



Concern Worldwide

Kibilizi (now Gisagara) District Health Partnership

Child Survival Program

Final Evaluation Report

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ACRONYMS

ACT	Artesunate Combination Therapy
AMDD	Adverting Maternal Mortality and Disability Program, Columbia Univ.
ANC	Antenatal Care (Prenatal Care)
AQ	Amodiaquine
ARV/ART	Antiretroviral/Antiretroviral Therapy
AS	Health Animators (Animateurs de Sante)
AT	Accoucheuse Traditionelle (TBA)
BCC	Behavior Change Communications
BHR/PVC	Bureau of Humanitarian Response/Private Voluntary Corporation
CA	Cooperative Agency
Cellules	Lowest administrative unit (equivalent to a village)
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Childhood Illness
CORE	Community Maternal & Child Health Programming Membership Org.
COSA	Comite de Sante (Health Committee at Health Center)
CSP	Child Survival Program
DHMT	District Health Management Team
DHT	District Health Team (includes management and health center officers)
DIP	Detailed Implementation Plan
DMO	District Medical Officer
EIP	Expanded Impact Project (USAID)
EPI	Expanded Program of Immunization
FARN	Hearth (French)
FE	Final Evaluation
GDO	Gender Development Officer
GESIS	Gestion du Système d'Information Sanitaire (HMIS)
GTZ	German Technical Assistance
HBM	Home Based Management
HFA	Health Facility Assessment
HIV & AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment (Malaria)
IRC	International Rescue Committee
ITN	Insecticide Treated Net
KPC	Knowledge, Practices and Coverage survey
LQAS	Lot Quality Assurance Sampling
MNC	Maternal and Newborn Care
MoH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-governmental Organisation
PD	Positive Deviance

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PEPFAR	President's Emergency Plan for AIDS Relief
PLA	Participatory Learning for Action
PMI	President's Malaria Initiative
PNLP	National Malaria Control Program
PLWHAs	Persons living with HIV & AIDS
PMTCT	Prevention of Mother-To-Child-Transmission
PVO	Private Voluntary Organisation (US based)
RBM	Roll Back Malaria
S/P	Sulfadoxine Perimethrine
TBAs	Traditional Birth Attendants
Titulaire	Clinician in-charge of health center
TOT	Training of Trainers
TRAC	Treatment and Research AIDS Center
TRM	Technical Reference Material
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Program
VCT	Voluntary Counselling and Testing
WR	World Relief

A. Summary

Concern's Kibilizi¹ (now Gisagara) District Health Partnership Child Survival Program began in 2001, and was designed only 6 years after the country's devastating 1994 war and genocide. The project was one of the first CSHGP programs in Rwanda and represented a paradigm shift in NGO maternal and child health programs away from direct service delivery and towards local partner capacity building and community-based behavior change programs. The goal of the program was to decrease mortality and morbidity of mothers and children under five through CS interventions in HIV & AIDS, malaria, maternal newborn health (MNH), and nutrition. Concern's primary partners were the District Health Management Team (DHMT) and the communities themselves. In reality, the impact of the program was significantly broader.

Though a relatively new organization to the CSGHP in 2000, Concern participated in the PVO capacity building opportunities offered in the program and used the lessons learned to strengthen their health programs around the world. In addition, Concern has been active in global health fora and contributed to strengthening the state of the art in Child Survival, Maternal and Newborn Care, Nutrition and HIV & AIDS programs.

Working in partnership with the Kibilizi District Ministry of Health (MOH) at the District Health Management Team (DHMT) and health center (FOSA) levels, while at the same time establishing and training community-based volunteer associations the project built health program capacity at multiple levels. Members of these community health associations in turn trained community members and encouraged changes in the key health and nutrition behaviours that were identified in the BCC strategy. These groups were also responsible for mobilizing communities to access basic health services (safe delivery, post partum care, malaria treatment, condom distribution, and growth monitoring) as well as for providing preventive health education. The program supported increased quality in health services in Rwanda by training health center staff as well as the management and mutuelle committees for each health center. A project "activist" was assigned to each health center in order to catalyze formation and build capacity of these structures and provide technical support for their activities.

Collaborating with the Rwandan Government and the USAID Mission-assisted programs, the CSP also contributed to the decentralization of health services in Rwanda and improved health care financing by promoting membership in local mutuelles which have significantly decreased health costs and increased access to care for most, but not all of the catchment population. Paying for health care for the poorest of the poor, who are at greatest risk for mortality and morbidity, remains a challenge for all partners, including the Rwandan government. The preventive health strategies promoted by the program have decreased the demand for emergency health services, but will never *eliminate* the demand. The shared value for equity between Concern, USAID and the Government of Rwanda provides the basis for seeking solutions to solving the continuing challenges.

¹ The CSP was originally located in Kibilizi District, which is now part of the redistricted, and much larger, Gisagara District. In the interests of clarity, this clarification will only be stated once in this report.

Concern was one of the first CSHGP grantees to make national advocacy for child survival interventions a major component of their program strategies. As part of their national advocacy strategy, Concern sat on national level committees for maternal and newborn care, malaria and HIV & AIDS. In the case of Home Based Management (HBM) of malaria, Concern was one of the strongest PVOs working in the country to actively encourage the government to adopt an innovative approach that had not been tried nationwide in any country. Concern's CSP also established the first two voluntary counselling and testing (VCT) sites in Kibilizi District (also some of the first in the entire country) and were the first in the country to link VCT to MNC services. They also introduced Prevention of Maternal to Child Transmission (PMTCT) services linked to rural antenatal clinics (also a Rwandan first) and started formal associations for Persons Living with HIV and AIDS (PLWHAs) and anti-AIDS clubs. While these programs are now standard in many HIV & AIDS programs in Africa, at the time they represented completely new approaches. As testimony of their value, they have been adopted wholesale into the current GOR HIV & AIDS programs. The CSP was one of the first programs in Rwanda to demonstrate to the national and district-level MOH the value of PVO/NGO capacity-building and community mobilization programs working with MOH partners in impacting health targets.

Over 2,500 subsidized insecticide treated mosquito nets (ITNs) from Concern were distributed through pre-natal care clinics throughout the project area, and providers were trained in a revised malaria case management protocol. This occurred prior to receipt of support from the Global Fund, the President's Malaria Initiative, or the national measles/ITN campaigns. Concern, along with World Relief and International Rescue Committee (IRC) were instigators of a CORE and USAID Mission grant to initiate HBM. This experience was documented in a recent CORE publication. Removal of the ITN luxury import taxes by the Rwandan government greatly increased the supply of affordable nets, but there were periodic nationwide ITN stock-outs of nets. Many of the nets that were provided by Concern, however, reached beneficiaries before import tariffs were removed and prices for even subsidized ITNs were reduced to affordable levels. Twenty-seven growth monitoring sites were established in selected areas and associated staff and district partners were trained and implemented the Positive Deviance (PD), Hearth model for malnutrition intervention. PD/Hearth implementation in the very food insecure communities that were selected provided valuable lessons learned that can provide input into refining the methodology of this community-based nutrition and development approach. Concern provided significant technical assistance to help the District implement the updated maternal and newborn care policies that are now in line with international standards.

Using these and other approaches, the project achieved most, and in some cases significantly exceeded its project targets. In addition, the project incorporated new approaches with accompanying measurement indicators during the program when indicated by developments in the state of the art or policy environments changed. Even in cases where the final coverage fell short of project targets, significant progress was achieved and important lessons were learned that will strengthen current and future programs, and will even impact programs in other sectors. The involvement of local and national MOH representatives in the program has greatly facilitated national recognition

for the impact of Concern's program on MOH health strategies.. A representative of the National Malaria Control Program (PNLP) participated in the entire evaluation field work and provided valuable input into the malaria components of the program.

Representatives of local government and the MOH spoke in favour of the CSP approaches at the national stakeholder evaluation presentation. This involvement is extremely relevant as Concern is the lead agency in the follow-on Expanded Impact Program with World Relief and International Rescue Committee that starts in October 2006. BASICS and the PNLN will be assessing the national HBM program shortly after the FE and Concern's participation in the pilot program is a key part of this assessment.

Concern responded to MTE recommendations with significant efforts to address management challenges, focus BCC strategies, and strengthen technical assistance in key interventions, (especially maternal and newborn care and nutrition). Capacity building was focused on those groups most likely to have impact on improving outcomes. Technical staff were relocated closer to the field and relieved of routine administrative duties. Technical exposure visits and conferences were attended by staff and DHMT counterparts to Bangladesh, Kenya, and Tanzania; to Concern Global Health meetings; and CORE and USAID-sponsored conferences and workshops. Lessons learned from these trips helped to build local support for the innovative approaches of the program and were incorporated into strengthening technical aspects of the program.

Typical of the first CSPs implemented in a country, the CSP encountered significant initial resistance to the capacity-building approach of the program within the District Health Management Team partners. Accustomed to NGOs as direct service or resource providers, the value of working in a partnership that extended to communities was not initially valued. But as results of the program became evident and collaboration between Concern and the DHMT was strengthened, the mortality and morbidity decreases became widely evident and the response from the DHMT and local government officials changed from sceptical to extremely enthusiastic. By the end of the program, the DHMT was publicly praising the CSP approaches and was requesting additional capacity-building support, especially in family planning and was proposing future collaborations for health programming in the District. Gisagara is one of the districts included in the Expanded Impact CSP beginning October 1, 2006.

Concern's major challenges revolved around retaining qualified Child Survival management staff. The initial Program Coordinator and the Monitoring and Evaluation Specialists left for better jobs and were very difficult to replace due to shortages of qualified and experienced public health professionals willing and able to work outside of Kigali. Gaps between managers meant that positions had to be filled temporarily with staff that lacked strong child survival management credentials. Although these experiences were unfortunate, they highlighted the management challenges faced by PVOs in Rwanda. Capacity building in quality management techniques focusing on team building could be introduced in new projects to train more Rwandan public health professionals for future leadership positions. In spite of the challenges, the project achieved or exceeded most of the project targets. In addition, Concern facilitated a change in the relationship between the Ministry of Health, NGOs/PVOs and

communities from service provision to capacity building both at the national level and in the project area.

Inclusion of a significant HIV & AIDS component, with VCT and PMTCT services in the CSP, has largely been seen as strength of the program. But even though considerable time and resources were allocated in the DIP to get the HIV & AIDS intervention started, attention was still diverted from other, equally complex, CS interventions. Late introduction of the MNC and nutrition components probably meant that their full impact might not have been captured by the final quantitative and qualitative assessments.

Close assessment of the CSP impact on beneficiary communities emphasizes how poverty and food insecurity underlie any development efforts in communities in the district. Some of the struggles that beneficiary families encounter in trying to feed their families and keep them healthy were mitigated by the impact of the CSP, but this is not enough to have sustainable impact on hunger and malnutrition in the area. Concern has provided the foundation for multiple potential public health and development impacts in the area based on the structures and approaches established in the CSP. Concern has already leveraged additional funding to try to extend some of the impacts of various components of the CSP. But other development efforts, especially in income generation and food security are desperately needed. Without them, the sustainable impact of the CSP will be questionable. Some of the health and nutrition behaviour change components of the program will continue to receive support through the follow-on EIP. USAID and other donors would be wise to look closely on the synergies that could be realized by building on the foundations the Concern CSP has laid in Rwanda.

B. Assessment of Results and Impact of the Project

B.1. Summary Chart

Indicator	Baseline KPC 2001	Midterm LQAS 2004	Final KPC 2006	Project's Target
HIV & AIDS				
Percentage adults who have received VCT services	10% (mothers only)	26% fathers 19% mothers	48% fathers 81% mothers	20%
At least 50% of antenatal mothers in Kansi catchment area participate PMTCT	0%	16% mother of children 0-12 mos	60% all mothers in District	50% (one H.C catchment area only)
Increase STD consultations by 50%	134 clients	334 clients	436 clients	201
Adults 15-49 years who know 2 ways to prevent HIV	34% Mothers	90% fathers 74% mothers	95% fathers 81% mothers	80%
Malaria				
Children 0-23 months who slept under an ITN the night before	0.1%	34% (0-11 mos) 5% (12-23 mos)	47%	10%
Children 0-23 mos with fever treated within 24 hours (HBM indicator)	N/A	13%	58%	60%
Maternal and Newborn Care				
Deliveries at health facilities	19%	28% (0-11 mos)	55%	35%
TBA referrals due to complications	N/A	20% by HMIS	56% by HMIS	25%
At least 2 doses TT last pregnancy	34% (by card)	68% (self-report)	62% (self-report) 40% (by card)	40%
Mothers who received PNC within 48 hours	2.9% (w/in one month)	N/A	36%	No target
Nutrition				
Reduced underweight (-2 SD) to 45%	59% (0-59mos) ²	38% (12-23 mos)	36% (12-23 mos)	45%
Children 6-23 mos receiving Vit A supplement in past 6 months	63%	90%	87%	No target
Child 0-23 months breastfed within 1 hour after delivery	38%	56%	61%	50%
Child weighed in last 3 months (by card)	49%	33%	65%	No target

² 1999 Concern Worldwide nutrition survey for Kibilizi District (not conducted under CSHPG)

B.2. Results: Technical Approaches

B.2.a. Overview

The project's broad goal was to contribute to a sustainable reduction in maternal and child mortality and morbidity, and increased life expectancy for 75,000 women of reproductive age and children under-five years in Kibilizi Health District, Butare Province, Rwanda. The program hoped to achieve these results through capacity building for high quality and sustainable health services, and by empowering communities to have better health with locally available resources. Focus interventions included HIV & AIDS, malaria, nutrition, and maternal and newborn care.

The four main strategies of the program were:

1. *Networking and advocacy for gender equity* at National/Provincial levels to gain support from all civil administrations towards a multi-sectoral response to the priority problems, especially HIV & AIDS.
2. To develop the *management capacity* of the DMO and supervisors via training, facilitation, coaching and participatory planning exercises and meetings.
3. Developing the *technical capacity* of the District Health staff on selected child health activities via training and workshops, on-the-job mentoring, and with the development of a staff support system.
4. Strengthening the District's *community outreach approach* through training, facilitation and supporting COSAs, TBAs and Health Animators resulting in a community based health promotion initiative.

The primary implementing partners of the programs were the Kibilizi District Health Management Team and Caritas' health center staff, Community Health Workers (CHWs), Traditional Birth Attendants (TBAs), Health Committee (COSAs) members, local leaders, and the client population.

Concern took a health system's approach in the design of the CSP. At the beginning of the project the anticipated impacts of this approach on district health services included:

- Improved management in district health services (needed for decentralization)
- Improved quality of health services
- Greater health care coverage
- More decentralized and institutionalized health services

At the end of the project, the overall impacts were:

- Noticeable drops in mortality and morbidity according to health workers, community members and leaders.
- Decreased workloads for first line health facilities

- Earlier recognition and referral for signs of serious child illnesses or complications of pregnancy
- Local capacity to manage priority health problems strengthened at every level
- Improved health care planning and delivery between Concern staff, DHT staff, and community-based health workers: TBAs, CHWs, HBM distributors, etc.
- Increased access and affordability of preventative and curative MCH services.

Results by Intervention

HIV and AIDS (32% of project effort)

When the CSP was designed in 2000 and 2001, there were no VCT or PMTCT services in the District, and none linked to health centers anywhere in the country. The only HIV & AIDS blood testing that was available was at the hospital and required sending the blood sample somewhere else in the country. Concern had to overcome considerable logistical and policy barriers to establish the first district VCT center. The first rural health center-based VCT/PMTCT service in the country was also started by Concern and opened on December 1, 2002. Since that time, Concern has assisted in starting two VCT centers and the first PMTCT centers linked to rural health center ANC services in the country. By the end of the project, VCT services were vastly expanded and being scaled up by TRAC, the government HIV & AIDS program. PMTCT services, which the project initially had only hoped would cover one health center catchment area, ultimately covered all of the health centers and were also turned over to the government HIV & AIDS program.

Consequently, the 2006 final KPC showed that mothers of children less than 24 months who had been tested for HIV rose from 24% at baseline to over 80% at the end of the program, meeting the program target. Fathers were not tested at baseline, but almost 95% of the fathers had been tested by the final KPC. In addition, original PMTCT targets were to reach 50% of women in ANC in only one (out of six) health center catchment areas. By the end of the project, 60% of the mothers of children 0-23 months in the entire district participated in PMTCT services. Efforts to increase STD consultations were successful (increasing over three-fold over baseline), but this indicator did not prove to be as robust an indicator of successful HIV & AIDS services as originally thought. Knowledge indicators of 2 ways to reduce risk of transmission increased from 24% to 85% with most of the increase taking place in the early years of the program when Concern was the major organization working on HIV & AIDS in the district. Since the original design of the project, knowledge of HIV & AIDS transmission has become much more wide-spread and programs are now emphasizing prevention behavior change over knowledge.

Follow-up of newborns born to HIV+ mothers has faced similar challenges to those experienced in similar programs in other countries. Increased percentages of facility deliveries will make it easier for newborns of HIV+ mothers to receive ART within 72 hours of delivery as these drugs become increasingly available in the project area. Newborns who are born at home will continue to be a challenge unless community-

based PMTCT programs begin in the future. Currently there is no provision for home-based postpartum ART (such as those delivered by TBAs) for infants in Rwanda. The groundwork laid by the CSP would be a good foundation for such services in the future. The alternative would be a program that focused on locating mothers of HIV+ infants and assisting them to get to the health center within 3 days of delivery. The decreasing stigma associated with HIV+ status may make it possible for communities to mobilize and assist these infants to receive care. Concern does not plan to seek new separate HIV & AIDS program support in the area, so identifying and providing ART services to newborns will be the responsibility of the government HIV & AIDS program.

Project assistance to PLWHAs was highlighted as a particular strength of the program. Members testified that stigma has been reduced as a result of the programs emphasis on universal testing and promotion of compassionate care for PLWHAs and OVCs (orphans and vulnerable children). At the end of the project, support to PLWHA groups was turned over to the District AIDS program, TRAC. Access to antiretroviral drugs (ARV) treatment from the Kibilizi (Gisagara) hospital will significantly increase in the near future. PLWHA group members are now asking for assistance in providing transportation for patients to access these services. As these new programs are rolled out, PLWHA groups say that their membership will increase as greater numbers of people go for testing if treatment is available.

Malaria (22% level of effort)

Many of the CSP's malaria capacity building activities were well documented in the MTE report. This FE report will focus on HBM, the major new and innovative malaria activity undertaken after the midterm evaluation and the extension of ITN coverage. Concern supported introduction of IPT into Rwanda's RBM strategy later in the program by raising awareness about the importance of IPT in community education as part of antenatal care promotion. Lessons learned from Concern's HBM activity will be used by the other CORE partners in the pilot program (World Relief and IRC) as well as the PNLN for scaling up HBM and the MOH to inform decisions about expanding into Community Case Management (CCM) for other conditions, including diarrhea and eventually pneumonia.

Malaria prevention and treatment services were very limited at the beginning of the program. High import tariffs, limited supplies and unfamiliarity the importance of using ITNs to prevent malaria cases and deaths resulted in extremely low ITN coverage. Intermittent Presumptive Therapy was not part of national policy at the beginning and was not introduced into national programs until 2005. High levels of drug resistance to mono-therapy in use at the time resulted in high reoccurrence of cases. Low awareness of malaria danger signs and poor access to health care meant that children with malaria were often not taken for appropriate treatment until the child was very seriously ill.

At the beginning of the program, Concern intended to promote net coverage through existing social marketing mechanisms in the country. For this reason, a relatively low (10%) target was set. However at the end of the first year, based on findings that awareness and demand for nets was high but financial access the key barrier, the

project worked with the NMCP to shift its strategy towards Concern subsidized nets to pregnant women attending ANC clinics. Bulk purchases of nets were made. Limitations in this methodology included initial net coverage in only the youngest children in the beneficiary population because their mothers received the nets as part of ANC. Although these approaches did not achieve full cost-recovery, they did provide the means for purchasing more nets than the initial budget would have supported.

Concern and the District Hospital collaborated closely with the National Malaria Control Programme (PNLP) to ensure a continuous supply of ITNs and insecticides (later long lasting LLINs) to the district. Concern partnered with Population Services International (PSI), who also had a CSP in Rwanda, to train health animators on net impregnation in all sectors. Parent committee members and teachers in primary and secondary schools on were also trained malaria information dissemination.

Final ITN coverage was four times that of the initial EOP target. ITN coverage would, in all likelihood, have been even higher had there not been a nationwide stock out for approximately 15 months during 2005-2006. As of September 2006, a massive nationwide ITN distribution to all children less than 5 years of age will be linked to a measles immunization campaign and will raise ITN coverage in households even higher. ITN use has achieved high levels of acceptability, but a few families with nets, do not use them. Qualitative assessments during the FE fieldwork revealed some cultural beliefs, as well as some lack of familiarity with how to hang nets in atypically-shaped houses or in houses without beds. These barriers can overcome in most cases with additional community education.

Home Based Management of Malaria (HBM)

Background Based on difficulty of poor malaria treatment access revealed in the baseline studies and alternative approaches seen in Kenya, Uganda and Senegal, discussion on community-based treatment of malaria began among the three CSHGP PVO headquarters (Concern, IRC and World Relief) backstops in 2000. Each of the three PVO programs had allocated significant program effort to malaria interventions targeting children under 5 and women of child-bearing age. USAID Washington staff at the time was encouraging joint activity planning within various countries. During the same time PVOs had already started discussions about creating a common model for community-based treatment of malaria.

At the same time the CORE Group expressed interest in supporting collaboration among its PVO members within countries. At the Spring 2003 CORE meeting, the availability of seed money was announced to members who were interested in pursuing joint child survival activities. This offer provided Concern Worldwide, IRC, and World Relief with the impetus to discuss a potential partnership focused on malaria. Concern Worldwide sat down with the other PVOS and developed an initial proposal for CORE, which was vetted and refined with input from CORE's Malaria Working Group.

Initially, the MOH was reluctant to support community-based disease management models. In 2003, however, the government showed interest in piloting a malaria strategy that included community case management.

This change in attitude was aided by:

- repeated visits by Concern Worldwide and IRC to the Ministry of Health to advocate for implementing community-based treatment of malaria;
- Concern facilitating a visit to CARE's community-based program in Kenya by Ministry of Health and NGO staff;
- advocacy and support from the USAID Mission for the NGOs' approach and involvement in implementation;
- development and release of a national malaria strategic plan; and
- advocacy from other organizations and donors, especially UNICEF, GFATM and Roll Back Malaria for more effort in the fight against malaria, and to consider piloting community-based programming.

Jules Mihigo, Concern's first CSP Project Coordinator strongly supported the mission's increased malaria programming and a community-based treatment model. He and other Mission staff helped the NGOs to gain access to meetings with the PNLP lent legitimacy to the proposed program and contributed an additional \$200,000 for implementation.

Concern Worldwide, IRC, and World Relief were responsible for the planning, implementation, and reporting of the program. This included drug distribution and monitoring.

The Rwanda PNLP was the overall program leader. The CORE-funded pilot program was initially limited to the three NGOs and the area of the three health districts where they were working. However, soon afterwards the PNLP wanted to expand to additional areas within the health districts, and added three additional districts that would be managed by UNICEF. Since 2005, the PNLP has started to include another nine districts (totalling 12 of 30 nationwide). More details about the PVO HBM partnership are documented in a CORE paper released in July 2006.

Throughout the program, Concern provided strong technical support to their field sites, via e-mail, phone, and in-person communication as needs arose and communicated with the other two PVOs via email and phone conversations. But it was the face-to-face meetings, especially during concurrent HQ field visits, that were the most productive opportunities for coordinating with the two other PVOs. In addition, Concern developed a focal team for malaria within the CSP that attended meetings and served as a liaison for communication with other partners.

Concern was also part of a National Technical Committee that was tasked with oversight of the HBM program and sponsored the very first meeting in 2003. This Committee included PNLP, USAID, the Quality Assurance Project, UNICEF, PSI, and representatives from each of the districts. Meetings were held monthly, and committee members visited the HBM distributors periodically during the pilot study to observe case

management, follow-up home visits and review of drug availability and conditions. USAID frequently facilitated the meetings between the partners.

Activities started in 2004 with two health center staff per facility and five Concern CSP staff. Distributors in their respective zones were selected by their communities and trained on various topics about managing simple cases of malaria and recognizing and referring children with danger signs of malaria to health centers. They also followed-up children who were treated by them and by the health center. The Distributors received yearly refresher training conducted by the District Health Management Team and health center staff. Table 2 illustrates increased use of community case management services as the intervention rolled out to different health center areas.

Table 2: Numbers of Suspected Child Malaria Cases Treated at Community and Health Center Level in Kibilizi District, Oct 2004 – June 2005 by Quarter

Health Center Area	Oct-Dec 2004		Jan-Mar 2005		Apr-June 2005		Total	
	Distributors	HC	Distributors	HC	Distributors	HC	Distributors	HC
Kirambogo	0	297	0	353	897	129	897	779
Kibayi	776	423	2509	124	2532	49	5817	596
Mugombwa	0	426	0	504	675	187	675	1117
Total	776	2062	2509	1601	4104	624	7389	4287

Source: Concern Worldwide HMIS

Coordination meetings were held three times a year where data were monitored for progress towards targets, Health centre staff and CSP staff held monthly meetings with distributors to distribute supplies, collect and analyze data and solve problems. DHMT, health center staff and distributor representatives participated in exchange visits to Kibungo and Kirehe Districts to compare how the program was being implemented in different areas. These exchange visits demonstrated that distributors could probably expand to additional community-based activities, such as distributing zinc, ORS and/or amoxicillin for pneumonia. This evidence will be used to support the C-IMCI design for the EIP.

Two types of supervisory field visits were conducted each month, one by district hospital supervisors to the health centres, the other from health centres to the distributors. Health centre staff supervisory visits were conducted between 5-12 times per month, with five distributors visited each time. A supervision checklist is used to document drug stocks on hand, replenishment and sales, referrals, compliance with filling out registers, as well as feedback on the reports that were submitted by the distributor during the last period.

The EIP will include a national scale-up and sustainability plan for home based treatment for malaria. BASICS and the PNLP will assess the results of the pilot phase of HBM and this will be used to inform the design of the next phase. The PNLP and MSH's RPM+ will try to identify longer term funding mechanisms, including the Global Fund, and will advocate for including these services in the national social health insurance exemption programs (e.g. *mutuelles*), or direct cost recovery for longer term supply. In addition, the EIP proposal included some money for drugs (including malaria)

in the budget USAID's new Presidential Malaria Initiative (PMI) has agreed to provide ACT drugs for facility level malaria treatment, and discussions are underway for this assistance to be included in HBM.

Both community groups and sector/cellule leaders were universally enthusiastic about the services provided by the HBM distributors and stated that they feel that the quality of the drugs and the services provided were very good. Project data confirm that care seeking for a child within 24 hours of the onset of fever increased at both the community and health center level. This was confirmed in the HBM assessment done by the PNL P and BASICS in November 2006. Even prior to the introduction of HBM, the CSP had done significant community education on early care-seeking. This indicator was not measured at the beginning of the program, and was found to be very low (13%) when it was measured during the MTE LQAS in 2004.

Since children under the age of 6 months are not eligible for HBM, increases in care seeking at the health center reportedly increased from referrals that were done by the HBM distributors as well as other community groups (such as TBAs and leaders) who were trained by the CSP. Focus groups conducted during the FE fieldwork revealed that the community recognizes the need to provide incentives (not necessarily monetary) to motivate distributors to continue their work at the same level of quality.

Over the course of the project, community beliefs about the causes of malaria changed from attributing the symptoms of malaria to poisoning or curse to the understanding that mosquitoes were the cause. Places where families sought care shifted from traditional healers, to drug treatment by distributors and health facilities. Even when much of the care seeking was at health centers, it was sought earlier in the course of the illness when the symptoms were less severe.

The project and DHMT HMIS and distributor data were used to determine the numbers and ages of children who were treated and to order supplies. In addition, data about the percentage of children who recovered and/or were referred per month were collected. This information was used to assess the quality of their work and to provide data for the PNL P. Distributors were also expected to follow up their clients who had been referred to the health centers

Distributors are now very knowledgeable about the malaria situation in their communities and are able to disseminate information with confidence to both the community and to the health centres. Health center staff can now analyse trends in malaria in their respective catchment areas from the reports provided by distributors. They also use the information collected to determine the strengths, weaknesses, and opportunities in the HBM intervention and decide what to do to improve services. For example, when report analysis revealed that a high number of children were still treated after 24 hrs, more community sensitization was conducted to encourage earlier treatment. Information from data collection is shared with the general population to make them aware of the situation and is credited with encouraging community members to promptly seek treatment and also to use ITNs to prevent malaria.

Maternal and Newborn Care (22% level of effort)

At the beginning of the program, the project focused on the MOH's outdated risk assessment approach. The Midterm Evaluation recommended that the District Safe Motherhood Strategy be updated based on international best practices. It was also recommended that the TBA curriculum emphasis be shifted from conducting home deliveries to recognizing danger signs, birth planning, clean delivery, post partum and newborn care. Most importantly, the emphasis changed to encouraging mothers to deliver at health facilities which is consistent with the new national and district MCH policies. The MTE also recommended that Concern get MNC technical assistance and conduct a Health Facilities Assessment (HFA), which was done in 2004 under the leadership of Susan Rae Ross and a team from Tanzania.

Key findings of the technical assistance assessment team included low knowledge among HF staff of how to identify serious maternal and newborn complications and how to stabilize and transfer them. They also found low knowledge of key service protocols, particularly the use of partograph and protocols for post-partum and newborn care. There was limited availability of basic equipment and supplies to provide high quality services, limited access to FP services. There was also low knowledge and lack of clear BCC messages/materials to educate men and women about all MNC services and danger signs. Women were found to prefer delivery at home with female relatives, even without a TBA. TBAs were found to have minimal knowledge of maternal and newborn danger signs and there was low knowledge and involvement of men in key MNC issues including family planning. The cost of health services, particularly for those who are not in a mutuelle, is a major barrier to use of services. Finally, the team found that there was limited use of data for decision-making.

After the assessment, much more emphasis was placed on postpartum and newborn care in the program overall. Additional recommendations included immediate production and distribution of clean birth kits for those women who won't, or are not able, to deliver at facilities.

Increasing emphasis on postpartum and newborn care was a significant technical change that directed project emphasis more in the direction of where maximum impact can be achieved in a community-based MNC program. Concern then helped to reorganize maternal and newborn care services as part of the implementation of the district assessment and recommendations of the HFA. Consistent with these current evidence-based practices, they shifted the focus of the MNC intervention away from TBA training towards mobilizing for the entire chain of care to address the 4 delays from household level to district hospital. Concern participated in all of the nationwide policy discussions in the revision of the MNC policy. They significantly helped to strengthen supervision and team building between DHMTs and HC staff.

The most important contribution to newborn care and mortality reduction was mobilizing communities, families and TBAs to increase facility deliveries. The second factor was raising awareness in the community, TBAs and health workers of danger signs in the newborn and when to seek care. Promotion of early and exclusive breastfeeding was

very successful. Exclusive breastfeeding coverage has been documented to be the single most significant child survival intervention that can reduce infant mortality as well as reduce infant malnutrition.

Program activities

Concern used cascade training for TBAs both at the beginning of the program and when the strategy was changed after the MTE. Refresher TBA training was done in 3 health centers. Family planning training of trainers was planned and jointly conducted with the DHMT after the MTE and included all 7 health centers.

The most significant changes in the project took place after Concern sponsored the CSP and DHMT staff for a 10 day exchange visit with a CARE community-based MNC program in Tanzania (a former CARE Child Survival site). Interviews with Concern and DHMT staff confirmed that seeing their program helped them to visualize the proposed new approaches in the MNC strategy. Training curricula and messages were significantly changed after the visit. Concern staff observed that the DHMT OB/GYN TBA trainer changed his training methodology from primarily academic to very practical as a result of this exchange visit.

TBA Associations

In accordance with the GOR emphasis on community development through assisting associations, the project helped to establish TBA associations as venues for training and also to provide mutual support and networking between TBAs after the program ends. TBAs were very enthusiastic about the associations and also for the support that Concern gave to getting them established. Each TBA contributes a small amount of money for dues to the association. In turn, these funds are used to assist TBAs who accompany women with obstetric complications to the referral hospital.

To provide sustainability for the associations, the TBAs are making clean birth kits for sale at the health centers to mothers who plan to deliver at home or who feel they might not make it to the health center on time. Funds generated from these sales are returned to the TBA associations. The government, in an effort to encourage facility deliveries, is starting to provide small financial incentives to TBAs for each woman they refer for facility deliveries.

Results

While health institution deliveries rose modestly from the baseline to the midterm (19% to 28%), the final percentage (55%) significantly exceeded the project target of 35%. These results probably reflect the increased attention given to this intervention after the MTE. TBA referrals for complications, measured for the first time at the midterm, increased from 20% to 56%, exceeding the target of 25%. Women receiving at least 2 TT doses met the target of 40%, and exceeded the target (62%) when self-reports were included. A significant gender impact is noted when, overall, 72% of mothers and fathers indicated that the woman alone, or with her husband decides the place of delivery. Only 32% answered the same way in the baseline.

Very significantly, the project followed the recommendations of the MNC TA after the MTE and measured changes in postnatal care (PNC). In 2002, only 3% of mothers stated they had PNC within *one month* of delivery. At that time, even when mothers delivered in health facilities, they generally were not kept for 24 hours and checked for complications. Now women stay at least 24 hours and the checks are routine. The final KPC showed that mothers receiving PNC within 48 hours rose to 36%, of these 61% of these services were provided by health center staff, and 18% by TBAs. These checkups included assessing haemorrhage (43%) and checking for fever (42%). Far fewer women were checked for anemia or foul vaginal discharge, and these checks were generally only conducted by health center personnel and not by TBAs. Even though much more could be done, Concern has demonstrated methodologies that could contribute significantly to reduced maternal mortality if expanded.

On the other hand, a smaller increase (28%) was noted in newborns who received checkups within 7 days after birth. TBAs performed 47% of these checkups, 53% were done by health center personnel. Similar to the efforts to increase postpartum care for mothers, Concern has developed a methodology that deserves further support and expansion. Along with skilled deliveries, increasing these actions is essential to decreasing newborn mortality in this environment. Since some of this mortality is likely to be due to pneumonia and sepsis, which are both included C-IMCI, (provided the national algorithm includes children under 2 months of age) promoting newborn checkups should be considered in the new EIP. Lessons learned from the Saving Newborn Lives program which has extensive experience in nearby Malawi and in many other countries could help in the design of this component of the new program.

Family Planning

Although not included in the original program design in the DIP, the MTE and a change in the GOR position from pronatalist to supporting family planning highlighted the great unmet need as well as demand for family planning services in the area. Spacing births is an extremely important component in quality maternal, newborn and child survival programs. In response to these recommendations, Concern collaborated with the DHMT and organized family planning training in association with ARBEF (Association pour le Bien-etre de la Famille) for health center staff. The DHMT was very happy with this collaboration and now recognizes the continuing unmet need for Family Planning Services, especially in the Catholic health center catchment areas. Evidence of the acceptability of these services was observed when an Animator/TBA described how she had organized 9 women in her community and took them to a Health Center in another catchment area where FP services are available when her own health center (which was in a Catholic area) would not provide them. The GOR is now putting pressure on all health centers that function as government facilities to provide the entire array of family planning services that are available in the country. Community-based services, in collaboration with the DHMT may be within Concern's managerial capacity. Concern should share this information with the USAID mission, UNFPA and other donors and discuss the possibilities of providing support for building on this positive environment and experience to expand access to family planning services.

Constraints

Early in the project, national maternal care policies as well as outdated approaches limited the quantity and type of training that Concern could actually provide to the health center personnel, regardless of their own knowledge and capacity to do so. The project (as originally designed) focused more on general quality of care issues and referrals to health centers by TBAs, without devoting much attention to the clinical quality of care given at those facilities. Shifting technical focus away from “risk” to the “4 delays”, as recommended in the MTE and MNC technical assistance, was required if the project were to upgrade practices to international standards. Concern used the cross-visit to Tanzania as an innovative advocacy and training approach to gain acceptance and support for significant changes in the DHMT maternal and newborn services.

While most of the danger signs of obstetric complications were recognized by respondents in the final KPC, prolonged labor was rarely (30%) rarely mentioned. While swelling (a sign of preeclampsia) and fever are included in the messages, the KPC indicated relatively little understanding on the part of mothers of this danger sign. On the other hand, community focus group discussions with mothers and TBAs about danger signs indicated that swelling and fever were understood by respondents. Further investigation is required to determine whether the disparity is somehow related to how the question was asked, or a true reflection of the impact. Cultural beliefs about the causes of prolonged labor need further investigation because in some parts of Africa, it is believed to be due to infidelity and therefore not worthy of intervention.

Nutrition (22% level of effort)

Concern appropriately identified nutrition as a priority intervention for their Child Survival Project as it contributes to the majority of infant and child mortality and morbidity for all other causes other than birth trauma. Although over 30% of children (higher in some studies) were malnourished (-2SD WFA) at the beginning of the program, this prevalence rate remained about the same in the program areas and the rest of Rwanda (DHS 2005) at end of the project. Beginning malnutrition estimates were based on a 1999 study of children less than 5 years of age, not under 2, so comparisons between the beginning and the end of the project area are not possible.

Multiple factors that contribute to malnutrition in poor families, including seasonal scarcity, and lack of land for poorest families were identified in the qualitative studies that were conducted for the DIP. Although PD/Hearth were mentioned in the original design, a detailed plan to address overall child malnutrition in the project, however, was not as clearly articulated in the DIP as would have been desirable. The MTE report recommended following up on procurement of medications that were listed in the DIP (primarily Vitamin A capsules, iron tablets and Mebendazole) as well as linking the Hearth intervention to any community growth monitoring activities. The government was responsible for many of the micronutrient and deworming activities through vaccination campaigns by the end of the project, so Concern was less involved in that aspect of nutrition by then.

Even though the DIP and MTE lacked specificity in how the nutrition intervention (including Hearth) would be implemented, the nutrition BCC approaches incorporated in the overall project strategy from the beginning resulted in increased coverage in several interventions that are known to have positive impact on nutrition status. Significant increased percentages of women initiating breastfeeding within one hour of delivery, and Vitamin A supplementation were already evident in the MTE LQAS. By the end of the project, exclusive breastfeeding of the child 0-5 months in the 24 hours preceding the final KPC exceeded 97%. Increased coverage of *this behavior alone* was documented by the Bellagio studies to be the most important single behavior that could contribute to decreases in infant mortality worldwide.

Concern staff mobilized communities to participate in Vitamin A campaigns and by the end of the project, 87% of children 12-23 months of age had received a vitamin A capsule within the last 6 months. Postpartum vitamin A supplementation also increased. As mentioned earlier, by the end of the project, micronutrient and Mebendazole supplies were the responsibility of the DHMT, and no longer a significant problem for Concern.

Concern participated in the Hearth training that was organized by World Relief and conducted by Gretchen and Warren Berggren, two of the founders of the PD/Hearth methodology. Concern's PD/Hearth intervention was never intended to cover the entire project area so area-wide impact assessment would not be indicated. Concern piloted the approach in one area and then expanded to other communities. The qualitative studies in the DIP identified that there were families who either did not have enough food at certain times of the year, or did not have sufficient land to provide adequate year-round food. It is not clear if background investigations undertaken during the time that Hearth was introduced determined if some of the communities that were selected could do Hearth sessions without supplementation during the "hungry" season.³ (This "season" takes place every year during the time of the "small rains" Sept-Dec but in the last 2 years of the project, a drought made this period much longer). Recent Hearth Technical Advisory Group (TAG), started after the CSP began, have indicated that the need to do temporary supplementation, in and of itself, is not a contraindication to do Hearth. But Concern's Hearth program would have benefited from this information and it would have helped to anticipate where and when supplementation would probably be required. Realizing that communities couldn't maintain the hearths on their own as the intervention expanded, Concern did temporarily subsidize them with maize, beans, and oil until these ingredients were harvested locally.

Concern obtained additional assistance from a consultant from the local university to develop the PD investigations. Some of the PD foods that were discovered included: Dried fish, soya, cassava leaves, mixed grain porridges, and guinea pig. Guinea pigs live in the area and survive droughts.

While the PD/Heath intervention started during the last half of the project, a total of 27 sites were established with 195 malnourished children gaining 200g or more (59% of all

³ According to PD/Hearth manuals, communities with food insecurity for more than 3 months in a year are considered too food insecure for Hearth to be successful without supplementation.

attending). Some sites had far more malnourished children than they could manage within health sessions and prioritized those under 36 months and those coming from most disadvantaged households.

Locally-Defined Food Security Assessment

Mama Lumieres in one community developed their own method of classifying families according to poverty and food insecurity. This framework proved to be more useful in classifying poor families in one community than the national poverty assessment tools in use in other programs.

The four poor family classifications included:

- 1) Families who have only enough to eat food from one type of crop at a time and barely make it until the next crop is harvested. They have no food to store, no food to save for seed, and lack sufficient food money to purchase food.
- 2) Families who have enough food to eat from one crop to another and some food to store, but have to buy seed for the next season.
- 3) Families who have enough food to eat, enough to store, and enough for seed.
- 4) Families who have food to eat, store and for seed, as well as enough to hire others and pay “food for work”.

Not surprisingly, most malnourished children come from families in the first group, and a few from the second group

3. Cross-cutting Approaches

3.a. Community Mobilization

The project’s basic community mobilization strategy was well described in the MTE Report. The community mobilization and the BCC strategies were closely integrated, but lacked sufficient focus up until the time of the MTE. Mobilization activities were expanded in some groups and scaled back in others after that time based on a more concerted behavior change intervention strategy using the BEHAVE framework. Field based staff were assigned to technical focus areas at the end of the first year to provide additional focus to each of the areas. Technical input was added after staff were reassigned to specific technical focus areas and relocated closer to the communities where they were working. Mobilization efforts were aided by the “real world” examples of the projects that were seen in the cross-visits. As recommended, after the MTE, less emphasis was placed on working with traditional healers and teachers and efforts were redirected to those community groups most likely to have impact on the specific technical areas. As recommended, local leaders were included to a much greater extent, as were local government (not specifically DHMT) staff.

Concern's mobilization in support for membership in the government's health insurance scheme (mutuelles) significantly contributed to increasing membership, reducing household health care costs, and increasing timely care-seeking and facility deliveries. Mutuelle members report that they receive better quality of care, more access to drugs and shorter waiting times. Income generated from mutuelle memberships and co-payments are retained by the health center to purchase drugs and pay additional staff. Concern played a key role in raising awareness and management capacity of local leaders and health center personnel to promote mutuelle membership. By the end of the project, mutuelle membership rose to 47% in Kibilizi; access to membership for the poorest of the poor remains a problem, but this is largely outside of Concern's control.

Over the life-time of the program, Concern established "associations" of community-based workers and provided support with training and materials. Concern aligned itself with the Government's promotion of associations as the venues for government assistance to communities. By the end of the program TBAs, CHWs, and HBM distributors had formed associations and were receiving assistance from the project. For the government to sustain these programs, however, it appears that TBAs and HBM Distributors will need to be classified as "community health workers" because currently they are the only designated community recipients of government support.

Constraints

Obligatory community public work days, weekly local genocide trials (Gacacas) and short-notice local elections made planning and implementing community level activities challenging throughout the program, and were even evident during the FE fieldwork. Nevertheless, staff and managers appeared to take such obstacles in stride and had the flexibility to work around them.

3.b. Communication for Behavior Change

The MTE recommended a shift from only delivering messages to developing and implementing a systematic approach to address specific intervention-related behavior change activities. Shortly after the MTE, Concern conducted a BCC Strategy workshop using the BEHAVE framework to refine and target project activities. Staff and partners from the DHMT were trained in BEHAVE, PD/Hearth and other techniques and these were applied in the program. Doer-NonDoer analysis for mutuelle membership, ITN use and health center deliveries were conducted as part of the final survey to further inform future work in these areas for the DHMT. Initially this helped the project to understand which behavioral compliance factors could be influenced by the CSP. Most of the "big differences" detected in the final analysis were related to perceived affordability, factors over which the CSP would have relatively little influence.

The BCC strategy helped target program activities to groups that could most influence behaviors and some other target groups were dropped. Rwanda has high literacy levels, so it was reasonable to include written BCC materials for community volunteers. On the other hand, common to many health programs, materials development took a

long time and they were available only at the end of the program. Fortunately, Concern will be continuing child survival, maternal care, and nutrition activities in the area and they are likely to be used in other programs for a significant amount of time. Some materials will probably be used in the EIP that starts October 1, 2006.

Concern devoted considerable effort to addressing gender influences on key behaviors, and commissioned the local University to conduct a Gender and Health Analysis early in the project. The project also measured changes in gender-related issues about decision making about place of delivery. By the end of the project, the vast majority of respondents to the KPC stated that husband and wife, or the woman alone now decide the place of delivery, which is a significant increase over baseline findings.

3.c. Capacity Building Approach

(i) Strengthening the PVO: Concern Worldwide

Concern Worldwide was one of the earliest “New Partner” organizations that joined the CSHGP after many organizations had already benefited from almost 15 years of organizational capacity building by the program. The Rwanda CSP was Concern’s second project in the program and the DIP was written before the Concern Bangladesh CSP Midterm Evaluation results were disseminated. Throughout their involvement with CSHGP, Concern has availed itself of many of the capacity-building opportunities offered through CSTS, CORE and other USAID-sponsored training. In addition, more than most PVOs, Concern has used the lessons learned from participation in the CSHGP to analysis strategic directions and their approaches to capacity-building in other programs. One example is the commitment to staff development by providing the equivalent 4% of staff salaries for staff training. During the Rwanda CSP, Concern incorporated many new CSP and health program methodologies into their programs around the world.

(ii) Strengthening Local Partner Organization

The major CSP partner was the District Health Management Team. As frequently happens at the beginning of child survival programs in areas that are accustomed to NGOs functioning as donors, the capacity-building aspects of the Concern CSP were not appreciated at first. Partnership challenges at the beginning of the program were documented in the MTE report. Over time, and especially after new DHMT representatives participated in the MTE, the capacity building objectives of the project were better understood and came to be greatly appreciated. As the effects on morbidity and mortality as well as quality of health services became obvious, the DHMT became very supportive of the program and recognized the value of the public-private partnerships between a PVO, DHMT and communities. At the end of the program, the DHMT was so convinced that these partnerships have significant health impact that they participated in the national stakeholders meeting in Kigali and shared their support for this approach.

Joint planning and information sharing were cited as significant achievements of the project. Community level data provided through the project's HMIS provided data to the MOH that it never had before the project. Changes in personnel at the district level challenged continuity of leadership, but fortunately some of the changes were promotions and this helped the project to continue to get support from these people.

The introduction of major decentralization in the national health system, along with shifts in decision making responsibilities to the districts has challenged all health programs in Rwanda. Some decisions are still made at the central level. At times, this has challenged decision making and sustainability planning between the partners. Central policies have both helped and hindered some program efforts. National labor laws and per diem policies have also sometimes slowed down planning or constrained activities. Community genocide trials 'Gacacas' and obligatory local activities, including elections and community-cleaning activities are sometimes organized with very little notice. Partnership with the DHMT has required significant flexibility on Concern's part. Schedules are frequently changed when DHMT or MOH staff are required to attend other meeting on short notice. On the other hand, Concern is highly valued as a local partner and activities are well integrated into the district.

(iii) Health Facilities Strengthening

Strengthening the function of Health Centers and the linkages between health facilities and the communities they serve was as major focus of the CSP. Decentralization, formation of community health center management committees (COSAs) and mutuelles have provided health facilities with more resources than they had at the beginning of the program. In addition to intervention specific training, additional areas of specific emphasis in the CSP included human resources and promoting formation of mutuelles.

Major improvements in health services have taken place since the beginning of the program. Significant stockouts of important drugs in facilities are much less evident. As in many cases, attribution to Concern when partnership is the methodology can be quite difficult. On the other hand, the DHMT was quick to give Concern much of the credit for the improvements that were observed.

Without a doubt, the Concern CSP initiated the first HIV & AIDS VCT in the District, and the first rural health center-based VCT in the country. This is a significant accomplishment which is hard to recognize now that VCT and PMTCT are almost standard in many African countries with significant HIV prevalence. Importation of reagents and providing necessary laboratory commodities was a major challenge that Concern met. Health Center staff members acknowledge that the capacity building of the CSP was extremely important. Some key activities included: planning community outreach, strengthening referral systems, HBM start-up and supervision and encouraging early care-seeking for children with danger signs or who are too young for community-based treatment. Staff stated that the obviously improved quality health care across the district had increased their satisfaction with their jobs. Capacity building also helped TBAs to feel respected at health centers, hence they became more likely to refer and accompany women to health centers for delivery.

Evaluators were initially sceptical that the ambulance provided to the hospital by Concern in lieu of the motorbikes that were in the original budget would be used appropriately. DHMT records documented, however, that dozens of mothers and children experiencing life-threatening conditions related to childbirth and malaria received timely treatment as a result of the increased access to emergency services. Abuse of ambulances is also now discouraged by a Presidential decree that all ambulances that are found inappropriately in Kigali are to be confiscated.

Concern's assistance in support of the mutuelles, especially sensitizing communities to their value, significantly increased mutuelle membership as well as utilization of health facilities. Since care is sought earlier, fewer serious cases are encountered and costs are reduced. Beneficiaries report that their waiting time is less and they now receive better treatment as mutuelle members.

Concern supported health center supervision throughout the CSP, including regular transport for site visits. The EIP will continue some support for IMCI-related activities and if the GOR continues the HBM program, it will also need to provide funding to encourage supervision. The major threats to continued supervision after these programs end will be transportation (both vehicles and fuel) and use of supervision checklists that include quality of care in addition to distribution of commodities (e.g. medications).

After the MTE Concern relocated the project office from Butare town to Kibilizi where they were closer to the field. Each Activist already had been given a technical focus and was expected to develop in-depth knowledge of a specific intervention. (See human resources and staff supervision in the Management section). This helped the project to provide more appropriate technical assistance to the health centers and gain credibility with the DHMT.

Concern provided support to the health center committees (COSAS) and despite the absence of a clear definition of « operational » all 7 COSAs are working and meeting regularly. COSAs participated in the midterm evaluation and provided support to the health mutuelles. Building capacity of the COSAs in the midst of decentralization has to be viewed as a work in progress. COSAs have control over hiring staff in excess of the numbers that are required by the MOH guidelines. The final HFA found that most health facilities had staffs significantly larger than what is thought necessary; indicating that health center capacity building in prioritizing items for allocating funds still needs some additional support.

DHMT staff turnover, which Concern could not control, challenged retention of some of the training content. Overall, however, the evaluation team was impressed with how much the health facilities had improved since the beginning of the program. It would have been easier to document these changes if a baseline Health Facilities Assessment in each of the interventions had been done at the beginning (It was not required).

(iv) Strengthening Health Worker Performance

In multiple FE focus group discussions, workers in health centers stated that the preventive and early treatment approaches had decreased their workload. Training programs, especially those conducted in collaboration with MOH programs (such as HBM and malaria case management) were particularly helpful. MNC training that encouraged health center staff to welcome referrals from TBAs encouraged them to accompany their clients for deliveries. This encouragement was enhanced when health centers were allowed to compensate TBAs for referrals.

Shifting the base of the Concern Activists to the Health Center for the area for which they were responsible encouraged staff to be out in the field more. (This was hard to document during the FE because field supervision records by the Program Managers and Assistant Program Managers were not available, but was confirmed by the Titulaires (Health Center heads) themselves who had complained about the absence of some Activists during the MTE.) Health center staff, as well as HBM distributors, TBAs and local leaders, confirm that Activists were available to help reinforce information from trainings.

(v) Training

Concern provided extensive training using both expatriate technical specialists (especially in Maternal Newborn Care, Nutrition, and Adult Education) in addition to providing training in all interventions in each level. A list of major training activities is provided in Annexes C & D. Training also included DHT capacity building in planning, supervision and clinic management. After the MTE, Concern devoted considerable attention to strengthening the technical approach to MNC and this included significant assessments and training programs to bring District MNC approaches in line with more up-to-date approaches (see section on MNC).

More than most other PVOs, Concern Worldwide has embraced the exposure visit approach as a training, advocacy and capacity-building strategy. Staff and partner DHT representatives visited Concern's CSP in Bangladesh, a C-IMCI/CCM program in Kenya and a community-based MNC program in Tanzania. Technical assistance and exposure visits helped staff and partners to envision completely different approaches to achieving maternal and child health outcomes. One of the local trainers, a physician from the University Hospital, updated his TBA training approach as a result of the visit. Concern showed considerable tenacity in overcoming some obstacles, including prohibitive government per diem policies to avail their Rwandan government counterparts of these extremely valuable training opportunities.

Staff training is addressed in the Program Management section of the report.

d. Sustainability Strategy

The DIP sustainability strategy was revisited as part of the MTE Action Plan. The third and fourth annual reports laid out specific components of this strategy that was to be completed by the end of the project. The FE team reviewed the list and found that the

majority of actions had been put in place, or were no longer necessary and that most of the recommendations in the MTE report had been acted upon. In several cases the CSP was able to go beyond the original plans. Some important project actions, such as development of the BCC print materials, occurred late in the program, but will be used in follow-on Concern health activities in the area. The planned follow-on activities, especially the EIP, also include local partnerships with the DHMT and community-based organizations so their impact should even increase over time.

Associations

At the end of the CSP Concern project, members of the community associations stated that they were willing to continue the activities started by the CSP project. They had already acquired the necessary technical skills and they are confident they will derive some income from the small projects that they will start in the near future. TBAs, however, want the same status and benefits that community health workers (incentives and other materials such as radios and bicycles) receive from the government to perform their duties. The government has funds to support CHWs, but it isn't clear what is required to classify other workers (such as TBAs or HBM distributors) as community health workers in order to be eligible for these funds. The source of these funds (GAVI, Global Fund, PMI, etc) is also unclear as well as how long this support will be available. Members of these associations say that, aside from the personal satisfaction that they get from serving others, they look to their communities and not Concern to provide the material "motivation" to sustain their activities after the program ends.

Financial Sustainability

Concern's support of the government health insurance program (mutuelles), health center cost recovery management (FOSAs and COSAs), potential linkages with other programs (food security, livelihoods, etc.) and commitment to continue effective programs with private resources, bode well for continuing impact of the program. Increased access to affordable services also means that women and children are seeking and receiving treatment earlier when their conditions are less severe and treatments are less costly to both the beneficiaries and the health system. The inability of the government systems to reach all of the poorest families with mutuelle membership will remain a challenge after the program ends. GTZ had been providing some free memberships to very vulnerable individuals but this tended to be orphans and widows, missing the target group of pregnant women and young children. The future of this support by GTZ was unclear at the time of the FE; however, DFID was also investigating support to this intervention. Income generation activities through the associations started by the program should help provide some families with more income and indirectly help sustain some health related behaviors.

The Expanded Impact Project (EIP)

Those activities related to C-IMCI from all three programs (Concern, IRC and World Relief) will be reviewed in the design and implementation of the EIP and more lessons will be learned about the sustainability of Concern's CSP impact over the next five years. Concern has already started planning the new program with the other two organizations

which means that activities are likely to start soon after October 1, 2006 and the carry over from the current program will be better than if there were a long gap between programs.

Synergies for the Multisectoral Platform

While the Rwanda CSP was not designed specifically with C-IMCI, the upcoming Expanded Impact Program (EIP) was. The multisectoral platform, which is an essential element in C-IMCI, includes elements that would likely impact on the effectiveness and sustainability of the child survival-specific actions were implemented in the CSP and that will be taken in the new program. The new EIP will have also to consider sources of the support that will be required during and after the project to address those issues because the EIP will not be able to fund them. Concern is already developing partnerships with many other development actors in the district. This is very important and should be encouraged.

C. PROJECT MANAGEMENT

1. Planning

Concern actively included their DHMT partner and communities in the initial planning processes including proposal development, the DIP and throughout the program. All program documents were translated and disseminated in French. But the original DHMT staff assigned to work with the program did not embrace the program as much as would have been hoped. This is likely due to the post-conflict programming context where districts were used to direct financial support and not capacity building. Since there had never been a CSP in the project in the area before, the whole program approach was new.

By the time the Midterm Evaluation was completed, however, personnel at the DHMT level had completely changed their attitudes. A change in the DMO to a more supportive person was the first major positive change. Representatives of the District Hospital and DHMT who participated in both the MTE and FE, stated that even though the DHMT may have been given documents and worked with Concern's CSP in the beginning of the program, when they came on board the former participants from the DHMT did not reveal to them what had gone on before and did not share any documents with them. When these new representatives were invited and actively participated in the MTE, they were given new copies of the documents by Concern that they should have received from the former DHMT staff. This helped them to understand the project better. Further, Concern organized a 2-day partnership workshop with all of the DHMT health center in-charges. They said that since the CSP was already beginning to show results, they could see the value of collaborating more closely with Concern and the project planning documents and early implementation then made sense to them. The documents also helped them to get on board with objectives, targets, and strategies and figure out how they could contribute to achieving the CSP targets. Even though this represented additional effort on the part of Concern, which in theory should not have been necessary, it was greatly appreciated by the DHMT members and served to solidify the partnership with them.

DHMT representatives interviewed at the time of the Final Evaluation also stated that it was their impression that in the early part of the program the DHMT, and to some extent some of the Concern staff, really didn't understand what the CSP was trying to do because they had never seen a project like it before. This is very similar to experiences in other CSP programs in new countries and does not represent a weakness in the design, or the staffing. Since the equivalent of DHMT partners in other programs are usually not accustomed to the capacity building approaches of CSPs, counterparts are often not as cooperative in the initial stages of the program as would be desired. The exposure visits to projects in other countries as well as other parts of Rwanda helped them to understand what they were trying to achieve and adapt it to their situation.

Concern Worldwide has learned a great deal about CSP planning and design since that time and the DIP guidelines have been streamlined since the Rwanda DIP was written. The original plan was, to a certain extent, almost a separate project for each intervention. Although Concern certainly involved the DHMT from the beginning, it was only after both the staff and DHMT counterpart staff really grasped how the CSP was designed that joint planning became easier and the partners became more supportive of Concern and the CSP.

Turnover in Project Coordinators, especially the departure of the original program manager, resulted in some problems with consistency in program approach throughout the entire project lifetime. Concern management recognized the problems as they occurred and did as much as possible to mitigate the effects of these personnel changes including stepped up technical assistance visits, seconding staff and increasing direct involvement of senior management to support project planning and implementation. As a result, there was coherence in the program approach that was understood by those who were implementing the program.

2. Staff Training

Staff participated in training in all interventions in addition to project implementation skills such as presentations and monitoring and evaluation. Concern obtained external technical assistance for adult education techniques, nutrition and HIV & AIDS. Annual report excerpts detailing specific training activities and more detailed lists are included in Annex C.

Staff gave multiple examples of the value of the professional training they received in the program. Specific training such as presentation skills, adult education techniques and planning in addition to technical intervention areas were particularly appreciated. Starting in 2002, Concern policy now sets aside the equivalent of 4% of national and international staff payroll that is used as a pool from which both national and international staff can benefit. This represents a commitment for building national staff capacity at every level.

The value of exposure visits for partner capacity building has already been mentioned. These visits also provided significant capacity building for Concern staff. Everyone who participated in these visits unequivocally stated their enthusiasm for them and how

much it helped them to visualize and plan what they were attempting to accomplish in their CSP.

3. Supervision of Project Staff

During the life of the program, Concern provided significant supervision to the project from Kigali, New York and Dublin. Senior staff from Kigali including the ACD for Programmes, the US Health Advisor and Administrative Managers from New York and Dublin made frequent visits to the project. During gaps between Project Coordinators the Assistant Project Coordinator supervised staff through weekly or bi-weekly meetings but did not visit staff in the field, even though field staff stated that they requested to have supervisory visits from him. The Concern staff members that were making visits to the project from Kigali were not told that the field staff had requested these visits from the Acting Program Manager, so they were not in a position to reinforce with him the importance of making them in order to provide supportive supervision.

The Kigali-based ACD for Programs and the HIV & AIDS Mainstreaming Manager (a physician and public health professional with previous child survival management experience) also made frequent visits and spent additional time in the field during the times when a new Program Manager was being recruited. Some decisions that the Butare office normally would have made on its own when there was a Program Manager were made by Kigali during that time. These changes were confusing for the DHMT partners and some of the staff. In FE interviews, they said they interpreted these moves as representing a decrease in autonomy of the Butare office. It is appropriate that Concern kept its personnel issues confidential, so it would have been hard to publicly share all of the reasons for decisions. These impressions largely came during periods of time when the partners were trying to see who could commit to what during joint training plans as well as during some of the time that it took to get commodities and materials into the field.

Administrative and logistic supervision was also done during frequent visits to Butare and by administrative staff attending meetings in Kigali. Concern Worldwide, in general, and Concern Rwanda in specific, provides much more supervisory support than many other PVOs implementing similar programs.

4. Human Resources and Staff Management

By far, the largest constraint the CSP faced during the project was the turnover in the Project Coordinator position. During the periods of time while a replacement was recruited, the staff that covered the supervisory roles did not have sufficient background or experience to assume the high level of responsibility and technical leadership required for such a highly-specialized type of program that was new in the country. The second Program Manager's style was not a good fit for the CSP staff. Although a replacement for the second Program Manager was identified in August 2005, delays in her work permit despite adherence to the requirements of the government system, made it impossible for her to start until January 2006. This current Project Coordinator is an experienced public health paediatrician familiar with maternal and child health programming and has worked with Concern Worldwide in other countries. Her

personality, experience and management style appear to be well-suited for motivating and leading her Rwandan colleagues and she is already respected by the DHMT.

Hiring an administrative assistant at the Butare office relieved the technical staff of the burden of many of the administrative tasks that field staff had been responsible for at the time the MTE was done. Morale among administrative staff is very high and all staff members say that they feel well-supported administratively. Some morale problems, however, remained amongst the field activists at the end of the program. These were probably related to the gaps in program managers mentioned earlier.

5. Financial Management

Although the project seemed to be under-spent (45%) by the end of the third year of the project, all USAID and Concern match funds were expected to be spent by the time of the final evaluation. Concern takes financial obligations very seriously and would supply funds from private sources in the unlikely event that there were to be overruns. In order to continue some activities that were started late in the project, Concern is planning to provide their own funds for a short time while seeking other financial support. Concern Worldwide has been compliant with submitting all required financial reports to USAID.

6. Logistics

Logistic challenges faced during the program primarily concerned VCT supplies, and micronutrient and deworming medicines. (Procurement and sales of ITNs and for HBM drugs have been described in the Malaria section.) Especially during the beginning of the program when they had to be imported and there were frequent national stockouts, supplying VCT reagents to centers was a challenge. But developing strategies for consistent VCT supplies was critical to the success of the intervention and Concern maintained a steady commitment to overcome the obstacles as long as they managed the program. By the end of the project, however, much of the VCT services were handed-over to the Rwandan government and other HIV & AIDS programs and no longer the responsibility of Concern.

Concern provided considerable logistical support to the District during the life of the project, including vehicles for supervision visits twice a week and a car for drug supplies twice a month. The ambulance that was provided directly supported reduction of maternal and child mortality. Very good records are kept at the District level to document that the ambulance supported the goals and objectives of the program.

D. Other Issues Identified by the Team

Equity in services, especially in terms of socioeconomic status and gender are important to Concern, the Government of Rwanda and to USAID. Poverty has a heavy overall impact on all aspects of the program and will continue to challenge the impacts of the health services. Cyclical or seasonal poverty, especially the impact on household

food security has implications on the nutritional status of the mother and child as well at the rest of the family. Concern found that standard national measures of poverty⁴ did not reveal significant differences between beneficiaries when the project tried to assess whether the project reached the poorest families. Child survival projects primarily address behavioural and health service contributions to poor maternal and child health status. The Final Evaluation revealed that poverty alleviation and household food security need to be high priorities if the behavior change and health systems strengthening impact of the program are to have sustained impact. (See nutrition and sustainability sections.) The final KPC survey revealed continued gaps across wealth quintiles of the population (reference Annex E, pages 29-30).

Overall public health workforce shortages in Rwanda present significant challenges to PVOs and NGOs who maintain relatively low salaries (relative to international organizations and projects implemented by consulting firms). Attracting and retaining qualified national staff members, especially females, is a continuing challenge. This may eventually improve since Rwanda has increased public health standards and training opportunities at the national level. Meanwhile, there is a delicate balance in making management decisions about retaining staff that lack full capacity to implement quality programs and build their capacity over time and/or replacing staff with other candidates who may not contribute to a more balanced workforce. Concern is making significant efforts to capacity building with Rwandan nationals, but have seen these efforts periodically thwarted when they have trained a staff member only to see them leave for a better paying job with another organization.

E. Conclusions

The CSP met, and in some cases significantly exceeded most of its program targets. Communities and health service providers in the district agree that overall child mortality and morbidity substantially decreased in the area. For the first time, Concern introduced a PVO health technical capacity-building partnership with the DHMT. Changes in health indicators in the District were a result of this partnership, and its extension to the household level through associations supported by the project. HBM introduced into the project area by this partnership, along with increased ITN access facilitated by Concern, significantly increased access to malaria case management, decreasing malaria morbidity and mortality and shows promise for expanded coverage in the new project.

Experience gained in the ending CSP has provided Concern Rwanda with a successful methodology to provide significant impact in reducing maternal and child mortality and improving the quality of life for households and communities in the district.

⁴ Type of housing, latrines, type of roof, type of floor, water source, etc.

Specific Lessons Learned

HIV & AIDS

Concern was a pioneer in matching new HIV & AIDS services and MCH clinics in Rwanda and one of the first PVOs to go beyond HIV & AIDS awareness and provide services in their program. In order to do this, Concern had to overcome several policy and logistical challenges to introducing new technical approaches to health programming in the country. Concern's community based and multi-sectoral approach significantly contributed to the decreased stigma faced by PLWHAs in the project area.

For obvious reasons, their clients were mostly pregnant women or women with small children, as they were clients for the ANC and MCH clinics as well as the target beneficiaries of the CSP. There was consensus amongst Concern Rwanda's senior management, however, that considerable resources such as financial, time and personnel were required to start HIV & AIDS clinical services where they had not previously existed. This probably took attention away from giving enough attention to starting the other interventions, particularly MNC and nutrition. This was especially true during the first two years of the program. In addition, the specific technical HIV & AIDS services linked with health facilities were not easily integrated with the other community-based components of the program. This was true to the extent that this intervention, at times, seemed like a separate project. Complicated procurements due to national stockouts of test reagents placed more pressure on the logistics system than most child survival programs experience.

There are definite pros and cons of including HIV & AIDS within a multi-intervention child survival project. But Concern responded appropriately to findings of the situation analysis and baseline studies and ventured into uncharted territory by committing to implement an intervention approach that until that time had never been tried in Rwanda.

Malaria

ITN

In the era of GFATM support, Presidential Malaria Initiative, and net campaigns it is easy to assume that the ITN coverage achievements in Concern's CSP were easy to attain. That fails to take into consideration the significant obstacles and challenges that the initial increases in coverage required. Importation luxury tariffs on mosquito nets were still in place at the beginning of the program. Concern had to purchase nets at market prices, but could not sell them to the beneficiaries for full cost recovery. Nevertheless, Concern honored the commitment to provide the nets. Concern put together distribution mechanisms at ANC and the community level that significantly increased access to these life-saving materials. Community-based surveillance, through the various surveys and community structures established in the CSP, has assured that the nets are reaching the target beneficiaries and that they are, for the most part, used properly. This type of surveillance is lacking in many RBM programs around the world and represents a significant contribution towards achieving targets in the national RBM program.

HBM

Not surprisingly, staff in all three of the PVOs, including Concern, reported that they would have benefited from more time to engage with their partners. But competing priorities and responsibilities were a challenge to having the time. PVO staff report that the collaboration required significant investment of time by those involved at both the HQ and field levels, though the exact amount is difficult to quantify. Nevertheless, the close collaboration and communication between Concern and the other two PVOs helped to keep the partnership moving in the same direction and encouraged the USAID Mission, PNLN and other partners to continue to support the new approach. Community mobilization and DHMT capacity building at every level was essential to the support for HBM that has been gained at the District, community and household levels.

Reconciling the differences in PVO organizational approaches, procedures and policies in order to work jointly took time and required flexibility not only by individual staff, but by the larger organization in Concern as well as the other PVOs. In particular, the differences in field staff capacity, recruitment, and allocation became significant issues because of their direct impact on implementation. Securing sufficient commitment from each organization's headquarters staff helped to overcome these differences, as HQ staff were able to build on their relationship with field staff to continue promote collaboration. Because there are differences in the program environment between the three organizations, cross-visits that were initiated and organized at the country level played a major role in building trust because Concern staff could see the situation that the other PVOs were addressing and vice versa.

Conflicts were avoided and resolved through patience, dedication, and Concern's Headquarters and in-country staff's strong belief in the collaborative process. PVO staff were willing to assume extra costs involved in the partnership because they believed in the project mission and rationale. For example, Concern sponsored the costs of the first national technical committee meeting in Butare prior to availability of CORE and USAID mission funds because of readiness of key actors from the NMCP, MoH, UNICEF, and Belgium Cooperation to get started. Many of the additional challenges faced were those found in any country tackling malaria with limited infrastructure, poverty, and poor health outcomes.

The PNLN's adoption and expansion of the program added significant legitimacy to the program and to the potential for great impact. At the time of the Final Evaluation, the PNLN was organizing an evaluation of the HBM program, with technical assistance from the BASICS project.

Overall, Concern's malaria program benefited significantly from this collaboration. Not only were there significant results, but the lessons learned there will be applied to the new EIP, as well as incorporated into the countrywide RBM process. These lessons including collaboration between PVOs to increase coverage and meet common program objectives, and between groups of PVOs and national public health programs, will be under study for several years to come. Because of Concern's overall flexibility in

incorporating new approaches in CS programming, it will be viewed as one of the pioneers in this area.

The community-based approach of the program and strong support for the approach from the District and National Health systems is being credited with helping the approach to be effective. Community members were very appreciative of the Distributor's work, even when the Distributor does not provide treatment but instead refers them to health centers. Providing the same drugs as those available at health centers provides credibility for HBM services. This may be threatened when the health centers begin using ACT (Coartem®) in late 2006 while AQ/SQ will still be used for the time being in the community. If communities are sensitized to these changes in advance, it is more likely that the differences will be understood and accepted.

Sustainability of HBM is thought by the community to be dependent on providing continued non-monetary support (flashlights, spoons, rain gear) especially to help the distributor to work at night and in the rainy season. One recommendation that came from the Distributors themselves would be for the authorities to recognize the value of their service and exempt them from obligatory rotations for community security duty.

IPT

When the program began, Concern was not able to make a plan to contribute to increasing the RBM indicator in this area because Rwanda lacked any policies or plans to implement it. After the MTE, Rwanda initiated the plan and rapid coverage increases were desired. Because Concern already was involved in ANC, through the integrated approach of the CSP, it was relatively easy to promote IPT even though Concern was not directly providing the service. Undoubtedly this contributed to the rapid uptake of the intervention, quickly raising coverage from zero to over 40% at the end of the program.

Maternal and Newborn Care

Along with other PVOs, Concern found that the state-of-the-art of addressing maternal and newborn deaths is technically demanding and requires considerable time and effort on the part of staff, as well as significant technical assistance. Focus on community-based programs shifted globally from improved home deliveries to increasing skilled deliveries (usually at a facility) during the lifetime of the program. In addition to Emergency Obstetric Care (EmOC) considerations, quality of delivery care and more attention to the postpartum newborn checkups became increasingly important over the life of the project. The clinical performance of the personnel conducting deliveries was not assessed at the end of the program and this was a missed opportunity to demonstrate impact on an important aspect of the intervention.

Although in many ways it made programmatic sense to phase-in the CS interventions, given how much of the project infrastructure had to be developed from scratch, the late introduction of the MNC intervention meant that beneficiaries had a very short exposure to some of the project activities relative to the amount of time it takes to change health facility practices *and* community beliefs and practices. Key BCC messages in some of the interventions were not developed until after the MTE. (See BCC section) This meant

that some beneficial practices were not promoted until the last year of the project. The HFA and the exposure visit to Tanzania proved to be critical to reorienting key stakeholders to the international standards mentioned in the MTE report. The potential overall impact of Concern's MNC activities on changing attitudes and practices might have only been starting to take effect when the Final Evaluation was conducted and actually may be higher as time goes on.

Health Facilities Assessments (HFAs) have never been *required* in the CSHGP, though assessment of quality of services for referral facilities were included the TRMs since the mid-1990s. Since Concern did not conduct a baseline HFA, the need for one became evident by the time of the MTE. Concern contracted expert MNC technical assistance and performed the Kibizi District MNC assessment.

New Government Approaches in MNC

Health reforms recently implemented in Rwanda have changed the incentive system for all essential PHC services, including labor and delivery services. Home delivery services are actively discouraged and TBAs are to be rewarded financially for referring women to health centers for delivery. Facilities are reimbursed based on the number of clients and services they provide, so their incentive system would also discourage home births. This makes quality of care at the health facility, as mentioned above, even more important. This has not taken full effect yet and Concern has provided TBAs with the means (through sale of clean birth kits and assistance to TBA associations) to do clean deliveries. Concern has to walk a fine line between supporting the government approach that focuses on facilities and addressing the reality that many births will continue to take place at home, no matter what programs are in place. On the other hand, TBAs expressed willingness to expand their roles in communities, especially in family planning, and appreciated the new respect they felt they were receiving from health facility personnel. Recent changes in government stances from anti-family planning towards encouraging family planning have also probably encouraged these attitudes.

The ultimate impact of the policy changes on newborn care remain to be seen. If the child is born in the facility, then it receives an initial check-up but one is not sure of the quality. Children born of HIV+ mothers would also more likely have access to PMTCT drugs. Children born at home of HIV+ mothers who are not taken to the health center for ARVs within 72 hours of birth miss the benefit of receiving these drugs when they are available at the facility.

Nutrition

At the time of the FE management self-assessment, Concern managers acknowledged that the intensive effort required to start the HIV & AIDS intervention probably detracted from devoting as much attention to starting the nutrition intervention early in the project as would have been desirable. Turnover of program managers also impacted the nutrition intervention. In spite of some initial challenges, PD/Hearth is a very acceptable way of approaching community-based nutrition programming and is much more

effective than the more common growth monitoring and cooking demonstrations found in other programs.

Based on the findings of the baseline assessments, there should have been more emphasis on feeding the sick child from the beginning. This is apparently due to selection of mixed maternal and preventive child health interventions which were not necessarily focused on the sick child. Baseline and final percentage assessments of caregivers who provide increased food and fluids to a sick child remained below 7%. If aggressively promoted, it would likely have had significant impact on the high levels of stunting evident in the area. The topic was introduced, but quite late into the BCC strategy. Although now included in HBM distributor and local leader training, this omission represents a missed opportunity.

Similar to other PVO programs that are implementing PD/Hearth, Concern found that implementing, supervising and monitoring Hearth requires significant investment of staff time. Without sufficient supervision, project staff tend to discontinue the Positive Deviant (PD) investigations in each new community that are central to the methodology. They generally do this on the false belief that PD foods have already been “discovered” and the process is no longer necessary. This appears to have been the case with Concern, but it was not clear from the documents. The current Program Manager was not working in the program at the time the Hearth sessions were started. Although the percentage of children with a weight gain of 200gm or 400 gm or greater over a specified period of time is considered a measure of Hearth impact, experience is revealing that accuracy and consistency of these measurements may not provide enough data to “tell the whole story.” On the other hand, empirical evidence suggests the Hearth group sessions on their own are a powerful BCC approach that has impacts beyond the rehabilitation of individual children.

If PD/Hearth is only considered as a nutrition recuperation program, one could say the results in the Concern CSP were mixed. Secondary benefits of PD/Hearth groups, however, may represent the heretofore unrecognized true development impacts of the intervention, especially to the overall status of women and children in the poorest of the poor Rwandan families. These benefits seem to go beyond whether or not a child gains a certain number of grams in weight. Interviews with mothers and volunteers (Mama Lumieres), as well as direct observation indicate that:

- Children in Hearth are more active, interact with their mothers more and vocalize more.
- Skin, hair and eyes are more reflective of a “healthy child”
- Children in Hearth “play” more and feed themselves more often
- Mothers report they didn’t know that they could “mix” foods for children and didn’t know that many locally available foods were good for children and that they learned about it from the Hearth sessions. They now apply these lessons with their other children.

In addition, the methodology appears to have a positive effect on changing a variety of social norms. Mothers appear to benefit from the social support of regular gatherings

with other mothers and are often reluctant to leave the group (some even refuse) after their child no longer qualifies for the intervention. Discussions that take place during the Hearth sessions have led participant mothers to examine the causes of food insecurity and start income generation activities (IGAs) to increase supplies of some of the deviant foods as well as increase household income. Concern has provided some assistance to these groups.

Poor women working as Mama Lumieres had a more useful way of identifying food insecure families than the national poverty assessment tool. It was more accurate at pinpointing which families were likely to have malnourished children who would be eligible for participation in Hearth. Dependency or subsistence farming leaves communities vulnerable to drought and unfavourable growing conditions. The recent drought was 2 years long and exacerbated the usual 2-3 months of the lean season. There are other foods that were identified in the Positive Deviance studies that help families maintain child nutrition during these times.

Community Mobilization

While the formation of PD/Hearth Groups and the Mama Lumieres were not originally envisioned as a “community mobilization” strategy for activities outside of nutrition rehabilitation and child care BCC, in fact, the methodology has served to create women’s groups with significant social cohesion which appear to have benefits even beyond the scope of the CSP. Groups interviewed indicate that some have started income generation activities with or without assistance from Concern. These income generating activities appear to remain connected to food security and food supply, e.g. raising guinea pigs, rabbits or goats that also address the underlying poverty that significantly contributes to poor maternal and child health. These groups appear to foster women’s empowerment for problem solving about all aspects of their lives, but this has not been validated. All of these groups have expressed their determination to continue meeting together after the project ends if they can. As mentioned already, there is reluctance for many mothers whose children have been rehabilitated in the Hearth groups to discontinue attending the Hearth sessions.

Communication for Behavior Change

Delivery of key behavioural messages through multiple venues, including health centers, local leaders and community-based health workers helped to reinforce targeted behaviors. Qualitative assessments during the FE fieldwork confirmed that the same message had been targeted to multiple sectors of the communities, and reinforced by the health facilities. As in many other CS programs, this is the most effective way to influence health behavioural changes, even if the target audiences are different.

Management

A complete detailed self-assessment done by Concern management staff in Kigali is included in Annex B. In the view of the evaluation team, this exercise enabled Concern managers to identify many of the important lessons themselves and that is more important than when it is done by outside parties. Taking the time to do such self-assessment was deemed to be very valuable by Senior Concern Rwanda management

staff. In the process, many ideas came out about how to strengthen management approaches in all of Concern's Rwanda programs.

Logistics

When any CSP becomes involved a commodity based intervention and activities, e.g. VCT supplies, ITNs, drugs, etc. The procurement part of the program design and implementation requires considerably more attention than in those programs that do not use many commodities.

The ambulance that was provided to the Kibilizi District was used appropriately for dozens of cases of serious child illnesses (mostly malaria) and obstetric complications. This appropriate use of the ambulance was aided by the Presidential order saying that any ambulances inappropriately found in Kigali would be confiscated by the government.

F. Recommendations

Overall

Concern should institutionalize the clinical HFA in new programs that intend to address quality of health facility care. Closer attention to the tools used and the elements assessed will help to measure the actual impact of the program on the quality of care.

Concern Rwanda, should continue to take HIV & AIDS into consideration in the EIP and in other programs they implement in the project area. This is consistent with Concern Worldwide's mainstreaming HIV & AIDS policy.

In future programs, if print materials are planned, the project should anticipate the time that will be required and organize the publication process very early in the project. The use of print materials over other communication methods should be carefully weighed considering the length of time it takes to produce and test the materials and the relative advantages and disadvantages of one communication channel over another.

Concern could make very good use of the motivation from the CSP achievements to build a team comprised of members with even more different types of expertise to plan and monitor many of their new programs. New team approaches to public health program management could be introduced. CSTS or USAID's Quality Assurance Program may be able to provide suggestions for technical assistance for team building and quality assurance (such as TQM or CQI) for future programs, including the EIP. Some of these approaches are described in the Technical Reference Materials (TRMs)

Specific Work in Gisagara

Improving the effectiveness of the Prevention of Mother to Child Transmission intervention: Concern and stakeholders specifically requested ideas on how NGOs could best address the challenge of reaching babies of HIV+ mothers within 3 days of birth to provide them with ART to prevent transmission of the virus to the baby. Increasing facility deliveries that also have ART capacity is the best way to achieve access to these babies. For those mothers who will not, or can not, deliver in a facility then identifying mothers and accompanying these women and their babies to the health facility during the critical time period is required. Programs with a census-based HIS that identify all pregnant women and newborns make this approach easier. This could be part of the expanded role of the TBA, since their role as birth attendants is diminishing. Decreasing HIV stigma, such as was started in the CSP and is supposed to be continued by GOR HIV programs, will also make it less risky for mothers to be tested and reveal their status within their communities and provide opportunities for communities to assist new mothers and their babies to access the complete PMTCT services.

Support to the community associations started during the CSP should be continued after the program by connecting them to income generation and other opportunities as well as to additional health capacity building activities conducted by health center personnel. Transportation will be the major vulnerability and should be negotiated with the DHMT, COSAs and the communities themselves.

Continued Support for Maternal & Newborn Care: Concern is currently negotiating with Columbia University's AMDD program to assist in helping them to extend their work in reducing maternal mortality. This is laudable. On the other hand, Columbia's program is considered to be heavily facility-focused and Concern should also seek support to continue and expand the promising community-level efforts in maternal and newborn care. Some aspects will be included in the EIP. The short period of time that Concern implemented this intervention during the CSP means that efforts to ensure the quality of care of services, especially in newer areas of emphasis (postpartum and newborn care) are sustained. The new MNC approach of the MOH deserves support.

If Concern intends to do MNC programming in the future, a baseline and finally quality of care health facility assessment specifically addressing antenatal, delivery, postpartum and newborn clinical care should be done. This assessment should include evaluating the clinical skills of the health personnel in those facilities.

Documenting PD/Hearth Experience: Concern should analyze the community-mobilization and nutrition BCC benefits from their Hearth experience and see how they might be modified to provide benefits beyond the focus of nutrition rehabilitation.

Considerable information on food types and utilization and their relationship to household food security in the most vulnerable families in the district were learned from implementing the nutrition intervention. Concern should share this information and the lessons learned and make sure that these lessons do not have to be learned again in the future. Nutrition BCC messages and communication methods should be shared

throughout Concern's programs in Rwanda and with other interested community based programs. They can be incorporated in programs that go beyond health.

Concern should consult the nutrition lessons learned in their CSP and those of their partners during the design phase of the new EIP C-IMCI project. Specific analysis of effective promotion strategies for appropriate infant and child feeding overall, but especially feeding during illness should be assessed thoroughly and incorporated into the new program. Nutrition is often a weakness of C-IMCI programs, but successful models and tools are available. Technical assistance may be indicated.

Concern's HQ Health & Nutrition Advisors should contact the Core Group Hearth TAG and offer to share the lessons learned about the successes and challenges of implementing Hearth in a "real world" context of a multi-intervention CSP in Rwanda. If the TAG is not meeting, Concern could collaborate with World Relief and conduct a session at a CORE meeting to share their experiences and provide feedback to the experts who are refining the methodology.

Improving Nutrition in Gisagara District: If Concern wishes to have impact on a significant number of the >30% of children who are malnourished, they should adopt population-based, in addition to rehabilitation-focused approaches. These would include promoting household behaviour changes in feeding sick children and promoting growing and possibly selling other types of foods, including animal source foods that are not dependent on the agricultural cycle. They should consider collaborating with local and national agronomists in planning these activities. The District agronomist in the CSP area has already expressed interest in doing this. If Concern does not wish to expand into all of the areas that are required to address these issues, they could network with other NGOs working in the country (Heifer Project and ADRA are a few of many) to encourage them to consider programs in the area.

Concern should build on the lessons learned in the CSP and consider PD/Hearth groups without supplementation in communities where food is available year round and malnutrition in children is thought to be primarily related to feeding behaviors and child illness. Experienced Mama Lumieres can help train groups in other communities. The PD investigation should take place in *each* community where Hearth is to be introduced. These groups should still be monitored for unanticipated threats to year-round food security (such as periodic droughts or major migrations in or out of the community.)

In areas with periodic food insecurity, Concern should plan for supplementing the Hearth groups, but only provide temporary additional supplies of the deviant foods. This was the approach Concern ultimately took. Mothers should still provide *something* to the sessions: water, cooking pot, labor, fire wood, etc. Staff should resist "taking over" and intervening without assessing the situation and should facilitate community self-assessments as to the causes of the food shortages and develop local problem solving skills within the community. In the future, the rest of the community should be approached to provide the food that the participants can not provide before Concern take steps to provide supplements.

Concern can build on the development progress evident in the empowered women participants of the already-formed Hearth groups (associations) and link them to other poverty-reduction programs (“livelihoods”). These programs are already part of Concern’s development approach in Rwanda. This should include involving the Gisagara District agronomist as mentioned earlier.

Since equity and poverty reduction are shared values between Concern, the GOR and USAID, Concern should consider conducting a social science assessment of the positive (and negative, if appropriate) impacts that organizing Hearth groups has had on women’s empowerment and also how these groups contribute to equitably addressing the needs of the poorest of the poor in Rwanda. This study should be undertaken in collaboration with Rwandan social scientists if at all possible. The family classification method developed in one of the program Hearth Mama Lumieres could be looked at as a model for developing a useful vulnerable family assessment tool. Lessons learned in these linkages should be shared with other development organizations and the GOR.

If Concern decides to pilot Community Therapeutic Care (CTC) in the same areas where Hearth (or other nutrition) interventions have been, or will be implemented, caution should be exercised not to undermine any efforts to support communities to solve their own food security problems with more sustainable approaches.

Behavior Change Materials: Even with private resources, Concern should seek ways to make sure that the BCC materials that were developed in the program are duplicated and distributed so that they can be used well after the program is over. If the materials prove to be effective, they can be offered to other MCH or development programs in Rwanda. Some will be very useful in the C-IMCI approach in the EIP, but others (such as HIV & AIDS and Maternal and Newborn Care) will need other venues to be used.

Working with COSAS: In the new EIP, Concern should continue to work closely with the COSAs to set priorities for allocating the funds that they now are responsible to manage. This may mean encouraging reductions in staff numbers that exceed the government standard if funds are needed for other reasons. This would be especially true to emphasize the need to provide funds for transport for supervision and support to community based activities such as HBM as well as to provide support to the associations which were started in the CSP.

Expanded Impact Program

Lessons learned from implementing the HBM program should be expanded upon in the C-IMCI approach of the new program. As has become evident in implementing HBM, Concern and partners should pay particular attention to how supervision, including funds for transportation, will be sustained after this next program has concluded. Cost-sharing from the beginning, MOUs and ascertaining allocation of funds by the COSAS for supervision should be part of these plans. This should apply to all of the interventions in the new program. As results from these efforts become known and are documented, the lessons learned from the Rwanda experience should be shared more

widely for possible adoption into programs in other countries, especially in Africa. Although less affected specifically by malaria, Concern should particularly note how the C-IMCI was or was not able to reach newborns through the C-IMCI approach.

Concern and partners should continue to promote IPT by incorporating this information into the new program's BCC strategy. Early studies in IPT service delivery revealed that women who know that they should expect to receive IPT were more likely to demand these services during ANC. Monitoring the availability of IPT drugs at facilities is important. Stock shortages are often compensated by withholding the drug for treatment and not providing it for IPT. That will be less of an issue once the switch to ACT is complete since Coartem® does not contain SP. Higher coverage of IPT, along with ITN use will decrease maternal anemia and thereby contribute to fewer premature and low birth rate babies who have a much higher risk of mortality.

To enhance the sustainable impact of the new program, special attention should be paid to the multi-sectoral platform. This will require partnership with a variety of partners working in the district in areas of education, water/sanitation, food security, family planning and microenterprise.

The C-IMCI approach of the new EIP MUST address appropriate messages about feeding the sick child in the new program design.

Quality assurance is an essential element of the new EIP and supervision sustainability by the DHMT after that program ends should be emphasized in the design of the new program. This will probably involve engaging the COSAs from the beginning with MOUs to guarantee that outreach supervision is an integral part of health center functioning and must be taken into consideration when making staffing and budget decisions.

Feedback to USAID from the Evaluator (as requested by the donor)

USAID CSHGP has long encouraged PVOs to collaborate within countries to implement programs for larger impact at scale. The small grant channelled through the CORE group was enough "seed" money to enable cooperation that had already begun between the PVOs to begin to bear fruit. Once the process was started, USAID mission and other support followed. This also allowed the innovative community-based case management approach of the HBM to receive much wider attention nationally and internationally than any single CSP could have accomplished. As a result, the unique contributions of PVOs in general and of Concern Worldwide in particular to scaling up effective CS approaches are more likely to get the attention from international programs, such as RBM and PMI, which they richly deserve.

The funding trend has moved back towards vertical disease-specific support and away from integrated multi-intervention programs like Concern's CSP. In order for the local health systems support approach that was used by Concern Rwanda to be scaled up, funding to do this must be available. This will require champions for these approaches within the donors as well as the research to support finding the best ways to scale up. PVOs have neither the staff nor the money to do this research on their own. Therefore,

it is recommended that USAID include analysis of the key factors for scaling-up programs, including those that are assisting health systems decentralization like Concern's in their research portfolio in the near future.

PD/Hearth was the first promising and potentially locally-sustainable child nutrition rehabilitation methodology to be introduced in recent years. For this reason, and also because it has other potential cross-cutting development benefits, USAID should sponsor a forum where all organizations that have implemented the approach can get together and share the lessons learned in their programs. Without this, the methodology may be abandoned by organizations because it was not completely refined based on experience. The CORE Group's Nutrition Working Group, CSTS+, FANTA and other appropriate organizations and projects that receive USAID financial support should be encouraged to be actively involved if it is appropriate in their workplans.

Building on Lessons Learned and Dissemination of Experience

Concern is committed to organization learning and disseminating its experience to CORE members as well as the global health community. The evaluation has already been disseminated through public presentation and discussion at the project site and in Kigali. Copies of the final evaluation report will be provided to the Ministry of Health and key program heads and District partners in Rwanda. An abbreviated version in French has already been shared. A copy of the English version of the report has been placed on the DEC.

Concern program staff in Burundi and Rwanda have expressed interest in holding a lessons learned and promising practices in community management of child malnutrition building on their growing experience and struggles using PD/Hearth and Community-based Therapeutic Care (CTC). This will be discussed with the CORE Working Group to mobilize greater interest and participation. Financial support from USAID for this event would be necessary.

Through this project, an excellent health education guides on each of the four interventions of HIV & AIDS, malaria, nutrition and maternal & newborn care have been developed in Kinyarwanda and in English. These will be posted on the Johns Hopkins University Communication's Programs Media Communications and the CORE databases. This is in addition to sharing within Rwanda with the MoH, UNICEF and the incorporation into the EIP and other Concern led projects. The materials have also been shared with our projects in Burundi for adaptation.

Concern will plan a US debriefing in DC in collaboration with its EIP partners The IRC and World Relief in early 2007 to facilitate processing experience across all three organizations. Abstracts of key project experiences will continue to be submitted for global public health conferences for broader dissemination.

G. Results Highlight

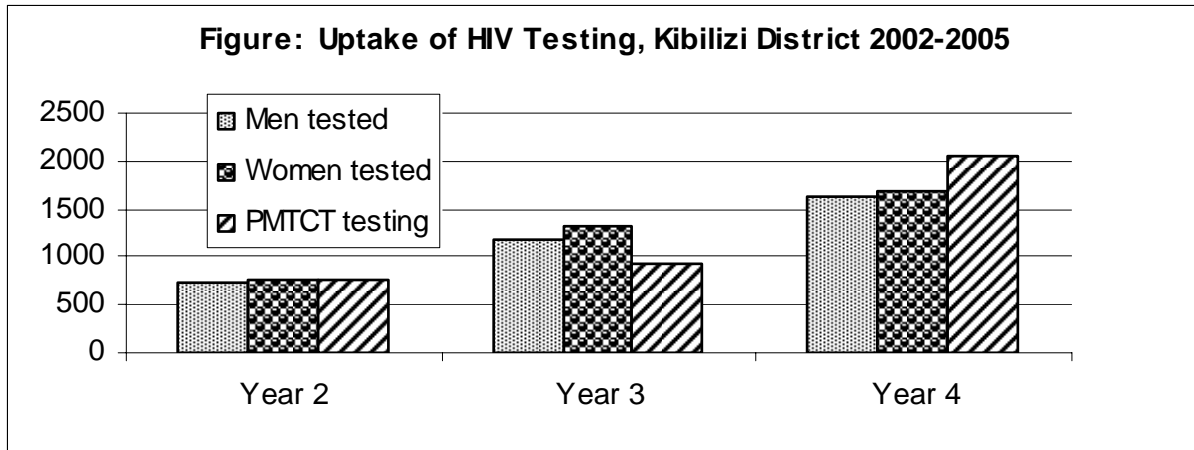
Integrating HIV & AIDS Interventions into a Child Survival Program

When Concern's DIP was written in 2001, most PVO Child Survival Projects HIV & AIDS activities in other countries focused on "awareness raising" and primarily measured impact on increasing knowledge on HIV transmission and prevention measures. But there was very little focus on testing or treatment. At the time, most health workers in Rwanda had no training in STI management, HIV counselling and testing or psychosocial management of PLWHAs. There were only a limited number of testing centers in the country and none available at health centers in Kibilizi District. Blood samples had to be shipped elsewhere in the country for testing and results were often delayed. Rapid testing was not available and only 15.7% of the population was considered to have access to HIV & AIDS services of any kind. No District HIV & AIDS services were considered to meet the level of access that was considered at the time to be necessary for STI/HIV & AIDS services. Only 10% of women in the baseline KPC had received VCT services.

Establishing access to VCT services was a priority of Concern's new CSP. Throughout the first years of the program, Concern had to overcome major obstacles to establishing VCT services, such as lack of testing reagents in the country, overcoming HIV & AIDS stigma, and quality assurance to meet this objective. To encourage the target beneficiaries (women of reproductive age and children) to benefit from these services, new centers were placed in health centers rather than in the free-standing centers that were common at the time.

PMTCT program methodologies were not well developed anywhere in Africa in 2000-2001. By the middle of the project, however, it was clear PMTCT was essential to prevent HIV transmission to infants. Concern also introduced PMTCT services into ANC clinics. Although initially targeting only 50% of one (out of six) health center catchment areas, the CSP actually achieved 60% coverage in the entire project area.

Concern's community mobilization and BCC activities worked through PLWHAs, local leaders, TBAs and community health workers and linked them to trained workers. The CSP partnership with the District Health Management Team increased awareness of ways to reduce risk from 24% (mothers only) to 81% of mothers and 95% of fathers. It also decreased stigma for PLWHAs and encouraged uptake of testing services by the general population.



By the end of the project, 81% of mothers and 48% of fathers had received VCT services, far exceeding the end of project target of 20%. Of these, 64% of the mothers and 71% of the fathers received services within Kibilizi District and therefore could be considered a direct impact of the Concern CSP.

ANNEX A: Evaluation Methodology

Literature Review

- Detailed Implementation Plan
- DIP Comments
- Midterm Evaluation Report
- Annual Reports
- HBM Baseline
CORE HBM report

Surveys and Assessments

- Knowledge, Practice and Coverage (KPC) survey
- Health Facilities Assessment (s)
- Project Timeline
- Doer/non-doer analysis of selected interventions
- Key informant interviews
- Focus group discussions: mothers, TBAs, health workers, local leaders, HBM distributors, PLWHAs, etc.
- Group synthesis sessions

Key Informant Interviews

- Conference call with IRC, World Relief, Concern and BASICS about planned national HBM assessment for Oct 2006.
- Concern Senior Management
- USAID Rwanda Health Team
- National Malaria Control Program (PNLP)
- District Hospital Manager (former DMO)
- Gisagara District Government (Health Sector)
- Concern Worldwide US managers

Management Reviews

- Concern Rwanda national management staff lessons learned self-assessment
- Staff interviews
Feedback sessions between evaluation consultants and management staff
- Local and national level stakeholder meetings

Stakeholder Meetings

- Partner sharing in Gisagara District
- National level dissemination meeting in Kigali
- National HBM assessment results meeting (done by NMCP and BASICS)

**ANNEX B: Concern Worldwide Rwanda CSP Final Evaluation
Results of Concern Worldwide Senior Management Self-Assessment
July 2006**

Overall Management lessons learnt

1. Changes to staffing structure at the end of year one - (modifications made to two of the officer posts and creation of Assistant Co-ordinator post) to improve the supervision at field level. But this supervision needed more supervision.
2. Changes to staffing structure at the end of year one - Activists being given technical intervention responsibilities as well as just geographic HC zone responsibilities.
3. The need for more formal, higher level meetings with the DHMT (ACD Programmes and CD from our side) for the purposes of continually clarifying the project methodology and outputs, clarifying expectations from both sides and following up any issues concerning the MOU. Such meetings could have been linked to the dissemination of the annual reports, for example meeting one month after the annual report had been shared.
4. The need for more frequent refresher training sessions or discussion seminars (methodology and outputs) for all CSP staff, and an evaluation of the success / impact of trainings through the Performance Development Review process.
5. The Capacity Building Health Activists were moved to the field at the end of year one. We should have used the momentum of this in order to move the office from Butare to Kibilizi at the same time or soon after.
6. The establishment of an HR unit in Kigali (as per the Country Strategic Plan objective) that provided a range of services, that could not have been provided when HR was managed in each project location.
7. Manuals (feedback and discussion during the design and drafting)
Workshops as part of the roll out for new policies and procedures Examples: National Staff HR manual, Performance Development Review training, Programme participant protection policy workshop.
8. Aware that the absence of a Co-ordinator did have an impact on the project at certain times – main issues were the field supervision and daily management of other CSP staff. However, the coverage and additional duties taken on by other Concern staff during the gap periods was impressive.
9. Was it too ambitious as a programme? Three interventions and the HIV&AIDS component (34% of expenditure) Concern Worldwide was one of the first to include HIV&AIDS as a component with a CSP. At the time in 2000 when the programme was

being designed there was almost no HIV&AIDS work in the district and so it seemed a logical intervention.

10. The need to get clarity on all allowances and per diems (and anything else to be provided at meetings e.g. food, drinks etc) issues from the outset of the new project. To agree standard rates for local authorities and other groups and get it documented so that all staff can use it as back up. The need to take a clear and firm stance on these issues from day one.

11. Issues in the working environment and the need for huge flexibility – gacaca, umuganda, elections and other meetings called at short notice or with no notice. In addition, District Health Management Team staff availability issues caused by ongoing studies in Kigali.

12. We liked the annual reporting – it was not so frequent as to be a burden and gave a good focus for the team each year. The format of the annual report was appreciated (particularly the first section on key achievements during the year and also the use of annexes to provide detail on innovations or good examples of work).

13. To assess the benefits of a closer relationship with the USAID mission (cost benefit analysis) in Kigali.

14. Flexibility in using our Concern Worldwide raised funds (general donations) has been an advantage (e.g. purchase of the ambulance)

15. The need to continue to promote a culture of reading and using policies, documents, manuals amongst the project staff.

16. The need to do more to keep the CSP team as part of Concern Worldwide rather than let them be seen as something 'different' or 'unique' – this would avoid issues and possible tensions.

Eddie Rogers,
Country Director,
Concern Worldwide Rwanda

28th August 2006

Annex C: Staff Training excerpts from Annual Reports

1st ANNUAL REPORT

In order to scale-up and spread learnings from CSP, Concern aims to strengthen its own capacity in planning, design, and management of district health programs. This includes promotion of cross-learning, continuing education, engagement in policy and standards, and documentation of experience.

Appropriately, much of the first year was aimed at orienting and strengthening technical skills of the project staff. The following is a list of training events that have taken place:

- Experiential training KPC and PLA,
- English course
- Updated national malaria control guidelines
- Mutuelle systems TOT
- Good governance and decentralisation
- ZOPP training (participatory project design)
- Cross-Visit to Kibungo, Cyangugu, and Ruhengeri health programs
- Gender concept training for all CSP staff 3 days,
- Strategic planning in preparation for 3-year CO strategy.

In addition, various members of the staff participated in national and regional trainings and health symposia as follows:

- Participation in National IMCI evaluation to better understand the extent of implementation in Rwanda, lessons learned, and supervision requirements
- Representation at Malaria Fresh Air conference in Zambia to learn more about ways to move the RBM forward in Rwanda
- Staff participation in national Gender TOT Workshop in Cyangugu to build core capacity of staff

The project staff was fully involved in the development of different sections of the DIP and most of the document has been translated in French, notably the executive summary, technical interventions and logical framework.

Priorities for year two include technical updates in maternal and newborn care and nutrition, quality assurance, managing data for action, behavior change communications strategy and community empowerment for project staff.

2nd ANNUAL REPORT

Table 8: Progress towards Output 7 objectives, Kibilizi District Child Survival Project, September 2003.

Indicators	Comments
35. Documented trimester CSP meetings where staff review, analyze and plan future activities	In August 2003, the project staff and partners conducted their first quarterly data analysis by health center catchment area and workplans to identify successes and priority areas. This followed to completion of its functional monitoring system based on basic data from the GESIS.

Indicators	Comments
36. Increased technical competency level of CSP staff in the areas of HIV & AIDS, malaria, nutrition and maternal and newborn care	Project staff have received training on all 4 technical interventions and have access to regular updates and refreshers.
37. Increased quality of performance objectives established and achieved by CSP staff	Performance management system in place and recently completed first cycle of assessments and planning.

During the year the following capacity building events took place:

Management

- Monthly CSP working group meetings
- Adult education methodology for 20 people for 5-days by Robb Davis of FFI
- Orientation on BEHAVE Framework for all staff for ½ day
- Strategic planning workshop for all staff for 1 day plus participation of Acting Project Coordinator in full process
- LQAS training with IRC for 2 staff for 7 days
- Security code training for 1 staff for 3 days
- Participation in national meeting to standardize mutuelle operations for 1 staff during 5 days
- Participation in CIFRA/GTZ training on public health and action research during six weeks for 1 staff
- Workshop on Guide for Mutuelles in Byumba and Kabgayi organized by PRIME II for 5 days with one staff and one district partner attending
- SPHERE standards training for 1 staff for a day

Intervention Areas

- Nutrition counseling for 11 staff and 10 district partners for 5 days based on FFI/Linkages Nutrition Education Module
- HIV & AIDS information and counseling for 6 staff and 2 district partners for 5 days based on FFI/WR HIV & AIDS Education Module
- Voluntary Counseling and Testing training for 10 days 11 staff and 17 district partners
- National Vitamin A Planning Workshop for 1 staff for 3 days
- Participation and presentation at CORE FreshAir Malaria Workshop in Bamako for 1 staff
- Training on malaria control and ITN strategy for 1 days by NMCP for all staff
- New Perspectives on Malaria conference for 7 days one staff

Exchange visits

- Gakoma District ITN strategy for pregnant women day exchange visit by 9 staff and 8 district partners
- Community malaria visit to Western Kenya for 3 staff 7 partners for 6 days
- TBA learning visit to IRC Child Survival Program in Kibungo 2 staff 7 partners to complete TBA training curriculum

- Nutrition learning visit to IRC program in Kibungo for 2 staff and 7 district partners to prepare for the Community Nutrition Program.

3rd Annual Report

Table 10: Progress towards Output 7 objectives, Kibilizi CSP, Sept '04.

Indicators	Comments
35. Documented trimester CSP meetings where staff review, analyze and plan future activities	On going. Health information system recently now includes community level data. Need training in data management, analysis and reporting.
36. Increased technical competency level of CSP staff in the areas of HIV & AIDS, malaria, nutrition and maternal and newborn care	Project staff have received training on all 4 technical interventions and have access to regular updates and refreshers.
37. Increased quality of performance objectives established and achieved by CSP staff	Performance management system in place.

Management

- Training on LQAS methodology for 4 days for all CSP staff and DSK in January 2004 in Butare. Facilitated by national trainers from Concern, IRC and the MoH.
- Midterm Evaluation design and implementation for all CSP staff and District Health Management Team, February 2004
- Partnership Building Workshop for CSP staff, and District Health Team, and local authorities for 2-days in March 2004.
- Training on BEHAVE Framework for Strategic Behavior Change for all CSP Staff and District Health Team in April 2004 for 5-days, facilitated by New York Technical Backstop.
- Training of Trainers for 2 CSP staff in Mutuelles for 3 weeks, organized by PRIME, July 2004
- Refresher training on Mutuelles for CSP staff, DHMT and local authorities, 5 days in September 2004.
- Management for International Public Health at the Centers for Disease Control and Prevention for the Assistant Project Coordinator for 6 weeks in September – October 2004

Intervention Specific:

- Training of trainers in Community Nutrition and PD/Hearth for 10 days for 2 CSP Activists and one DSK nutrition center worker. Training was organized by World Relief and facilitated by the Bergrens in Cyangugu – October 2003
- PD/Hearth Training and Nutrition refresher for 5 days in Kigali by the CSP Coordinator in June 2004
- Maternal and newborn care best practices update and local assessment for all CSP staff and DHMT in August 2004, organized by Susan Rae Ross
- Home based management of Malaria training for all CSP Activists, 3-days in June 2004, organized by the NMCP

- Gender and HIV & AIDS orientation for 5 days in November 2003 for all CSP staff in Ruhengeri organized by the Country Office

Exchange visits:

- Uganda learning visit on Home based Care for PLWHAs for 6 days for 4 CSP staff, one member of the DHMT, and the in-charge of Kansi Health Center in November 2003
- Community Health exchange visits with Concern Burundi including LQAS in Cibitoke in July 2004.
- Participation in midterm evaluation of CSP World Relief in Cyangugu by Assistant Coordinator

4th Annual Report

Table: Progress towards Output 7, Kibilizi District Child Survival Project, Sept 2005

Indicators	Comments
26. Documented trimester CSP meetings where staff review, analyze and plan future activities	- The system in place established by Concern to organize monthly and quarterly reporting allowed CSP to regularly collect important and relevant data and share information with the other programs. - CSP working Group (World Relief, IRC, and Concern World Wide) has been a mutual exchange of experiences which has helped to progress vis-à-vis to our common indicators through shared documents/reports.
27. Increased technical competency level of CSP staff in the areas of HIV & AIDS, malaria, nutrition and maternal and newborn care	CSP staff has been well equipped with different trainings and workshops concerning the four areas of program intervention.
28. Increased quality of performance objectives established and achieved by CSP staff	Performance management system reviewed. A CSP staff attended a performance workshop. The performance review begun with a Concern core team who in turn will brief and train the program staff.

Management

- One CSP staff attended a Human Rights Based Approach to Programming workshop organized by UNICEF at Kigali / Mamans Sportive for 5 days in August 2005.
- One CSP staff attended a Monitoring and Evaluation of health Program at District level in Senegal for 17 days from 20th June to 8th July.
- One CSP staff attended a Nutritional Policy Analysis and Advocacy Workshop organized by UNICEF & MoH in 2 sessions held in Kigali from 26th February to 2nd March 05 continued for 5 days in July 05.

Specific intervention

- One CSP staff participated in HIV & AIDS and Mainstreaming workshop organized by Concern World Wide at Goma / DRC for five days in April 2005
- Three CSP staff participated in Gender and Health Training organized by Concern in Butare for 5 days from 18th to 22nd July 05

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- Two CSP staff participated in Family Planning training organized by Concern in Butare for 15 days in May and July 05
- Capacity Building Officer attended a training on Health & Nutrition CTC/ Community Therapeutic Care at Naivasha / Kenya for 10 days.
- Exchange visit
- Three CSP staff participated in Maternal and New Born Health strategy field & Training in Mwanza organized by Concern Rwanda for 14 days from July 4th to August 15th / 2005.

Exchange visit to Bangladesh for Activist on community IMCI and social mobilization in May 2006

Annex D Major District Health Team Training Provided by Concern CSP

Note most of staff training reported in annex C above included counterparts from both the District Health Management Team and Health Centers. The below trainings were specifically for

1. Deliveries/ANC/Postnatal care:

*2005/6 Training of 14 TBA trainers from the seven Health Centers (2 each) for 10 days

2. VCT/PMTCT

*2002 training of 14 HC personnel on VCT/PMTCT for 5 days (contracted to TRAC)

*2002 training 7 lab technicians for lab diagnostics for 5 days (contracted to TRAC)

More recent trainings were by TRAC independently of our resources so we could focus energy

On nutrition counseling for health workers and PLWHAs

3. Nutrition

*2003 training of 7 nutrition workers on infant & young child feeding for 5 days (w/Robb Davis)

*2003 training of 1 nutrition worker on PD/Hearth for 10 days (org by WR with the Berggrens)

*2003 training for 5 days + exchange visit to IRC area on CBGM for 2 HC staff in Gikore and 1 from Kibilizi HC

*2005 training for 1 nutrition worker on PD/Hearth demonstration trial for 4 weeks (Kigembe)

*2006 training of 17 HC staff as trainers on nutrition and HIV

4. Malaria

*2002 training of 14 health workers (2 per HC) for 5 days on case management (w/NMCP)

*2004 TOT on HBM for 7 health workers (1 per HC) for 4 (or 5?) days (w/NMCP)

5. Mutuelles

*2002 training 7 clinical staff for 3 days on mutuelles (w/GTZ)

*2004 ToT training on mutuelles - 1 per HC for 5 days

*2005/6 training of mutuelle committees which sometimes included HC personnel on management aspects

6. Family Planning

*2005 training of 14 HWs for 5 days (w/ARBEF)

7. Gender

* 2003 Gender & health orientation for 5 days - 2 per HC

*2005/6 Gender and health ToT - 1 per HC

8. IEC - well we call it behavior change approaches

*2004 BEHAVE training and strategy design with 7 HC staff for 5 days

*2006 training of trainers on health messages and materials - 2 per HC

ANNEX E: Final Evaluation Team Members

Name	First Name	Position	Title
. Nzibaliza	Naphtal	Directeur de la Santé, Protection de l'enfant	District de Gisagara
. Kagubare	Jean	Consultant National	UNR
. Kouletio	Michelle	Technical Advisor	USA
. Luz	Rose	CSP Coordinator	Concern/B
. Hailu	Yilma	ACD Programmes	Concern/K
. Dr Migambi	Patrick	Medical Director	Hôpital Ki
. Niyitega	François	In charge of HBM	NMCP/PN
. Ngaruye	Désiré	Superviseur	Hôpital Ki
. Kanyabute	Frédéric	Superviseur	Hôpital Ki
0. Habiyambere	Christophe	Assistant Coordinateur du CSP	Concern B
1. Rutijanwa	Bonifrida	Capacity Building Officer	Concern B
2. Muhozali	Madeleine	M&E Officer	Concern B
3. Gakera	Léonard	CBHA	Centre de de Kansi

Concern Worldwide Rwanda Child Survival Project Final Evaluation Report

Final Evaluation Briefing Participants
Kigali, August 25, 2006

1. Hailu Yilma ACD-P CW Rwanda
2. Julienne Mukarusanga CW Rwanda
3. Napthal Nzibaliza Health Director, Gisagara
4. Pascal Nkuru CW Health Activist-Kigembe
5. Madeline Muhozali CW M & E Officer
6. Christophe Habiyambere CW Asst CSP Coordinator
7. Chris Donovan IRC Country Director
8. Eddie Rogers CW Rwanda Country Director
9. Dr. Denise Ilibagiza MOH Focal person IMCI
10. Alphonsine N.habineza MOH – Nutrition
11. Chantal Nykarunzagiriza MOH – Nutrition
12. Glenn Cunnings Concern USA
13. Maurice Kwizera World Relief
14. Jean Paul Ndagijimawa World Relief
15. Stephan Bauman World Relief
16. Dr Aline Mukundwa MOH –MCH
17. Dr Jean Kagubare Consultant
18. Dr Patrick Mugambi Medical Director Kibilizi Hospital
19. Edouard Musonera CW Rwanda-Admin Coordinator
20. Consolee Hwibambe IRC Kibungo
21. Bonifrida Rutijanwa CW Rwanda Capacity Building Officer
22. Athanase Karemera District Health Director, Nyaruguru
23. Francois Niyitegeka In-charge HBM –NMCP/MOH

ANNEX E KPC Survey Report
(insert as separate document)

ANNEX F HFA REPORT

(insert as separate document)

ANNEX G : Rapid Catch Indicators & Project Summary Print-out

(printed from PDF file from CSTS database)