery and did not receive pre-lacteal foods appears to have improved from 62.0% [CI 56.2-67.5%] at baseline to 76.0% [CI 66.3-84.2%] after the Nutrition I intervention (January 2009), the confidence intervals do overlap by 1.2%, calling into question the statistical significance of the apparent change. This behavior will require more emphasis in future Care Group training. The percentage of children 0-5 months who were exclusively breastfed during the last 24 hours has remained unchanged from 86.4% [CI 77.0-

93.0%] at baseline to 86.5 [CI 78.0-92.6%] after the Nutrition I intervention (January 2009), though this already represents a high level of exclusive breastfeeding in the project area according to Knowledge Practice and Coverage (KPC) survey data.

Community-Based Oral Rehydration Solution (ORS) Distribution: The project aims to improve availability and access to essential health commodities, particularly by making Long-Lasting Insecticide Treated Nets (LLINs) and ORS available at the community level through mobilization of CG volunteers to participate in community-based distribution. Over the past year the project has mobilized CG volunteers to distribute over 10,000 ORS packets to children with diarrhea at the household level. The first distribution of over 5,000 ORS packets took place from November 2008 through January 2009 and the second distribution of over 5,000 ORS packets took place from June 2009 through October 2009. The project tracked the distribution of the ORS packets by CG volunteers to children with diarrhea in the community, described below.

The project's diarrhea intervention was implemented in the first year, so all CG volunteers have been trained in the prevention, case management (including the proper preparation of ORS) and danger sign recognition of diarrhea. Each CG volunteer was given two ORS packets and was instructed to distribute the packet to any child under five years with diarrhea within her area of responsibility. The CG volunteers informed caregivers that they could provide ORS if their child had diarrhea, so caregivers began to seek out the CG volunteers when their children under five experienced diarrhea. Additionally, CG volunteers would observe children with diarrhea during regular household visits and would then offer to provide ORS to the child. The CG volunteer would demonstrate the preparation and administration of the ORS to the caregiver, thus providing a practical learning opportunity as well. The CG volunteers reported ORS distribution and outcome of the child to their CG and the Promoters in charge of CG facilitation would follow-up with a visit to the child during regular household visits.

The MOH Province Head has agreed that supplies to the project will continue as long as reports are submitted to document the successful distribution at the community level, but future supplies must come from MOH District Head in line with the health system decentralization process. The CG volunteers have taken great satisfaction in being able to distribute ORS to children who need it in their community, child caregivers have been convinced of ORS effectiveness and accessibility to ORS at the community level has increased.

Monitoring and Evaluation (M&E) System: The project's monitoring and evaluation system was well established in the first year and has been well implemented and maintained in the second year. This is evidenced by the completeness of the data reported in the M&E Plan (Annex 1) as well as by the availability of the data necessary to track and assess the status of implementation activities. Numerous M&E activities have been accomplished over the past year, including two Lot Quality Assurance Sampling (LQAS) monitoring surveys, monthly collection and compilation of Community-Health Information System (C-HIS) data and Care Group Activity Indicator data, as well as registration and monitoring of PD/Hearth participants. The second LQAS monitoring survey for the project was focused on the Nutrition I intervention and was conducted in January 2009; the third LQAS monitoring survey was focused on the Immunization intervention and was conducted in April 2009. For both monitoring surveys the M&E Officer led the fieldwork for data collection, data entry into Epi-Info and participatory team hand tabulation of the results. The MCH Specialist conducted further analysis of results using Epi-Info and the results were provided to the CSP Leadership team.

Maintaining a complicated and extensive M&E system for a community-based project such as *Ramba Kibondo* is a considerable challenge, so this represents a significant accomplishment by the project in its second year. Over remaining years of the project, it will be important to continue working towards greater data driven action on all levels of project implementation, improved data sharing with health facilities and the District MOH as well as better integration of the project C-HIS with the MOH HIS. It will be necessary for the Project Manager to take strong leadership and responsibility in these key areas where project interface with partners affects impact and sustainability.

B. Activity Status

Table 1. Activity Status of Project Objectives

Project Objectives	Key Activities	Status of Activities
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.
	Comments	Care Group meetings and C-HIS data collection began in August 2008. Integration of the C-HIS with the MOH HIS has continued to be limited by the low attendance of CHWs and TPS at Care Group meetings thus far. CSP staff will continue focusing efforts on collaboration with the District MOH to encourage CHW attendance at Care Group meetings. The Promoters and Supervisors have been encouraged to share monthly C-HIS data with the health centers in their respective areas, but this has been rarely done. There have continued to be discrepancies between the data being reported by the district and the project, which reflects a lack of integration. The Project Manager met with the District Director in August 2009 to discuss the situation and resumed quarterly reporting of the C-HIS to the District MOH.
	1.2 Invite MOH staff to participate in Promoter training workshops for child survival project interventions	On target.
	Comments	The MOH Provincial Director, District Director, District Supervisor, 3 Supervisors, 4 TPS, 11 Titulaires attended the Nutrition I Training Camp (October 2008). The MOH Provincial Director, District Supervisor, 3 Supervisors, 4 TPS, 11 Titulaires attended the Immunization/Vit A Training Camp (February 2009). The District Supervisor, 2 Supervisors, 4 TPS, 11 Titulaires attended the Nutrition II Training Camp.
	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	On target.
	Comments	Volunteers and Promoters have mobilized families during the MCH weeks in January 2009 and June 2009. The CSP was congratulated by the MOH for helping to make KHD the highest performer of Gitega's three Health Districts in the areas of EPI and LLIN distribution during MCH weeks.
	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.
Comments	No formal referral and counter-referral system has yet been established, although the CSP has documented four referrals of sick children during PD/Hearth sessions. Three of these children returned to the PD/Hearth sessions after visiting the health facility. There should be improvements in this area as CHW attendance at CGs and collaboration with HC staff increases. This objective will be of particular focus during CCM activities in FY10 (pending approval).	
2. Improved	2.1 Facilitate increased access to LLINs in the project area in collaboration with public sector funders, Global Fund, DFID and other donors	Not yet on target.

Project Objectives	Key Activities		Status of Activities
availability and access to essential health commodities at the community level.	Comments	Malaria intervention is now planned to begin in January 2010. Last year the CSP leadership participated in meetings regarding Global Fund's 2009 Malaria Campaign for Burundi and LLIN distributions, but this year the CSP did not follow up with adequate engagement at the national MOH level, so the CSP was not as involved with LLIN distribution as expected. However, CSP volunteers did assist with the MCH week in June 2009 where LLINs were distributed in conjunction with local associations. All households with children U5 and pregnant women were eligible for the LLINs; three LLINs were given per eligible household, but stock was insufficient, so remaining households will be targeted in December 2009 or January 2010. For greater involvement with the upcoming LLIN distributions, there must be more dedicated follow-up by the Project Manager and Country Office Leadership with the national level MOH.	
		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	On target.
	Comments	Over 10,000 ORS packets have been given to the CSP by the Provincial MOH for distribution by Promoters and volunteers. Distribution is expected to continue as supplies are available from the District MOH. Zinc has been approved by the National MOH, but supplies still have not reached the districts. CCM for malaria has been approved by the MOH and is entering the pilot stage, but the protocol still needs to be defined. The CSP will need strong representation and follow-up at the national level MOH to ensure inclusion in upcoming pilot activities.	
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.
		MOH staff attended the Nutrition I, Immunization and Nutrition II training camps (as detailed in Key Activities 1.2).	
		3.2 Train Care Group volunteers in BCC messages every two weeks through Care Group Promoters	Not yet on target.
	Comments	CG meetings began at the end of July 2008 and have been facilitated over the past year, but only 32.6% of the CGs have met at least twice per month; 65.7% of CGs have had 70% attendance or more during the CG meetings (M&E Plan; Annex 1). The CSP needs to better organize project activities, so that the time of Promoters is used more effectively to reach all CGs twice per month. The benchmark for biweekly visitation is based on WR experience in settings with a similar ratio of field staff to numbers of Care Groups.	
		3.3 Saturate communities in the project area with focused BCC messages, reaching every household every two weeks through Care Group volunteers	Not yet on target.
	Comments	CG volunteers began visiting households at the end of July 2008 and household visitation has continued over the past year. However, only 63.9% of households have been reached at least once per month (M&E Plan; Annex 1). As the frequency of CG meetings increases, then the frequency of household visitation will be expected to increase due to better mobilization of CG volunteers. The CSP will also add an indicator to track how many households receive a CG volunteer visit at least twice per month.	
		3.4 Mobilize religious leaders and community opinion leaders to learn BCC messages and share these messages with their congregations and communities	Not yet on target.
	Comments	As of September 2009 there are 329 religious leaders organized into 24 Religious Care Groups, which are intended to meet with a Promoter once per month to learn the same BBC messages taught to Care Group volunteers. During the second year, just 75.7% of Religious Care Groups have met once per month and only 35.5% of members have attended the meetings (M&E Plan; Annex 1). Promoters need to be better organized to meet with all Religious Care Groups every month and the CSP must explore strategies to encourage increased attendance and engagement with the religious leaders.	
		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 now planned to begin in January 2010.		

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 BCC messages related to these issues. The Provincial MOH gave the CSP over 10,000 ORS packets, which were 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. The diarrhea intervention messages have been reviewed by CGs while PD/Hearth has been implemented in other limited CG areas.</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: Not yet on target.</p> <p>Comments: The Immunization/Vitamin A intervention was implemented from February-April 2009. The CSP has participated in two MCH weeks (January 2009 and June 2009), particularly through CG volunteers mobilizing families to seek EPI services and participate in MCH week activities. However, there has been no progress in the related project objectives (see Annex 1: M&E Plan). One contributing factor to the lack of any change for the indicators related to the immunization objectives may be lack of immunization cards or proper documentation of immunizations. The Project Manager should follow up on these issues with the District Head and HC staff.</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: Not yet on target.</p> <p>Comments: Nutrition I intervention was implemented from October-December 2008; Nutrition II intervention (including backyard gardens and PD/Hearth) commenced in May 2009 and was scheduled to conclude by December 2009. However, backyard garden lessons have not been covered in CG meetings (although some backyard garden messages were covered during Light Mother trainings and PD/Hearth sessions) and only a fraction of the PD/Hearth sessions have been conducted. PD/Hearth was piloted in July 2009 in 14 sites, then expanded to 18 additional sites in September 2009, thus reaching a total of 316 children (including those who abandoned participation). This means that only 17.8% of all CG areas have been reached (37 out of a total 208 CGs), although all CG areas should be reached by the end of the Nutrition II intervention (December 2009). The PD/Hearth intervention was not implemented in line with the DIP or implementation plans developed in conjunction with the PD/Hearth consultant, CSP Leadership Team and Technical Backstop, which has resulted in deviations from essential standards of PD/Hearth methodology, inadequate progress in implementation and excessive cost of the intervention. These implementation problems must be remedied as described in the Factors of Impeded Progress and Technical Assistance Needs sections. PD/implementation will then continue during roll out of the Malaria intervention, so that the at least the first round of PD/Hearth implementation is completed throughout the project area by the time CCM of malaria commences (Workplan; Annex 2).</p>

Malaria: (30% Level of Effort)

Project Objectives:

- 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%.

Key Activities: Community-wide education to improve malaria prevention/Tx-seeking behaviors; improved LLIN access.

Activity Status: Activities not yet commenced.

Comments: Malaria Prevention and Care-seeking intervention is now scheduled to begin January 2010. The training curriculum is currently under development. The CSP participated in LLIN distribution during the MCH week in June 2009. The CSP plans to be more directly involved with future LLIN distribution, but the timing of this is subject to the MOH's schedule (most likely to occur in December 2009 or January 2010).

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. These messages have been reviewed by CGs while PD/Hearth has been implemented in other limited CG areas.

C. Factors of Impeded Progress

Resignation of Second Project Manager: The first Project Manager hired for the CSP resigned in July 2008 during the first year of the project. This position remained vacant until a new Project Manager was identified and hired in November 2008. In August 2009 the second Project Manager expressed concerns about her ability to continue in the position and ultimately resigned in October 2009. The WRB Country Office has advertised the vacancy, but a suitable candidate has not yet been identified.

Lack of Communication with WR HQ Technical Unit: There has continued to be a hindrance of communication between the CSP staff and the WR HQ Technical Unit, which has continued to significantly limit technical oversight of the project. This situation has resulted in the implementation of activities that contradict the project's DIP and technical input provided by the Technical Unit. For example, PD/Hearth activities were not implemented according to the DIP or the plans elaborated jointly by the CSP Leadership Team, PD/Hearth Consultant and Technical Backstop. There were also changes made to the functions of some CSP leadership staff, including the naming of the Training Officer as Deputy Project Manager by the Project Manager. The Project Manager has stated that she was instructed to do this by her superiors, but the WRB Country Office states that this was a point of confusion. It should be noted that the DIP does not include such a role and members of the Country Office and Technical Unit had discussed and agreed that the naming of a Deputy Project Manager would counterproductive in light of staff qualifications and responsibilities.

The year two Project Manager has recommended that future Project Managers initiate phone calls with the Technical Unit when there is a lack of clarity about a technical issue, especially when internet access is not available. The Technical Unit has proposed that regular phone calls be arranged between the CSP Leadership Team and the Technical Unit on a monthly basis to support better communication. The WRB Country Office has proposed that the Director of Programs and Communications Manager assist the Project Manager in being responsive to Technical Unit information requests by informing the Project Manager of requests when he or she lacks regular internet access.

National Level Networking: There has been insufficient representation of the CSP in national level forums with the MOH. This has caused the CSP to fall off the national MOH radar screen and thus inhibited maximization of the CSP's role in activities like LLIN distribution.

D. Technical Assistance Needs

Major areas for specific technical assistance needs in the coming year, which will be fulfilled by the WR HQ Technical Unit:

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 on a regular monthly basis. Close communication between the Project Manager and Technical Unit regarding project implementation and progress will be particularly necessary over the first few months after hire.

PD/Hearth Implementation Strategy: The PD/Hearth intervention was not implemented in line with the DIP or implementation plans developed in conjunction with the PD/Hearth consultant, CSP Leadership Team and Technical Backstop, which has resulted in deviations from essential standards of PD/Hearth methodology, inadequate progress in implementation and excessive cost of the intervention. The current members of the CSP Leadership Team and Technical Unit are discussing implementation adjustments to remedy this situation. PD/implementation will then continue during roll out of the Malaria intervention, so that the at least the first round of PD/Hearth implementation is completed throughout the project area by the time CCM of malaria commences (Workplan; Annex 2).

Community Case Management (CCM) of Malaria Strategy: It will be necessary to develop appropriate plans for the CSP to support the implementation of CCM alongside other project activities as national protocols and strategies for CCM are defined by the MOH. The Technical Unit will advise the CSP Leadership staff on critical issues that should be discussed with appropriate representatives of the MOH and other partners as well as provide information related to lessons-learned from implementing CCM in other country contexts. Project implementation plans will be developed jointly by CSP Leadership staff and the Technical Unit as the MOH protocols and strategies are elaborated.

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 CG 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). However, very little progress has been made in these areas as is evidenced by the relevant indicators. Over the past year, there have been only 18.6% (38.8/208) of CGs with a CHW in attendance in at least one meeting per month; only 4.5% (9.3/208) of CGs with a TPS active in CG supervision per month and 0% of the health facilities or COSAs have been involved in the management of C-HIS data per month.

The CSP has linked Promoters and Supervisors to specific Health Centers (HCs) to facilitate the process of Care Group and health system integration. Promoter territories were created within HC catchments, so that each Promoter serves CGs within one HC catchment area. The CSP Project Manager and other members of the Leadership Team must make Promoter interaction with HC staff a priority. Promoters should not only be encouraged to share C-HIS data with the HC in their project area, but should be required to do so as this is perfect opportunity for Promoters to discuss the project and related concerns with the HC staff. The CSP was designed so that all Supervisors would be 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. It turns out that COSA meetings are currently happening on Sundays when CSP staff are not working or present in the working area, so the project must identify alternatives to ensure collaboration. For instance, perhaps a meeting with a COSA representative could be arranged for during the week by the Supervisors.

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. In the coming year, the Project Manager must focus efforts on improving collaboration with the District MOH, in order 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

There is no additional baseline data or assessment results to report.

I. Challenges and Updates to Project Management System

Financial Systems: New financial systems were instituted in October 2008 by the WRB Country Office. The Project Manager states that she has been able to receive monthly financial reports over the past year. At the writing of this report, there remain some WRB Country Office expenses charged against the CSP grant that are not included within the CSP budget. The HQ Finance Department continues to follow-up with the WRB Finance Manager and Country Director about these charges.

Human Resources: All CSP staff vacancies were filled by November 2008. Over the past year there was turnover of two Promoters (one in July 2009 and another in September 2009); both positions have been filled. The second Project Manager was hired in November 2008 and has now resigned in October 2009. Lack of continuity in this key CSP leadership position continues to present problems for team building, consistent standards of leadership and tracking of staff performance. The WRB Country Office has commenced recruitment for a third Project Manager, but a suitable candidate has not yet been identified. The Technical Unit will need to repeat the process of technical orientation for the third Project Manager once a replacement is identified and hired. The miscommunication to the CSP team regarding the naming of a Deputy Project Manager needs to be rectified, so that job functions of all members of the CSP Leadership Team and appropriate modes of job performance review for CSP Leadership Team members are clarified and consistent with the DIP.

Communication Systems and Team Development: 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. Team development has been supported by the three day Conflict Resolution Workshop (January 2009) that was led by MIPAREC as well as participation of the Project Manager in the three day WRB Leadership and Management Retreat in Bujumbura.

PVO Coordination/Collaboration: Concern Worldwide consulted with the WR CSP in designing their CSP, which commenced in October 2008. World Relief participated in Concern Worldwide’s CSP stakeholders meeting and presented an overview of the WR CSP. An exchange visit between WR and CW is anticipated during the visit of Michel Pacque (Technical Advisor, MCHIP) during the first week of November 2009. The WRB Country Office has participated in USAID coordination meetings (September 2009).

Logistical Systems: The Promoters and Supervisors have received a second round of driver’s training and all have passed their driver’s test, except for the most recently hired Promoter. However, the processing of the driver’s licenses has continued to be delayed by the government agency responsible for issuing the licenses. Thus some staff continue to rely on drivers they have contracted to assist them (14 drivers at the beginning of FY09; 6 drivers at the end of FY09; additionally, some drivers are called only when driving conditions are unfavorable). The WRB Country Office has committed to following up with the government agency to urge issuance of the licenses as soon as possible. Significant increases in fuel consumption have become an issue of concern over the past year. The Project Manager attributes marked increase in fuel use to the advanced age of the motorbikes, now one year old.

Training Systems: The first annual report indicated that verbal tests of intervention knowledge with Care Groups would commence in November 2008, but this systematic supervision activity has not yet begun. The Training Officer and future Project Manager need to work with the Technical Unit to review training supervision tools that can be used by the Project Manager, Training Officer, Supervisors and Promoters to assess the quality of training and provide constructive feedback to trainers at both Care Group and household levels of training.

J. Local Partner Organization Collaboration and Capacity Building

The CSP continues to work with administrative authorities and local leaders in Kibuye District. Over the course of the year, 30.5% of Care Groups had a village leader in attendance at least once per month, demonstrating support for the project’s activities. Religious leaders continued to meet in 24 Care Groups to learn the same key messages as Care Group volunteers, so they can share these health messages with their faith communities. In year two, 75.7% (18.2/24) of these groups met in any given month. Attendance at meetings held averaged 35.5% (122.5/345.1) per month (M&E Plan; Annex 1).

Beginning in November 2008, the CSP collaborated with the Provincial MOH to use CG volunteers as distribution agents for ORS at the community level. The initial installment of over 5,000 ORS packets was successful, leading to a second installment of the same number that is concluding in October 2009. This activity has the potential to expand to other commodities as supplies become available.

Collaboration with COSAs is an area that has not yet taken off as anticipated. It has been difficult for Promoters to participate in COSA meetings as intended because the COSAs meet on Sundays, when

the Promoters are not working in the project area. One potential solution is that the Promoters identify a time to meet with the chair of the COSA, so that information could at minimum be passed between the Promoter and the COSA chair, who could then update other members of the COSA.

As of the first annual report, Healthnet-TPO had commenced demonstration gardens at two HCs in Kibuye Health District. The Training Officer visited the gardens in Gisikara and Itaba Communes in July 2009. However, the model being used did not appear to be suitable for replication by the CSP due to costs in excess of project resources. Nonetheless, information provided by the agronomist who works for the Ministry of Agriculture in Bukirasazi was appreciated. Performance Based Financing (PBF) is another initiative of Healthnet-TPO that relates to CSP objectives. At the community level, government CHWs collect household data for PBF indicators that overlap with CSP intervention areas. However, to date communication with Healthnet-TPO has been rare and not succeeded in the synergies envisioned in earlier stages of project planning.

As already mentioned in Section I, MIPAREC built CSP staff capacity to resolve conflict in their personal and professional realms during a three day training in January 2009. The Training Officer noted that over the course of the year he has seen particular improvement amongst the Supervisors in handling conflicts that arise between Promoters and amongst themselves. Albeit anecdotal, the technical backstop observed a Promoter identifying an applicable principle from the training and drawing it to the attention of her peers several months after the workshop. Based on this, it appears that the training established a common framework for the team to think about and discuss dynamics related to conflict.

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. Dr. Donatien Ntakarutimana, a Foreign Service National, is responsible for monitoring and supporting USAID/Burundi's health programming and the individual that WR has been directed to communicate with regularly. In March 2009, Jim Anderson from USAID/Burundi and Andy Karas from USAID/East Africa made a site visit to the CSP. They observed a Care Group meeting and interacted with village leadership in the same location during their time in the field.

USAID/Burundi convened a health coordination meeting for NGOs in September 2009 attended by the CSP Manager and WRB Communications Manager. Other USAID-funded projects in FY09 with interventions that relate to this CSP include the Maternal and Child Health Project implemented by Pathfinder with Management Sciences for Health, a recently begun Food For Peace Title II/Multi-Year Assistance Project implemented by CRS and Food for the Hungry as well as the USAID/Washington CSP implemented by Concern Worldwide. As the Concern Worldwide CSP is also using Care Groups, its staff visited the WR project and requested WR's monitoring and evaluation tools, which WR provided. The WR M&E Officer also was contacted for follow up and gave a presentation about the WR CSP at the CW DIP stakeholder's meeting.

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 80.0%.	<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 / October 2008	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	2,080 (Nov 08) 1,893 (Dec 08) 1,591 (Jan 09) 1,980 (Jun 09) 1,834 (Jul 09) 1,538 (Aug 09) <i>Distributions did not happen every month in Y2; Sept 09 numbers not yet available.</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	100% (Y2 average)	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/ October 2008	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> Percent of children 0-23 months with diarrhea in the last 2 weeks offered the same amount or more food during illness	KPC/Baseline & Final Monitoring Survey / October 2008	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/ October 2008	18.0% <i>Confidence Interval:</i> 13.8-22.8%	35.4% <i>Confidence Interval:</i> 25.9-45.8%	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/ October 2008	53.7% <i>Confidence Interval:</i> 47.8-59.4%	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/ October 2008	58.2% <i>Confidence Interval:</i> 52.4-63.8%	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/ October 2008	9.0% <i>Confidence Interval:</i> 6.0-12.8%	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/ October 2008	1.7% <i>Confidence Interval:</i> 0.5-3.8%	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/ October 2008	23.7% <i>Confidence Interval:</i> 19.0-28.9%	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/ January 2009	62.0% <i>Confidence Interval:</i> 56.2-67.5%	76.0% <i>Confidence Interval:</i> 66.3-84.2%	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/ January 2009	86.4% <i>Confidence Interval:</i> 77.0-93.0%	86.5% <i>Confidence Interval:</i> 78.0-92.6%	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 / January 2009	25.6% <i>Confidence Interval:</i> 14.7-36.5%	72.0% <i>Confidence Interval:</i> 52.5-91.5%* <i>Calculated by CSHGP Data Form Tool</i>	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	57.6%*	60.0%	Promoters and volunteers conduct community based Hearth sessions for underweight children.
				*48 (52.8%) gained 200-600 grams per month on average and 5 (5.4%) gained over 700 grams per month on average out of a total 92 children who completed Hearth and were available to be weighed for at least 2 months. Data only from July 2009 Pilot.			
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/ January 2009	3.2	4.7	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/ January 2009	81.7%	67.7%	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/ January 2009	16.4%	13.2%	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 September 2010	50.0%	Coordinate with the MOH to assist in community based distribution of LLINs procured through DFID, Global Fund and

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
	<i>For monitoring purposes.</i>	Number of LLINs distributed by volunteers (pending availability).	Promoter distribution records/Monthly	N/A	Anticipated September 2010	N./A	other mechanisms.
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 September 2010	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 September 2010	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.
	<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	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.

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 September 2010	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 September 2010	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/ April 2009	62.5% <i>Confidence Interval:</i> 53.8-70.6%	63.5% <i>Confidence Interval:</i> 53.1-73.1%	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/ April 2009	94.9%	100.0%	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/ April 2009	61.0% <i>Confidence Interval: 52.3-69.3%</i>	63.5% <i>Confidence Interval: 53.1-73.1%</i>	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/ April 2009	73.5%	99.0% <i>Confidence Interval: 94.3-100.0%</i>	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/ April 2009	55.1% <i>Confidence Interval: 46.4-63.7%</i>	58.3% <i>Confidence Interval: 47.8-68.3%</i>	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/ April 2009	89.0%	94.8% <i>Confidence Interval: 88.3-98.3%</i>	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
IR1	For monitoring purposes.	<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/ April 2009	94.0% <i>Confidence Interval: 90.7-96.4%</i>	100.0%	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	For monitoring purposes.	<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/ April 2009	73.3% <i>Confidence Interval: 67.9-78.3%</i>	63.5% <i>Confidence Interval: 53.1-73.1%</i>	N/A	
IR1	For monitoring purposes.	<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/ April 2009 <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
		BCG		72.0%	62.5%	N/A	
		Polio0		69.7%	62.5%	N/A	Encourage health workers to check immunization health cards for all children who present at HC for well child, sick child, or
		Polio1		65.3%	63.5%	N/A	
		Polio2		61.7%	63.5%	N/A	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
		Polio3		56.0%	63.5%	N/A	sibling visits and to provide vaccines as needed to bring children up-to-date with immunization schedule.
		Measles		55.1%	58.3%	80.0%	
		Pentavalent 1 (DPT1, Hib, and HepB)		62.5%	63.5%	80.0%	
		Pentavalent 2 (DPT2, Hib, and HepB)		63.0%	63.5%	N/A	
		Pentavalent 3 (DPT3, Hib, and HepB)		61.0%	63.5%	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/April 2009	2.5%	0.0%	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/October 2008	62.2% <i>Confidence Interval: 56.4-67.7%</i>	90.6% <i>Confidence Interval: 82.9-95.6%</i>	80.0%	Train volunteers and caregivers to recognize danger signs of child illness that require immediate care seeking.

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
CAPACITY BUILDING & SUSTAINABILITY							
IR1 IR3	Mobilization of Community Volunteers through the Care Group Structure.	<u>Care Group Meetings:</u> Number and percent of Care Groups with at least two meetings per month.	Promoter & Supervisor Reports/Monthly	N/A	67.7/208*= 32.6% (Y2 average)	70%	
		<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	136.7/208= 65.7% (Y2 average)	70%	
		<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	8/2732.7* =0.29% (Y2 average)	<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 was to begin in Nov 2008, but has not yet commenced; now planned for Nov 2009.	70%	
		<u>Households Visited:</u> Number and percent of households visited at least once per month.	Promoter & Supervisor Reports/Monthly	N/A	15326/23981* =63.9% (Y2 average)	70%	
		<u>Village Leader Support:</u> Number and percent of Care Groups with a village leader in attendance in at least one meeting per month.	Promoter & Supervisor Reports/Monthly	N/A	63.3/208* =30.5% (Y2 average)	70%	
		<u>Pastoral Groups:</u> Number and percent of pastoral groups that meet per month.	Supervisor Monthly Reports/Monthly	N/A	18.2/24* =75.7% (Y2 average)	70%	
		<u>Pastoral Group Attendance:</u> Number and percent of Pastoral Care Group members that meet per month.	Promoter & Supervisor Reports/Monthly	N/A	122.5/345.1* =35.5% (Y2 average)	70%	
IR1	Integration of Care Group Model with	<u>CHW Integration:</u> Number and percent of Care Groups with a	Promoter & Supervisor	N/A	38.8/208 =18.6%	70%	

IR	Objective/ Result	Indicators	Source/ Frequency	Baseline Value	Monitoring Value	EOP Target	Related Activities
	Existing Ministry of Health C-IMCI Structure	CHW in attendance in at least one meeting per month.*	Reports/Monthly		(Y2 average)		
		<u>TPS Integration:</u> Number and percent of TPS active in Care Group supervision per month.	Promoter & Supervisor Reports/Monthly	N/A	9.3/208* =4.5% (Y2 average)	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% (Y1 average) (Y2 average)	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% (Y1 average) (Y2 average)	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% (October 2008)	80%	

*These numbers represent averages of monthly data. It should be noted that total number of Care Groups, Care Group Volunteers and Pastoral Care Group Members have fluctuated over time.

NOTE: Two new adjusted indicators must be collected in year three:

- 1) **Care Group Meetings: Number and percent of Care Groups with at least one meeting per month.**
- 2) **Households Visited: Number and percent of households visited at least twice per month.**

Annex 2: Workplan

Result	Major Activities	Year 3 (2009-2010)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Introduction of Child Survival Interventions													
	Backyard Gardens	X	X	X										All CSP Staff
	PD/Hearth	X	X	X	X	X	X			X			X	All CSP Staff
	Malaria Prevention & Care-Seeking				X	X	X	X	X	X	X	X	X	All CSP Staff
	Home-Based Management of Malaria (Pending Approval)										X			All CSP Staff *Exact timing depends on direction from the MOH
	Curriculum Development													
	Develop Curriculum for Malaria Prevention & Care-Seeking	X	X	X										Training Officer, Project Manager, MCH Specialist
	Develop Of Training Materials/Protocols for Home-Based Management of Malaria (Pending Approval)									X				Training Officer, Project Manager, MCH Specialist <i>*This activity depends greatly on the timing and direction of the MOH</i>
	Training Sessions													
	Survey Training/Refreshers							X					X	M&E Officer
	Malaria Prevention & Care-Seeking Training Camp				X									Training Officer, Project Manager, M&E Officer
	Home-Based Management of Malaria Training Camp (pending approval)										X			Training Officer, Project Manager, M&E Officer
	Home-Based Management Training for Distributors (pending approval)										X			Training Officer, Project Manager, M&E Officer

Result	Major Activities	Year 3 (2009-2010)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Sensitize PDSs, THs and TBAs about danger signs and care seeking through small community level meetings										X	X	X	Promoters, Supervisors, Training Officer, Project Manager, M&E Officer
	Management of Project Personnel													
	Recruit and hire replacement Project Manager	X	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 Religious Leader 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													
	Meetings with National MOH	X		X		X		X		X		X		Project Manager, Training Officer, M&E Officer, Country Office Staff (Country Director or Director of Programs)
	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, Project Manager
	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

Result	Major Activities	Year 3 (2009-2010)												Personnel Responsible
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
	Monthly C-HIS Reporting to Health Centers and District MOH	X	X	X	X	X	X	X	X	X	X	X	X	Project Manager, M&E Officer
	Quarterly C-HIS Reporting to Province MOH			X			X			X			X	Project Manager, 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													
	Nutrition II Intervention Monitoring Survey							X						M&E Officer, Supervisors, Promoters, Project Manager, MCH Specialist
	Malaria Prevention & Care-Seeking Intervention Monitoring Survey												X	M&E Officer, Supervisors, Promoters, Project Manager, 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, Promoters
	Technical Assistance Trips													
	Headquarters Maternal and Child Health Specialist Visit	X											X	MCH Specialist

Note: The only major change to the workplan for year three from the DIP workplan is extension of the Backyard Garden and PD/Hearth activities due to delays of implementation in year two.

Annex 3: Papers or Presentations

Jean Baptiste Sibomana, M&E Officer for the WR Burundi CSP, presented the CSP's objectives, strategies and M&E system at the Concern Worldwide DIP Stakeholder's meeting in Bujumbura, Burundi in February 2009.

Annex 4: Results Highlight

World Relief Burundi's Child Survival Project, *Ramba Kibondo* ("Live Long Child"), 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. In KHD the health system is stretched financially and transportation systems are weak, so ensuring that essential commodities, such as Oral Rehydration Solution (ORS), reach all health facilities regularly can be a challenge. Even when these supplies are available at the health facilities it can be difficult for individuals to access these supplies given long distances to the facility, lack of affordable transportation options and the opportunity cost of time lost to agricultural work. These factors that cause disincentives or delays for accessing essential health commodities can contribute to childhood morbidity or mortality, but this could be prevented if essential health commodities were made available at the community level. *Ramba Kibondo* aims to improve availability and access to essential health commodities, particularly by making Long-Lasting Insecticide Treated Nets (LLINs) and ORS available at the community level through mobilization of Care Group (CG) volunteers to participate in community-based distribution.

Ramba Kibondo currently mobilizes 208 CGs comprised of 2,732 CG volunteers throughout KHD; this network of community-based volunteers has been leveraged to distribute over 10,000 ORS packets to children with diarrhea over the past year (Nov 08: 2,080; Dec 08: 1,893; Jan 09: 1,591; Jun 09: 1,980; Jul 09: 1,834; Aug 09: 1,538). This first distribution of ORS took place from November 2008 through January 2009 after the MOH Province Head of Gitega supplied the project with over 5,000 ORS packets. The project's diarrhea intervention had been implemented in the first year, so all CG volunteers had been trained in the prevention, case management and danger sign recognition of diarrhea. This CG training also included the proper preparation of ORS. Each CG volunteer was given two ORS packets and was instructed to distribute the packet to any child under five years with diarrhea within her area of responsibility. The CG volunteers informed caregivers that they could provide ORS if their child had diarrhea, so caregivers began to seek out the CG volunteers when their children under five experienced diarrhea. Additionally, CG volunteers would observe children with diarrhea during regular household visits and would then offer to provide ORS to the child. The CG volunteer would demonstrate the preparation and administration of the ORS to the caregiver, thus providing a practical learning opportunity as well. The CG volunteers reported the distribution and outcome of the child to their CG and the project's Health Promoters in charge of CG facilitation would follow-up with a visit to the child during regular household visits.

A second supply of over 5,000 ORS packets was provided to *Ramba Kibondo* after a report was submitted to the MOH Province Head describing how the first supply of ORS was distributed to the CG volunteers and children with diarrhea. The second ORS distribution has taken place from June 2009 through October 2009. The MOH Province Head has agreed that supplies to the project will continue as long as reports are submitted to document the successful distribution at the community level, but future supplies must come from MOH District Head in line with the health system decentralization process. The CG volunteers have taken great satisfaction in being able to distribute ORS to children who need it in their community, child caregivers have been convinced of ORS effectiveness and accessibility to ORS at the community level has increased.

Annex 5: Social Behavior Change Strategy

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

Annex 6: Child Survival and Health Grants Program (CSHGP) Data Form

Child Survival and Health Grants Program Project Summary

Oct-30-2009

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: Donatille Siniremera
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: Dr. Donatien Ntakarutimana

Field Program Manager Information:

Name: Donatille Siniremera
Address:
Phone: +257-222-50375
Fax:
E-mail: DSiniremera@wr.org

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 (Int'l./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
- Measles Campaigns

Nutrition (25 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- ENA
- Gardens
- Comp. Feed. from 6 mos.
- Hearth
- 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 Mngmnt./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:	7,199
Children 12-23 months:	6,322
Children 0-23 months:	13,521
Children 24-59 months:	17,500
Children 0-59 Months	31,021
Women 15-49 years:	38,176
Population of Target Area:	169,747

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 diarrhoea 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

Annex 7: Summary of Key Recommendations for Year Three

The following summary of recommendations, although not comprehensive, is intended to help focus efforts on those areas that posed challenges in year two and deserve special attention.

Fidelity to Care Group Model: The Care Group Model is based on regular *biweekly* meetings and home visits, as described in the DIP. Greater attention is needed with regard to the planning and utilization of Promoters' time, including the communication of a regular meeting schedule to Care Group volunteers to increase meeting frequency to twice a month. Likewise, continued attention to regular home visits and effective BCC communication is needed.

CSP Manager Recruitment: CSP Manager recruitment is essential to realization of project objectives. While the process is initiated by the HR Manager in Burundi, the MCH technical unit in Baltimore also needs to play a significant role in screening and interviewing viable candidates. This is necessary both for technical input and to solicit USAID approval of the top candidate.

CSP Leadership Team Functions: Correction is needed to restore the CSP leadership team members to the roles and responsibilities agreed upon in the DIP and described in the job descriptions for Training Officer and M&E Officer. This correction needs to be formally communicated to the entire CSP staff, so that CSP Leadership Team roles are understood by all staff. In the absence of the Project Manager, any additional authority and responsibilities should alternate between the Training Officer and M&E Officer.

Networking: The project needs to improve representation at applicable MOH and other partner meetings, especially at the national level in coordination with the WRB Country Office in Bujumbura. Key relationships include those with government representatives related to C-IMCI and malaria (for both CCM and LLIN distribution strategies) as well as with NGOs implementing similar interventions and/or methods (e.g. MSH, Pathfinder, Concern Worldwide, CRS, Food for the Hungry, PSI and Heathnet-TPO) and donors (Global Fund & USAID).

Training Systems: The first annual report indicated that verbal tests of intervention knowledge with Care Groups would commence in November 2008, but this systematic supervision activity has not yet begun. The Training Officer and future Project Manager need to work with the Technical Unit to review training supervision tools that can be used by the Project Manager, Training Officer, Supervisors and Promoters to assess the quality of training and provide constructive feedback to trainers at both Care Group and household levels of training.

Positive Deviance Hearth: The PD/Hearth intervention was not implemented in line with the DIP or implementation plans developed in conjunction with the PD/Hearth consultant, CSP Leadership Team and Technical Backstop, which has resulted in deviations from essential standards of PD/Hearth methodology, inadequate progress in implementation and overruns in cost of the intervention. Members of the CSP Leadership Team and Technical Unit need to continue following up on plans to remedy this situation.

Finance: The project's resources are stretched thin such that extra attention to spending according to budget is imperative. As mentioned, PD/Hearth plans need to be reviewed for more economical and sustainable implementation. In the same vein, WRB Country Office expenditures need to stick to what was budgeted in the DIP budget.

Data Sharing: The CSP needs to increase the regularity of sharing and discussing project data with government and community stakeholders. All members of CSP staff with programmatic responsibility should be responsible for sharing appropriate data with their counterparts in the government and community. This process should be overseen by the Project Manager.

Sustainability: The project needs to increase steps toward sustainability of Care Groups through greater integration of the Care Groups with MOH structures for C-IMCI, as elaborated in the DIP. This includes increased participation of CHWs in Care Groups and significant involvement of TPS in Care Group supervision. Furthermore, C-HIS data management needs to extend to permanent parallel structures in the government and community. Negotiating both aspects of sustainability will require the leadership of the Project Manager.