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

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 Kibilizi[1] (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 PNLP 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 Heath 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 PNLP 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 PNLP 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 to 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 PNLP. 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 then they could manage within hearth 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).
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(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 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 poverty[4] 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 unchartered 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, PNLP 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 PNLP'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 PNLP 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 update 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 Kibilizi 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 Communtiy-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

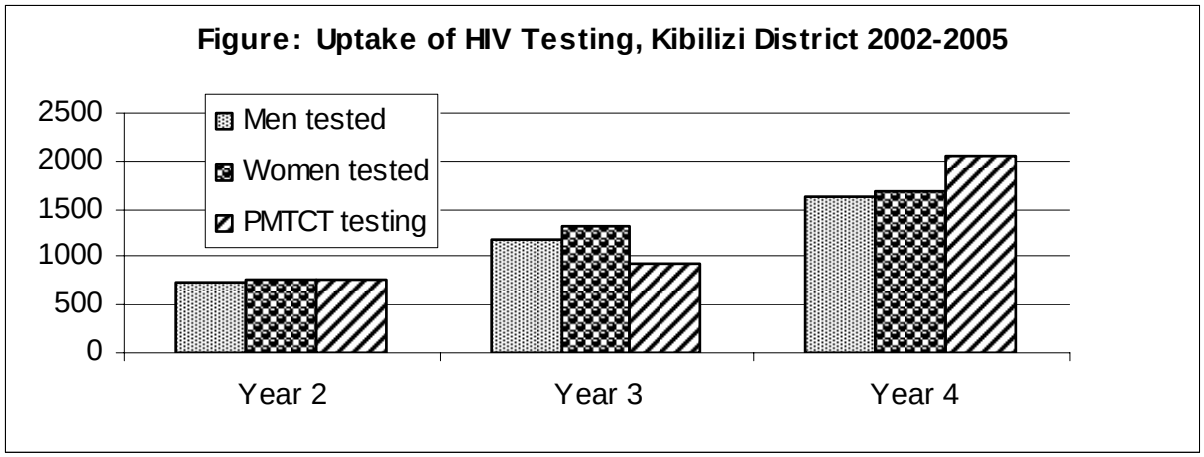
Integrating HIV & AIDS Interventions into a Child Survival Program

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 Ruhengheri 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

- 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.
- Exhange 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 form 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 nutriton 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

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)

CONCERN WORLDWIDE

Gisagara Health District (Rwanda)

CHILD SURVIVAL PROGRAM

Knowledge, Practice and Coverage
Final Evaluation

June. 2006

Prepared by: Dr Jean Kagubare, Consultant

SUMMARY

The main objective of this study conducted in June 2006 was to evaluate the knowledge, practices and coverage of services (KPC) of the population in Gisagara (former Kibilizi) district, with regard to socio- medical objectives and indicators, as defined in the child survival project. This study aims specifically at: (i) identifying the social and demographic characteristics of the target population; (ii) describing the status of health services with regard to knowledge, practices and coverage related to the four interventions of the project, namely HIV & AIDS, malaria, nutrition and maternal and child health.

This is a cross-sectional and descriptive study, based on a household survey method. The target population consists of all households residing in Gisagara district where a sample of 420 households were randomly selected that were composed by mothers aged between 15 to 49 years who had children aged between 0 to 11 months and 12 to 23 months.

A previous KPC survey was conducted on a sample of 133 fathers who had children aged less than 5 years and of 266 mothers, which results helped to inform this KPC survey. Comparative analyses are noted in this report in reference to gender questions.

The main results in the four interventions of the project are the following:

1) Malaria

- 76% of mothers know at least 2 danger signs in sick children that required an urgent medical attention and 80% know that they should seek care within first 24 hours of symptoms of fever
- 58% of children aged between 0 to 23 months who had fever were treated within 24 hours.
- 52% (versus 4.3% in 2001) of mothers have impregnated mosquito nets
- 47% (versus 0.9% in 2001) of the children slept under mosquito net the night before the survey.

2) HIV & AIDS

- 81% (versus 24.4% in 2001) of mothers know at least 2 means for prevention HIV transmission
- 81% (versus 9.5% in 2001) of mothers were tested for HIV, against 48% of fathers.
- 60% (versus 0% in 2001) of mothers recived PMTCT screening services

3) Nutrition

- 87% (versus 62.6% in 2001) of children aged between 6-23 months received vitamin A in the last six months
- 65% (49.2% in 2001) of children aged between 0-23 months were weight during the last 3 months before the survey
- 36% (versus 38% in 2003) of children aged 12-23 months had chronic malnutrition (<80% weight-for-age)
- 76% (versus 64% in 2001) of children were fully immunized before the first birthday

4) Maternal and Child health

- 40% (versus 34% in 2001) of mothers received at least 2 doses of Tetanus Toxoid vaccine during their last pregnancy (verified by card)
- 55% (versus 19.0% in 2001) of mothers delivered at a health facility
- 50% (versus 8% in 2001) of mothers were assisted by a qualified health personnel during their last delivery
- 15% (versus 2.8% in 2001) of mothers know at least 3 danger signs during the post natal period
- 41% of mothers with children 0-11 months had received 2 or more intermittent presumptive treatments for malaria during their last pregnancy (confirmed by card)

In **conclusion**, the "Child Survival" program in Gisagara district attained and even exceeded its objectives. The knowledge of the population, with regard to the four interventions, has considerably improved; however the practice remains a challenge. This study will provide CONCERN/RWANDA and the Gisagara district health staff with

relevant information on the success and/or failure of the strategies and actions that were carried out, and will allow them to set up new strategies, in order to solve the remaining problems and future challenges.

Summary key indicators (KPC survey June 2006):

Questionnaire Ref Number(s)	Indicator	Numerator	Denominator	Total in Percentage	95% Confidence Interval	
					lower bound (%)	upper bound (%)
	Nutrition					
67/(91)	Child weighed in past 3 months (as per card)	273	420	**65.0**	60.4	69.6
68	Child aged 12-23 months received Vitamin A in past six months	141	162	**87.0**	81.9	92.2
92	Child underweight (-2 SD WFA) (12-23 months)	85	235	**36.0**	29.9	42.1
93	Child 6-23 months with MUAC <125mm	32	265	**12.1**	8.2	16.0
	HIV & AIDS					
25	Mother correctly cites at least two known ways to reduce risk of transmission of HIV & AIDS	338	420	**80.5**	76.7	84.3
26	Ever tested for VCT	339	420	**80.7**	76.9	84.5
27	Ever tested for VCT in Gisagara/Kibilizi District	299	420	**71.2**	66.9	75.5
37	Ever participated in PMTCT	252	420	**60.0**	55.3	64.7
	Malaria					
22	Household has a mosquito net (observed)	219	420	**52.1**	47.4	56.9
16+17	Mosquito net treated in past 6 months or long lasting net (17 seulement)	195	240	**81.3**	76.3	86.2
18	Child slept under treated mosquito net last night	195	420	**46.4**	41.7	51.2
70	Mother knows child with fever requires treatment within 24 hours	336	420	**80.0**	76.2	83.8
71	Mother who correctly cites at least two signs that febrile children need urgent attention.	232	420	**55.2**	50.5	60.0
73+75	Child had fever in past 2 weeks	88	420	**21.0**	17.1	24.8
751+76+77	Proportion of children with fever received malaria treatment within 24 hours (in past 2 weeks)	51	88	**58.0**	47.6	68.3
	Maternal & Newborn Care					
32 +45	Attended at least one ANC visit in last pregnancy (verified on card)	405	420	**96.4**	94.7	98.2
45	Attended 4 or more ANC visits (verified on card)	18	232	**7.8%**	4.3	11.2
35	Mother received 2 or more doses of TT during last pregnancy (self report)	262	420	**62.4**	57.7	67.0

Questionnaire Ref Number(s)	Indicator	Numerator	Denominator	Total in Percentage	95% Confidence Interval	
					lower bound (%)	upper bound (%)
44	Mother received 2 or more doses of TT during last pregnancy (as per card)	169	420	**40.2**	35.5	44.9
41	Mothers with child 0-11 months received 2 or more presumptive malaria treatments during last pregnancy (self report)	94	248	**37.9**	31.9	43.9
47	Mothers with child 0-11 months received 2 or more presumptive malaria treatments during last pregnancy (Verified on card)	64	158	**40.5**	32.9	48.2
48	Deliveries at health institution	230	420	**54.8**	50.0	59.5
49	Delivery by a skilled attendant (doc, nurse, aux)	209	420	**49.8**	45.0	54.5
(49.5)/ 50	Deliveries by trained TBA	104	420	**24.8**	20.6	28.9
51	Used a clean delivery kit if delivered in the home	43	202	**21.3**	15.6	26.9
52	Mother knows 3+ danger signs during labor & delivery	63	420	**15.0**	11.6	18.4
53	Infant breastfed within first hour of birth	258	420	**61.4**	56.8	66.1
54 / (57)	Mother received postnatal check within 48 hours of delivery (checked at least one danger sign)	151	420	**36.0**	31.4	40.5
58 / (61)	Baby received newborn check within 7 days of delivery (checked at least one danger sign)	117	420	**27.9**	23.6	32.1
62	Mother received postpartum vitamin A	237	420	**56.4**	51.7	61.2
63	Mother knows 3+ danger signs during postpartum period	18	420	**4.3**	2.3	6.2
64	Mother know 3+ danger signs for newborn	71	420	**16.9**	13.3	20.5
	Additional Rapid Catch Indicators					
9	Mothers with child age 0-23 months who was born at least 24 months after the previous surviving child (child spacing)	110	139	**79.1**	72.4	85.9
9	Mothers with child age 0-23 months who was born at least 36 months after the previous surviving child (child spacing)	56	139	**40.3**	32.1	48.4
66	Infants aged 0-5 months exclusively breastfed in the last 24 hours	151	155	**97.4**	94.9	99.9
66	infants age 6-9 months receiving breastmilk and complementary foods	35	71	**49.3**	37.7	60.9
72	Mothers who know at least **two** signs of childhood illness that indicate the need for treatment	317	420	**75.5**	71.4	79.6

Questionnaire Ref Number(s)	Indicator	Numerator	Denominator	Total in Percentage	95% Confidence Interval	
					lower bound (%)	upper bound (%)
90	Children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday [denominator=those with cards]	108	143	**75.5**	68.5	82.6
90	Children age 12-23 months who received a measles vaccine (card or self reported, denominator=all children)	137	168	**81.5**	75.7	87.4
79	Sick children age 0-23 months who received <u>increased fluids</u> during an illness in the past two weeks	24	147	**16.3**	10.4	22.3
80	Sick children age 0-23 months who received continued feeding during an illness in the past two weeks	27	144	**18.8**	12.4	25.1
85 / (88)	Mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	56	420	**13.3**	10.1	16.6
	Other					
12	Household currently mutuelle subscribe (card holder in 2006)	197	420	**46.9**	42.1	51.7
23	Mothers who state that a she either alone or jointly with her husband decide(s) on expenditure of the household income.	221	420	**52.6**	47.8	57.4
24	Mothers who state that the decision of place of delivery for pregnancy resides with her alone or jointly with her husband.	336	420	**80.0**	76.2	83.8

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Our special thanks go particularly to the people of Gisagara district (old Kibilizi district) in the Southern province, as well as local leaders and health officials, whose support was decisive in realizing this study.

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ABREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
ANC:	Antenatal Clinic
ARI :	Acute respiratory infections (ARI)
CA:	Catchment Area
CHW:	Community Health Worker
COSA :	Health Committee
CSP :	Child Survival Program
DHS:	Demographic and Health Survey
DMHT:	District Management Health Team
EPI:	Expanded Program of Immunization
FARN :	Hearth
FP:	Family Planning
HBM:	Home Based Malaria Treatment
HC :	Health Centre
HF:	Health Facility
HIS:	Health Information System
HIV:	Humane Immunodeficiency Virus
KPC :	Knowledge, Practice, and Coverage
Minisanté:	Ministry of Health
PLWHA:	People Living with HIV & AIDS
PMTCT:	Prevention of Mother To Child Transmission
STD:	Sexually Transmitted Diseases
TBA:	Traditional Birth Attendant
TT:	Tetanus Toxoid
USAID :	United States Agency for International Development
VCT :	Voluntary Testing Center
WHO:	World Health Organization

I. INTRODUCTION

CONCERN/RWANDA has set up a project entitled "CHILD SURVIVAL" in the district of Gisagara (former Kibilizi district), in the Southern Province of Rwanda, since October 2001, for 5 years period, financed by the USAID. This project has as overall objective to contribute to the reduction in maternal and child mortality and morbidity, and increased life expectancy in Kibilizi District, Butare Province of Rwanda.

Concern Worldwide US, Inc. is an affiliate of Concern Worldwide which began activities in Rwanda in 1994. It is in 1998 that CONCERN/RWANDA started its technical assistance programme to the health district of Kibilizi (now Gisagara).

To achieve its goal, the project worked out an action plan with strategies based on the objectives of the Ministry of Health as well as those of the USAID in Rwanda. The main strategies are primarily based on the staff capacity building in health services and of community based organizations in order to encourage them to participate in the prevention of health problems and addressing the local population health issues.

An initial evaluation of the knowledge, practices and coverage (KPC) status of the Kibilizi district population was done at the beginning of the project, in 2001, in order to allow planning and resources allocation, related to the district health issues, specifically for the mothers and children, but also to establish basic indicators for the best follow-up and the evaluation of the program. The present study aims at evaluating the project impact on the status of knowledge, practices and coverage (KPC) of the people living in Gisagara district, at the end of the project.

II. BACKGROUND

The former health district of Kibilizi (currently called Gisagara) is located in the Southern province and includes seven Health centres which provide a minimum package of health activities to the population. The district hospital is not operating yet but its construction is almost completed. The district of Kibilizi covers two administrative districts (Mugombwa and Kibingo), with 43 sectors and 142 cells (the smallest administrative unit). In 2006, the total population is estimated at 178,502 inhabitants.
The former health district of Kibilizi was characterized by high child and maternal morbidity and mortality due mainly to poor access and quality of health services.

The ***CONCERN*** programme entitled " Child Survival" in Kibilizi, used three main strategies to achieve its goal: (1) Building the management capacity of the District health staff and supervisors; (2) Developing the capacities of the health staff of the district in the four program fields of intervention; and (3) to strengthen the district's community outreach approach.

The four major fields of interventions of the program are:

1. HIV & AIDS prevention
2. Malaria Control
3. Nutrition and prevention of chronic malnutrition
4. Mother and Newborn care.

The expected program outputs are:

1) Improved district health management systems
2) Improved quality of services on the four selected interventions
3) Increased health care coverage
4) Decentralized and institutionalized health services
5) Sensitized District Health Team and population on gender health issues
6) Empowered population for disease prevention and risk reduction
7) Improved Concern-CSP planning, design, and management capacity

This study's main objective is to describe the overall status of knowledge, practices and coverage (KPC) of the Kibilizi district population with regard to social and health objectives and indicators, such as defined by the project. This study aims specifically at:
(i) identifying the social and demographic characteristics of the concerned population;
(II) describing the status of health services with regard to knowledge, practices and coverage, related to the four intervention fields, namely HIV & AIDS, malaria, nutrition and maternal and child health.

This study will give CONCERN/RWANDA and the health staff, and the community based associations, the impact of their interventions and also the challenges which still remain ahead.

III. METHODOLOGY

This is a cross-sectional and descriptive study, based on a household survey method. The target population consists of all households residing in the Kibilizi health district.

1. Sampling

This KPC study targets all the households of the former Kibilizi district. This survey used a two-stage cluster sampling design. The first level involved sampling sectors, and the second level involved cells. The selection of sectors and cells were selected proportionally to their size. Ten of these sectors were selected and an average of 3 cells within each sector, for a total of 30 cells to be surveyed (see annex 1).

The sample size of this study was determined by using the formula for the simple random sampling for proportion estimate, and was adjusted for the design effect of a two-stage cluster sampling design. The sample size was obtained using the formula:

$n \geq [Z2\ (P)\ (1\text{-}P)]/D\ 2$

n= minimum sample size required

Z= z-score corresponding to the level of confidence

P= estimated prevalence coverage rate level to be investigated.

D= minimum tolerable error

For this survey, we used: Z=1.96; P=0.5 and D= 10%. The minimum sample size obtained is 97 (n=97). With the design effect of 2, the minimum sample size is 194. To be conservative, a total of 420 households were selected.

Thus, 14 households were surveyed in each of the 30 cells of Gisagara district. Selection of households was done as prescribed in the EPI Coverage Survey Training Manual (2):

1) Having reached the survey site, the team supervisor asked the local leader to lead the team to the center of the cell.
2) Once at the center, the team leader spun a pen or bottle to choose a direction.

3) The first household in that direction was chosen to participate in the survey.
4) Once the household was selected, the team chose the closest house in any direction as the next target.

The target population was composed of mothers aged 15-49 years which had children aged 0-23 months.

2. Development of questionnaires

One questionnaire was used for this KPC survey to collect data on mothers with children aged between 0 and 23 months old. This questionnaire was developed by the team of the CONCERN / Rwanda project, entitled "Child Survival " and used several questions from IRC questionnaire concerning the sick child module. Questions are related to the indicators in connection with the four program intervention areas. The questionnaire was tested beforehand on the field; the corrections made following this pre-test were included to the final version (see annex 2).

These questionnaires have allowed collecting individual information on mothers and their child, but also about the household characteristics, such as assets, the main source of water, the type of toilets, the type of floor, the main source of cooking energy. The questionnaire also contains more specific questions about the surveyed households such as knowledge, practice and health services coverage.

In summary the questionnaire has questions on the following topics:

1. General questions:
    - Social and demographic characteristics
    - Possession of assets and other durable goods
    - Health mutual
    - Gender aspects
2. Specific questions:
    - Antenatal consultation
    - Antenatal, per partum and postpartum consultation
    - Breastfeeding and feeding practices related to children
    - AIDS and STD

- Immunization
- Children's diseases
- Children nutritional state and growth monitoring
- Breastfeeding and nutrition
- Diarrhea diseases
- New born babies' health care
- Deliveries

3. Training of investigators and field data collection

A dozen of surveyors and 4 supervisors (from the National University of Rwanda/school of Public Health) were recruited and trained during two days in field survey techniques. The training courses related primarily to: 1) the objectives of the assessment, 2) the objectives and indicators of the "Child Survival" project 3) sampling and data collection techniques, 4) data quality control and data collection 5) member's role and responsibilities.

After the training, a pre-test was carried out at Gisagara center and this site was selected because it is located close to the training site and also because it does not belong to the survey area.

For field data collection, surveyors were divided into 3 teams composed with 3-4 surveyors and one supervisor each. Each team was assigned specific sectors and cells to be surveyed. Data field collection was conducted during the period from 03 to 15 July 2006. As planned, all the 420 households were successful surveyed.

It should be noted that CONCERN/RWANDA had received a written approval from the mayor of Gisagara district before the beginning of the survey. Moreover, a verbal consent from each person interviewed was given before the beginning of the survey.

4. Data entry and Analysis

The data entry was carried out by the 3 investigators, using MS WORD and EPIDATA software. The internal coherence of the answers was checked before the analysis of the data. The statistical analyses were done MS EXCELL and STATA (version 7) software.

The data entry begun immediately on the first of field survey in order to correct potential mistakes as early as possible, and was completed one day after the end of the field survey. The internal coherence of data was checked before analysis. The statistical analyses were done using SPSS and EPINIFO 2000 software. The anthropometric analysis was done using EPIINFO 2000 in reference to CDC/WHO (3). The method used in analysing the population's wealth index was comparable to the one used in the Demographic and Health Survey (DHS) of Rwanda in 2000 (4).

The results of anthropometric analysis for weight-for-age are based on international standards of 1978. Data analyses using the new 2006 WHO/UNICEF standards are also available.

A dissemination of preliminary results was held with CONCERN team and other key partners of the district which comments and recommendations were integrated into the final report.

5. Equity Analysis

An assets index was constructed using principal components analysis on clustering of key assets of electricity, furniture, motorcycle, television, dwelling construction materials, sanitation facilities and cooking fuel. This was based on the construct developed for the 2001 Rwandan Demographic & Health Survey. Results for key project indicators were stratified among five asset quintiles which depicted the poor and richest households represented in the survey.

There are several steps to the construction of a wealth index: determination of indicator variables, dichotomization (i.e. variables that take a value of 1 if the household owns the asset and 0 if the household does not), calculation of indicator weights and the index value, and calculation of distribution cut off points. The wealth index is constructed using the method of principal components following SPSS factor analysis procedure which assign each asset a weight (factor score). In this process only the first scores were standardized in relation to a normal distribution with a mean zero and standard deviation of one. Each household was then assigned standard scores for each asset calculated based on the formula. Results are described in section 8 of this report.

IV. RESULTS

1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF HOUSEHOLDS

A total of 420 mothers and their children aged 0-23 months were surveyed during this study.

1.1 Age of Mothers and Children Surveyed

As shown in table 1, the average age of the surveyed mothers is 30 years and for children it is 9 months. The majority of the mothers (27%) are aged between 25 and 29 years, followed by the group of those aged between 30-34 and 20-24 years respectively. The mothers aged less than 20 years and those over 40 years constitute only less than 15 % of the total. Children aged less than one year constitute over 61% of the total.

Table 1: Age of mothers and children

Age group of mothers (years)	**Number**	**Percent**
<20	23	5.5
20-24	88	21.0
25-29	115	27.4
30-34	91	21.7
35-39	62	14.8
40-44	35	8.3
45-49	6	1.4
Age group of children (months)		
0-5	166	40
6-11	90	21
0-11	***256***	***61***
12-23	164	39
Total	**420**	**100**
Average of age for mothers :	*29.74 years*	
Average age for children	*9 months*	

1.2 Childbirth spacing

Among the children surveyed, the proportion of boys and girls are 52% and 48% respectively. The average number of children aged less than 5 years per household is 1.5 children. In regard to child spacing, we notice that the proportion of mothers who have children born within 24 months interval is 79% and this rate goes down to 40% when the interval is of 36 months as shown in the table 2 below.

Table 2: Childbirth spacing

Category	Number	Total	Percent
Sex			
Girls	202	420	48.1
Boys	218	420	51.9
Mothers with children aged 0-23 months born within 24 months interval	110	139	79.1
Mothers with children aged 0-23 months born within 36 months interval	56	139	40.3
Average number of children aged < 5 years per household			1.5

1.3 Living conditions of the households

Information concerning the living conditions of the households was collected during this survey, and particularly for the possession of modern assets (radio, bicycle, telephone, motor bike, vehicle, etc.) and the housing characteristics, such as the type of toilets, the type of drinking water supply, the cooking energy source, and the type of floor of the main house. These characteristics are used as proxies for the socio-economic status of households and are comparable to the ones used for the DHS Rwanda 2000(5).

Type of materiel owned by households

As shown in table 3 below, 46% of households have a radio and 19% have bicycles. Less than 1% of the households have other durable assets such as a telephone and motorcycle. No household has refrigerator nor vehicle, or electricity

Table 3: Proportion of households with durable assets

Type of assets	Number	Total	Percent
Radio	194	420	46.2
Bicycle	78	420	18.6
Telephone	6	420	1.4
Television	1	420	0.2
Refrigerator	0	420	0.0
Motorcycle	3	420	0.7
Vehicle	0	420	0.0
Electricity	0	420	0.0

Type of toilets in the households

As described below in table 4, almost 80% of the households use traditional pit latrines, 13% of the households use improved latrine, and only 0.2% of the households have a flush toilet. 6% of households have no toilet and use the bush.

Tableau 4: Toilet Type

Type of Toilet	Number	Total	Percent
Traditional pit latrine	335	420	79.8
Improved pit latrine	54	420	12.9
Flush toilet	1	420	0.2
Other latrine	3	420	0.7
No latrine, use bush	27	420	6.4

Drinking water

Most of the drinking water comes from protected public well (90%) and unprotected public well (15.4%), and only small minority get water from the river as it is indicated in the table 5 below.

Table 5: Drinking water supply

Source of drinking water	Number	Total	Percent
Open water source	12	420	2.9
Public fountain, protected	379	420	90.2
Public fountain, unprotected	29	420	6.9

Cooking energy source

The main source of energy used by almost 99% of the households to cook their food is firewood, and only 0.2% of the households use straw and/or leaves for their cooking. Please note in table 6 below that none the surveyed households use gas, electricity, or charcoal.

Table 6: Source of cooking energy

Main source of cooking energy	Number	Total	Percent
Wood	419	420	99,8
Other	1	420	0,2

Type of floor

As shown in table 7 below, the majority of the households (76%) have a dirt/sand floor, 11% of the households have cement, a small proportion of households (1-2%) has floor with dung/manure, and 7% have other types of floor.

Tableau 7: Type of floor

Type de floor	Number	Total	Percent
Dirt/sand	321	420	76.4
Dung/manure	8	420	1.9
Cement	48	420	11.4
Tile	4	420	1.0
Carpet	9	420	2.1
Other	30	420	7.2

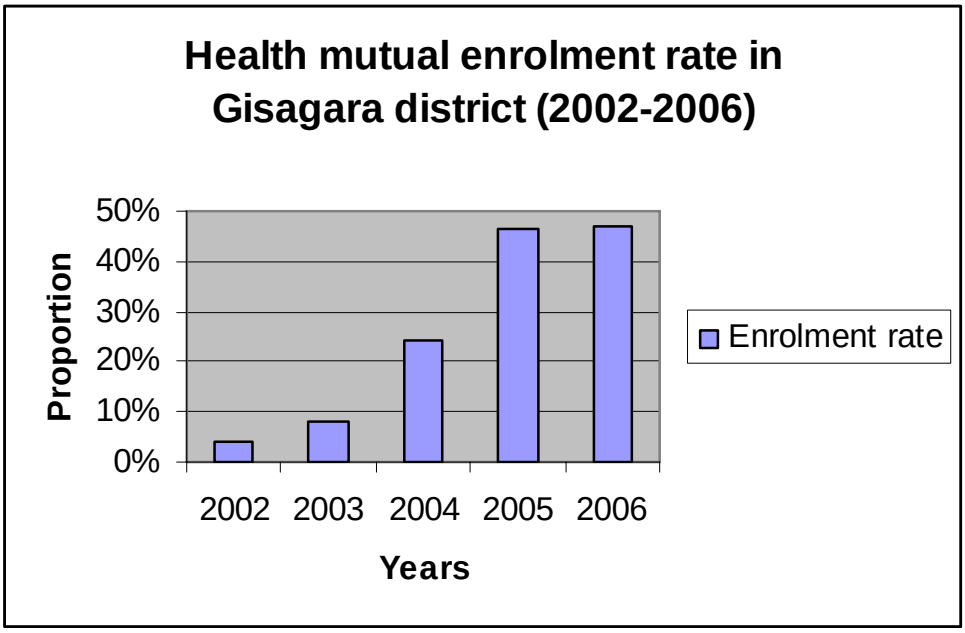
1.4 Health mutuelle enrolment

During the course of this survey, information was collected on households' enrolment into health mutual. As described in table 8 and figure 1, the average enrolment rate rose from 4% in 2002 to 47% in 2006. Households which have ever participated in health mutual is 62% with a subscription to a health insurance scheme at the time of the survey amounts to 66% but only 46% of them could be verified on cards, and the raison of this difference being that some members had expired membership for 2005 but do consider themselves as current members.

Table 8: Enrolment in health mutuelle in Gisagara District (2002-2006)

Category	2002	2003	2004	2005	2006
Members	17	34	102	195	197
Total households	420	420	420	420	420
Enrolment rate	***4.0%***	***8.1%***	***24.3%***	***46.4%***	***46.9%***

Figure 1: enrolment rate in Gisagara district de 2002-2006 (on cards)



1. 5 Gender and decision making

The issue about decision-making in a couple was also tackled at the time of this survey. As shown in the table 9, the decision to use the money from family production is often taken by the man in 42%, by the couple in 43%, and by the woman alone in 11% of the cases. The proportion of mothers who decide alone and or with their husband is 54%.

Tableau 9: Decision of use of money from family production

Category	Mothers (%) N=420	Fathers (%) N=133	Total (%)
Fathers	178 (42.4)	57 (43.2)	235 (42.5)
Mothers	57 (13.6)	3 (2.3)	60 (10.8)
Couple	164 (39.0)	72 (54.5)	236 (42.7)
Mother or couple	221 (52.6)	75 (56.3)	296 (53.5)
Others	19 (4.5)	0 (0.0)	19 (3.4)
Don't know	2 (0.5)	0 (0.0)	2 (0.4)
Total	**420**	**133**	**553**

With regard to making a decision about the place of delivery, mothers stated that they are the only ones who make the decision in 40% versus 11 % for fathers alone. The decision is jointly taken by the couple in 40% of the case. The decision is either taker by mothers or jointly with the fathers in 80% of the case. The health workers, the traditional birth

attendants and other family members intervene in the decision making process concerning the delivery site in very few cases (2.6%) as shown in table 10.

Table 10: Decision making for Place of Delivery

Category	Mothers (%) N=420	Fathers (%) N=133
Father	48 (11.4)	64 (48.1)
Mother	168 (40.0)	24 (18.0)
Couple	168 (40.0)	38 (28.6)
Mother alone/ or with husband	336 (80.0)	63 (47%)
Health worker	4 (1.0)	2 (1.5)
Traditional birth attendant	9 (2.1)	3 (2.3)
Step mother	5 (1.2)	1 (0.8)
Others	11 (2.6)	1 (0.8)
Don't know	7 (1.7)	0 (0)

2. MALARIA

2.1 Household knowledge and bed net utilization

The knowledge of households of malaria and use of anti-malaria preventive measures was assessed during this investigation. Table 11 presents a summary of the results obtained. 55% of mothers interviewed could name at two danger signs in children with fever that require immediate medical attention, and 80% of mothers know that a sick child with fever need treatment within 24 hours. More than 54% of mother stated that they had malaria during their last pregnancy, but only 40% of them slept under bed net at least for 3 months period.

The proportion of households with bed nets (physical verification) is 52%. Mother who declared that their child slept under bed net the night before the survey is 47% and the proportion of treated bed nets (including the long lasting net) within the last 6 months period is 81%.

Table 11: Malaria knowledge and practice of households

Category	Number	Total	Percent
Mothers who know at least 2 danger signs in children with fever that require immediate medical attention	232	420	55
Mother who that a sick child with fever needs to be treated within 24 hours	336	420	80
Mothers who had malaria during the last pregnancy	227	420	54
Households with bed nets (verified)	219	420	52
Children who slept under bed net the previous night	198	420	47
Mothers who slept under bed nets at least for 3 moths during the last pregnancy	171	420	40
Treated bed nets (long lasting) within 6 months period	195	240	81

2.2 Type and duration of malaria treatment

Among the children who had malaria during the last 2 weeks, 46% of them were treated within 24 hours, the majority were treated in the health facility (45%), 24% were treated by community distributors of anti-malaria drugs, 5% by pharmacists, and 5% by traditional healers as shown in table 12. 15% of children with fever were never treated.

Table 12: Place of treatment for fever

Place of treatment	Duration of treatment		Total (%)
	<= 24 hours	> 24 hours	
Distributors of anti-malaria drugs	14	7	21 (24%)
Pharmacies	2	2	4 (55%)
Health facility	21	19	40 (45%)
Traditional healers	1	3	4 (5%)
No treatment received	0	13	13 (15%)
Total (%)	**38 (46%)**	**44 (54%)**	**82 (100%)**

The types of drugs prescribed are Amodiaquine alone (12%) or in association with Fansidar (8%), Fansidar alone (4%), Quinine (17%) and Paracetamol (22%). The duration of treatment varied between 3 and 7 days. Drugs that were used came from health facilities (63%) and from community distributors (18%) and only small percent of drugs were bought from private pharmacies (8%) or from traditional healers (4%) as described in the table 13 below. It was noted that many mothers don't know the actual

name of specific drugs taken but rather identify them by color or packaging which many result in false reported treatments.

Tableau 13: Type and duration of treatment against fever

Treatment received	Distributors of anti-malaria drugs	Private Pharmacies	Health facility	Traditional healers	Others	Total	Average duration (days)
Fansidar + Amodiaquine	3	1	3	0	1	**8 (8%)**	3
Fansidar	3	1	0	0	0	**4(4%)**	4
Amodiaquine	7	1	5	0	0	**13 (12%)**	3
Quinine	1	0	17	0	0	**18 (17%)**	7
Paracetamol	3	0	19	0	1	**23 (22%)**	4
Other	2	6	23	4	5	**40 (38%)**	
Total	**19 (18%)**	**9 (8%)**	**67 (63%)**	**4 (4%)**	**7 (6%)**	**106 (100%)**	

3. HIV & AIDS AND STD

3. 1 Households knowledge about HIV and STD

Table 13 summarizes the level of knowledge and practices concerning HIV and STD of the surveyed population. We notice that the majority of mothers (81%) know at least two means of preventing HIV transmission and the common means of prevention are abstinence, fidelity, avoiding promiscuity, and the use of condom. Most of the mothers (86%) had heard about sexually transmitted disease (STD) but only 35% could cite correctly at least 2 common signs of an STD. The major signs that were cited are pain while urinating, genital discharge, and genital ulcers.

Table 14: Knowledge about HIV and STD

Category	Number	Total	Percent
Knowledge of signs			
Mothers who know at least 2 means of prevention of HIV transmission	338	420	81
Mothers who heard about STD	360	420	86
Mother who know at least 2 signs of STD	148	420	35
Means of prevention against HIV			
Abstinence	103	420	25
Faithfulness	100	420	24
Condom	163	420	39
Avoid of sharp objects	234	420	56
Avoid charlatans	132	420	31
Avoid promiscuity	296	420	71
Don't know	13	420	3

Signs of STD			
Pelvic pain	35	420	8
Genital ulcer	103	420	25
Vaginal discharge	9	420	2
Infected discharge	149	420	36
Pain while urinating	118	420	28
Hematuria	12	420	3
Don't know	119	420	28

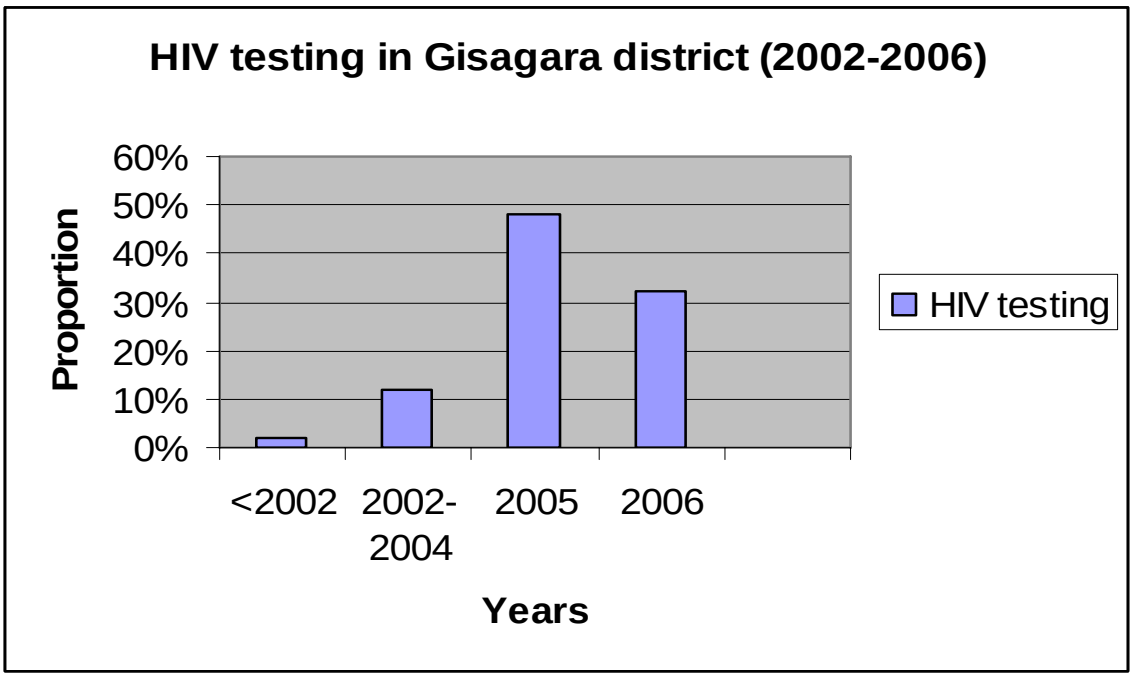
3.2 HIV Testing

As indicated in table 14 and figure 2, 81% of mothers have been tested for HIV in voluntary counselling and testing center (VCT) versus 41 % of fathers. The proportion of pregnant women who attended PMTCT counseling & testing service are 60%. HIV testing is often done at a VCT center in Gisagara district (71). The proportion of mothers who underwent HIV testing has increased over the years from 3% in 2001 to 48% in 2005. Note that in 2006 at the time of this survey, HIV testing rate was at 32%, this is because it was in mid-year and that the rate will likely increase during the remaining months of the year.

Table 15: HIV testing at VCT and PMTCT sites

Category	Mothers (%) N= 420	Fathers (%) N=133
Mothers/fathers who were tested for HIV in VCT sites	339 (80.7%)	64 (48.1%)
Mothers/fathers who were tested for HIV in VCT sites in Gisagara district	299 (71.2%)	40 (63.5%)
Mother who attended PMTCT services	252 (60.0%)	n/a

Figure 2: HIV testing in Gisagara district (2002-2006)



3.3 Support to People Living With HIV & AIDS

As indicated in table 15 below, the majority of mothers stated they were willing to help the people living with HIV & AIDS (PLWHA) and said to do the following: moral comfort (78%), feeding (27%), accompany to the health facility (15%). Less than 10% were ready to wash their clothes. Only 2% said that they would not want to help a sick AIDS patient.

Table 16: Type of support to People Living with HIV & AIDS

Category	Number	Total	Percent
Feeding	115	420	27
Washing clothes	34	420	8
Washing	24	420	6
Accompany to the health facility	63	420	15
Moral comfort	329	420	78
Nothing	7	420	2

4. NUTRITION, VITAMIN A SUPPLEMENT, AND IMMUNIZATION

4.1 Children nutritional status

It is known that the nutritional status of a child influences significantly its health. The malnourished child runs a higher risk of morbidity and mortality. This study conducted anthropometric measurement on children aged 0-23 months. Measurements of the weight and the size of their brachial perimeter (MUAC) were systematically taken to evaluate their nutritional status. These data were used to calculate indices for weight compared to the age (weight-for-age or WFA) and the MUAC compared to the age (weight-for-age). The latter was used as proxy to estimate the acute malnutrition in children (3).

The indices of WFA are expressed in terms of a number of units of standard deviation as compared to the median of the International Reference Population of NCHS/CDC / WHO or Z-score. Children who fall under less than two standard deviations below the median of the reference population are considered as malnourished, while those who are at less than three standard deviations below the median are considered to be severely malnourished (3,5).

Standard categories used for MUAC for children aged between 6-23 months are:
1) MUAC <110 mm: severe malnutrition; 2) MUAC 110-125 mm : moderate malnutrition, and 3) MUAC >125 mm : normal nutrition status. Children with MUAC below 125 mm are considered to have a delayed growth which is a sign of acute malnutrition usually due to bad feeding or disease.

In our sample, we note that 19.5% of children aged between 0-23 months have malnutrition (< 2 SD WFA) of which 12.1% have moderate malnutrition (children 12-23 months) and 7.4% with a severe malnutrition. For comparison to midterm results (2004 – 36%), the proportion of children aged 12-23 months with (< 2 SD WFA) was 36%.

As for those children with MUAC < 125 mm, we note that 12.1% aged between 6 to 23 months (total number is 265) have delayed growth; 11.3% with moderate form and 0.8% with severe form. Oedema in children was found to be present in 1.7% of cases.

Malnutrition distribution is almost equal for both boys and girls. Table 17 gives the Z-score for the weight-for-age and the MUAC.

Table 17: Nutritional status for children aged 0-23 months.

Category	Boys	Girls	Total	% total
Weight-for-Age (WFA)				
- 2 SD WFA (12-23 months)	29	22	51	12.1
- 3 SD WFA (0-23 months)	15	16	31	7.4
Normal (0-23 months)	152	177	329	78.3
Normal (12-23 months) (N=164)	n/a	n/a	105	64
MUAC : 6-23 months (N=265)				
>125 mm	117	116	233	87.9
110-125 mm	8	22	30	11.3
<110 mm	1	1	2	0.8
Oedema				
No (0-23 months)	199	214	413	98.3
Yes (0-23 months)	2	5	7	1.7

NB : SD = Standard Deviation

4.2 Growth Monitoring

Motoring of growth in children allows detecting children with a risk of having malnutrition and this help to take appropriate preventive measures to prevent malnutrition. During this survey, investigators had to verify this information on the children health cards. After analyzing the data, we noticed that 65% of the children were had their weight checked during the last 3 month before this survey, and 29 % of children aged 12- 23 months (42 out of 143 children, and verified on cards) had received de-worming drug, mebendazole.

4.3 Infant and Young Child Feeding

Breastfeeding provides the child with a passive immunity which helps to protect him from several diseases. In Rwanda, the Ministry of Health recommends that mothers exclusively breastfeed their child as of from the first hour and during the first six months after the delivery. In addition, the Ministry advises mothers to continue breastfeeding their children up to two years old of age, with the introduction of food supplements from the age of 6 months.

The survey was carried out in all children aged from 0 to 23 months, and as shown in table 18 below, it was noticed that 96% of the children were being breastfed at the time of the survey of which 40% were still exclusively breastfed with only mother's milk.

The type of food supplements that the children received a day before the survey is basically made of cereals and starchy vegetables (41%). A quarter of the children had green vegetables, 17% had animal proteins, and only 12% had fruits. Food supplements were gradually introduced according to the age of a child; 1-2% of children at 0-5 month, 30% in children 6-11 months and 65% in children 12-23 months.

Table 18: Breastfeeding and food supplement

Category	0-5 months	6-11 months	12-23 months	Total	% (n=420)
Breastfeeding now	153 (38.1%)	92 (22.9%)	157 (39.1%)	**402**	**96%**
Food received previous day					
Milk alone	151 (89.3%)	11 (6.5%)	7 (4.1%)	**169**	**40%**
Water	0 (0.0%)	3 (18.8%)	16 (81.3%)	**16**	**4%**
Food supplement					
Starchy Vegetables	2 (1.1%)	39 (22.4%)	133 (76.4%)	**174**	**41%**
Cereals	3 (1.7%)	53 (30.5%)	118 (67.8%)	**174**	**41%**
Green vegetables	1 (1.0%)	24 (22.9%)	80 (76.2%)	**105**	**25%**
Animal Proteins	1 (1.4%)	23 (32.9%)	46 (65.7%)	**70**	**17%**
Fruits	1 (2.0%)	19 (37.3%)	31 (60.8)	**51**	**12%**

4.4 Immunization coverage and Vitamin A supplement

An adequate immunization coverage and Vitamin A supplement is essential to protect the child against most of childhood diseases and visual loss. In our survey, the study on the immunization coverage was limited to the children aged between 12 and 23 months which total was 168 children out 420.

More than 85% of children (143 out 168 children) had their child health cards at home at the time of the survey, which helped to confirm the self reporting of the mothers about the immunization status of their children. Table 18 gives a summary of immunization coverage of children on basis of self reporting, on cards and before the first birthday.

Immunization coverage in children is very high and overall above 96% except for measles and polio 1-3 which (91-95%). Children who are fully immunized are 76%. 42% of children had received Vitamin A supplement.

Table 19: Immunization coverage of children aged 12-23 months

Vaccines	Number	% immunization on the day of survey (cards: Total 143)	% immunization (total 168)	% immunization on the first birthday (cards: total 143)
BCG	140	97.9%	83.3%	96.5%
Polio 0	131	91.6%	78.0%	90.2%
Polio 1	138	96.5%	82.1%	95.1%
Polio 2	141	98.6%	83.9%	97.2%
Polio 3	139	97.2%	82.7%	95.8%
DPT 1	138	96.5%	82.1%	95.1%
DPT 2	141	98.6%	83.9%	97.2%
DPT 3	138	96.5%	82.1%	95.1%
Measles	137	95.8%	81.5%	91.6%
Children fully immunized[1]	***114***	***79.7%***	***62%***	***76%***
Vitamin A : 6-23 month	**141/162**	**87.0%**		

[1] *Child is fully immunized if he receives BCG, Polio1-3, DPT1-3, and measles vaccine*

5. MATERNAL AND CHILD HEALTH

5.1 Antenatal Consultation

Antenatal visit (ANC) is important since many conditions and diseases related to pregnancy can be detected and treated earlier on. As indicated in table 19A below, the number of the antenatal visits is very high because more than 96% of mothers surveyed declared that they had at least an antenatal visit during their last pregnancy, and those who self reported to have had more than four ANC are estimated at 27% versus 7% verified on cards.

Tetanus Toxoid (TT) Vaccine is given to pregnant women to prevent neonatal tetanus, which is one of the major neonatal mortality. It is advised that the mother receives at least two anti-tetanus injections during her pregnancy or only one if she already received an injection at the time of the previous pregnancy. The proportion of the mothers who received at least 2 doses of TT during their last pregnancy is 40.2%.

Tableau 19A : Antenatal Visits and Services

Category	Number	Total	Percent
Had at least one ANC during the last pregnancy	405	420	96%
Had at least 4 ANC during last pregnancy (self report)	18	253	7%
Had at least 4 ANC during last pregnancy (on cards)	68	420	27%
Had 2 TT during last pregnancy (on cards)	169	420	40%
Had 2 TT during last pregnancy (self report)	262	420	62%
Had at least two preventive treatments for malaria during the last pregnancy (mothers with child 0-11 months only) verified on card	64	158	41%
Had received iron tablets during the last pregnancy	138	420	33%
Average months of iron treatment during the last pregnancy	1.5 months		

43% of mothers stated that they took malaria preventive treatment during their last pregnancy and among this group only 6.4% took iron during more than two preventive

treatments. Iron supplement for pregnant women reduces the risks of anaemia, and anemia is often associated with a high maternal and neonatal mortality. We notice that 38% of mother had iron supplement during their last pregnancy for an average duration of 1.5 months.

Table 19B shows the relationship between the number of ANC and place of delivery, and we can see that mothers who had more than 4 ANC tend to deliver less at home (33%) as compared to those who had less than 4 ANC (42-60%), and also mothers with more than 4 ANC tend to deliver at referral hospital (11%) than those with less ANC (6%).

Table 19B: Number of ANC and place of delivery

	Place of Delivery					Total
Number of ANC (on cards)	**Home**	**Public HC**	**Missionary HC**	**Referral hospital**	**Other**	
4+ANC	6 (33%)	4 (22%)	6 (33%)	2 (11%)	0 (0%)	**18 (7%)**
3 ANC	34 (42%)	21 (25%)	19 (23%)	6 (7%)	2 (2%)	**82 (32%)**
2 ANC	68 (60%)	16 (14%)	18 (16%)	7(6%)	4(4%)	**113 (45%)**
1 ANC	17 (43%)	12 (30%)	8 (20%)	2 (5%)	1 (3%)	**40 (16%)**
Total	**125 (49%)**	**53 (21%)**	**51 (20%)**	**17 (7%)**	**7 (3%)**	**253 (100%)**

5.2 Delivery

As indicated in table 20A, more than fifty percent of the surveyed mothers (55%) stated that they had delivered at a health facility (48% in a health center and 7% in a hospital), and 45% had delivered at home. Concerning the assistance received during delivery, half of the mothers were assisted by the health personnel, 25% by a TBA, and 25% by either the mother herself (11%), by parents (5%), by husband (5%), or by others (5%).

Table 20A: Place and assistance during delivery

Category	Number	Total	Percent
Place of delivery			
Home	190	420	45%
Health center	230	420	55%
Hospital	30	420	7%
Assistance during delivery			

Category	Number	Total	Percent
Health staff	209	420	50%
Trained TBA	104	420	25%
Herself	48	420	11%
Parents	23	420	5%
Husband	15	420	4%
Others	21	420	5%
Use of delivery kits (among home deliveries)	43	202	21%
Mothers who know at least 2 danger signs during delivery	197	420	46%
Mothers who know at least 3 danger signs during delivery	63	420	15%

Twenty-one percent of mothers who delivered at home declared to have used a clean delivery kit. Sixty-one percent (258/420) of all mothers, regardless of place of delivery, breastfed the newborn within one hour of birth.

The knowledge of mothers of the danger signs during delivery was assessed in this survey, and we noticed that 46% of mothers knew at least 2 danger signs of delivery. Table 20B summarizes the knowledge of danger signs during labor and delivery that require urgent medical attention, and most of the signs that were cited are retention of placenta more than 30 minutes (53%), haemorrhage (48%), and prolonged labor of more than 8 hours (29%).

Table 20B: Knowledge of danger signs during labor that require medical attention

Category	Number	Total	Percent
Fever	18	420	4.3%
Chills	5	420	1.2%
Labor of more than 8 hours	123	420	29.3%
Convulsions	12	420	2.9%
Loss of lot of blood	202	420	48.1%
Severe low abdominal pain	55	420	13.1%
Retention of placenta of more than 30 minutes	221	420	52.9%
Facial and hand oedema	2	420	0.5%
Others	100	420	23.8%

5.3 Post natal care

36% (151 /420) of mothers received a post natal visit within 48 hors after delivery, and this visit was done by a health personnel (61%), 21% by a pharmacist, and 18% by a TBA. This visit consisted of checking the haemorrhage (43%), the presence of fever (42%), as indicated in table 21. More than half of the mothers received Vitamin A supplement after delivery.

Table 21: Consultation of mother in post partum

Category	Checking of haemorrhage	Checking of fever	Checking of anemia	Checking vaginal discharge	Total	% of total
TBA	16	2	0	1	**19**	**18%**
Pharmacist	0	22	0	0	**22**	**21%**
Health staff	29	20	7	8	**64**	**61%**
Total	**45 (43%)**	**44 (42%)**	**7 (7%)**	**9 (9%)**	**105**	**100%**

28% (117 out of 420) of new born had medical visit within a week after delivery, and as indicated in table 22, this visit was done by a TBA (52%) and by a heath staff (43%), with the aim of checking if the new born was feeding well (47%), to check the weight and the breathing (9%), to check if the umbilicus was not infected or fever (5%).

Table 22: Consultation of newborn

Category	Checking feeding	Weighting	Checking umbilicus	Checking Breathing	Checking Fever	Nothing or other	% of total
TBA	32	1	3	1	3	21	**61 (52%)**
Health staff	23	9	2	9	2	5	**50 (43%)**
Other personnel	0	0	0	0	0	6	**6 (5%)**
Total (%)	**55 (47%)**	**10 (9%)**	**5 (4%)**	**10 (9%)**	**5 (4%)**	**32 (27%)**	**117 (100%)**

Knowledge of danger signs during the post natal period

The knowledge of the mother of the danger signs during the post natal period for the mother and the new born was assessed in this survey. As indicated in table 23, 28% of

mothers know at least 2 danger signs for mothers in post partum period that require urgent medical attention. Danger signs for mothers that were the most cited are haemorrhage (88%), fever (16%), and genital tear (14%). 47% of mothers know at least 2 danger signs in new born that require medical attention and danger signs most cited are refusal to breastfeed (58%), fever (47%), and dyspnoea (21%).

Table 23: Knowledge of danger signs during the post natal period

Category	Number	Total	Percent
Danger signs for mother			
Fever	66	420	16%
Chills	22	420	5%
Smelly vaginal discharge	5	420	1%
Genital tear	58	420	14%
Loss of lot of blood	371	420	88%
Don't know	21	420	5%
Other	82	420	20%
Know at least 2 danger signs that require medical attention	118	420	28%
Danger signs for new born			
Do not breast feed	242	420	58%
Sleepy	9	420	2%
Fever	119	420	47%
Dyspnoea	87	420	21%
Vomiting	29	420	7%
Convulsions	18	420	4%
Diarrhea	26	420	6%
Born with less than 2.5Kg	13	420	3%
Do not know	26	420	6%
Other	159	420	38%
Know at least 2 danger signs that require medical attention	197	420	47%

6. TREATMENT OF CHILDHOOD ILLNESSES

6.1 Prevalence of most frequent childhood illnesses

Adequate treatment of malaria, acute respiratory infections, and diarrhea diseases can greatly reduce infant mortality in developing countries. In this survey, information was collected on the prevalence and treatment of these diseases in children. As indicated in table 24, the proportion of children aged between 0-23 months that were sick during the

last 2 weeks is estimated at 35%. Treatment of sick children was done by health personnel (42%), by community health workers (16%), and by pharmacist agents and traditional healer (<5%). Overall, the most common symptoms or diseases seen in children aged between 0-23 moths fever (60%), diarrhea (40%) et vomiting (21%), et la cough (37%) ; and dyspnoea (8%).

Table 24: Prevalence and treatment of childhood diseases

Category	Number	Total	Percent
Sick during the last 2 weeks	147	420	35.0%
Who first treated the child			
None	34	147	23.0%
Traditional healer	5	147	3.4%
TBA	0	147	0.0%
Community health worker (distributors of malaria drugs)	23	147	15.5%
Pharmacist agent	7	147	4.7%
Health staff	62	147	42.2%
Other	16	147	10.8%
Type of symptoms of diseases			
Fever	88	147	59.5%
Cough	55	147	37.4%
Dyspnoea	12	147	8.2%
Vomiting	31	147	21.1%
Diarrhea	58	147	39.5%
Bloody diarrhea	2	147	1.4%
Others	33	147	22.2%

6.2 Type and quantity of food received during illness

As indicated in table 25 below, the proportion of sick children that had fluid more than usual is 16%, less than usual (43%), as usual (31%), and 9% of children never received any fluid during their illness. During illness, we notice that 19% of children had food as or more than usual, 14% had food as usual versus 34% who had less than usual. 26% of children were exclusively breastfed. After the illness, 25% of children had food more than usual, 38% had food as usual versus 17% who had less than usual. 16% of children were exclusively breastfed

Table 25: Type of food received during illness

Category	Number	Total	Percent
Fluid received during illness			
None	13	147	8.8

Less than usual	64	147	43.5
As usual	46	147	31.3
More than usual	*24*	*147*	*16.3*
Quantity of food received during illness			
Exclusively breastfed	37	144	25.7
None	31	144	21.5
Less than usual	49	144	34.0
As usual	*20*	*144*	*13.9*
More than usual	7	144	4.9
As or more than usual	27	144	18.8
Quantity of food received after illness			
Exclusively breastfed	23	144	16.0
None	3	144	2.1
Less than usual	25	144	17.4
As usual	55	144	38.2
More than usual	36	144	25.0
Do not know	2	144	1.4

6.3 Treatment of diarrhea diseases in children

Diarrhea diseases

Diarrhea in children can rapidly lead to a severe dehydration and can cause death if corrective measures are not taken promptly. It is recommended, in child diarrhea, to increase liquid consumption and more specifically the use of oral rehydration salt (ORS).

As indicated in table 26, almost a third of the children with diarrhea had used ORS. The proportion of children with diarrhea who used modern drugs or traditional medicine is 29%. We noticed that 21% of children who had diarrhea never took any treatment.

Table 26: Treatment of diarrhea diseases

Category	Number	Total	Percent
SRO	19	58	33%
Antibiotics and anti-diarrhea drugs	17	58	29%
Water	1	58	2%
Other (Traditional medicine)	17	58	29%
None	12	58	21%

Malaria

This disease was described in details in the previous chapter of this report.

7. PERSONAL HYGIENE

Hygiene conditions and more specifically the use of the soap by the households were assessed in this survey. As indicated in table 27, 80% of the mothers reported that they had soap at home but only 21% had actually soap after inspection. More than three quarters of mothers declared to have used soap the previous day. Mothers declared that they wash their hands with soap before cooking meals (28%), before breastfeeding (18%), after cleaning a child who defecates (13%), after being to the toilet (25%). Less than 4% of mothers had never used soap to wash their hands. Toilets were present in 92% of the households, and after inspection, we noticed that only 6% of households had adequate system for washing hands.

Table 27: Personal hygiene and usage of soap

Category	Number	Total	Percent
Have soap at home (self report)	335	420	79.8%
Have soap at home (verified)	90	420	21.4%
Used soap the previous day	321	420	76.4%
When soap is used :			
Before cooking meals	117	420	27.9%
Before breastfeeding	76	420	18.1%
Before feeding the child	70	420	16.7%
After cleaning the child who went to toilet	56	420	13.3%
After being to the toilet	103	420	24.5%
Never washed hands with soap	15	420	3.6%
Others	27	420	20.5%
Have toilet at home	388	420	92%
Adequate hand washing system	24	420	6%

8. Equity of Health Coverage and Practices

The following table demonstrates equity of health coverage and practice for key project indicators. Wealth index is measure based on the principle parts analysis using household assets, construction material and water and sanitation as proxies for wealth. The measures are based on the Demographic & Health Survey methodology used by ORC Macro.

Child survey (June 2006): Summary indicators

Questionnaire Ref Number(s)	Indicator	Numerator	Denominator	Total in Percentage	WEALTH INDEX COVERAGE				
					Q1	Q2	Q3	Q4	Q5
	Nutrition								
68	Child aged 12-23 months received Vitamin A in past six months	141	162	**87.0**	92.3	89.7	76.5	88.9	89.3
	HIV & AIDS								
26	Ever tested for VCT	339	420	**80.7**	76.5	83.7	76.7	76.3	90.4
37	Ever participated in PMTCT	252	420	**60.0**	57.6	60.5	54.7	60	67.5
	Malaria								
18	Child slept under treated mosquito net last night	198	420	**47.1**	83.3	75	78.9	69.2	92.3
	Maternal & Newborn Care								
45	Attended 4 or more ANC visits (verified on card)	18	232	**7.8**	10.2	6.7	7.7	2	8.6
44	Mother received 2 or more doses of TT during last pregnancy	262	420	**62.4**	66.3	67.9	60.5	61.7	68.6
48	Deliveries at health institution	230	420	**54.7**	36.5	44.2	46.5	53.8	65.1
51	Used a clean delivery kit if delivered in the home	43	202	**21.3**	24.1	20.8	21.7	24.3	20.7
53	Infant breastfed within first hour of birth	258	420	**61.4**	61.2	53.5	58.1	62.5	72.3
62	Mother received postpartum vitamin A	173	418	**41.4**	48.2	32.6	48.8	35.9	41.4
	Additional Rapid Catch Indicators								
12	Household currently mutuelle member	197	420	**46.9**	36.5	37.2	46.5	50	65.1

V. DISCUSSION

The analysis of indicators related to the four main interventions of the program "Child Survival" shows that there is a big improvement as compared to the before the implementation of the project (KPC survey of 2001) as summarized in the annexes 3 and 4 of this report.

For **malaria**, knowledge and practices of households' for the prevention of malaria had improved. We noted that more than 53% of the mothers know at least 2 danger signs in children that require urgent medical attention. Currently, 52% of the mothers (versus 4.3% in 2001) have bed nets and 47% of their children slept under the bed net the previous night (versus 0.9% in 2001). The knowledge and practices indicators in the former Kibilizi district are higher than the national average, as compared to the results of the DHS of 2005 where less than 5% of households had bed net and only 21,4% of the mothers who had bed net at home stated that their children sleep under bed net (6, 7).

For **HIV & AIDS and STD**, the knowledge of the population also has improved, and we notice that more than 80% of mothers know at least 2 means of preventing HIV transmission compared to 24% before the beginning of the project. The other important improvement is the proportion of mothers who were tested for HIV; the rate is now 81% as compared to 9.5%, before the beginning of the project. The proportion of mothers who attended PMTCT service is 60% in 2006 versus 0% in 2001. Though a large majority of the people (86%) has heard about STD, only a third of them could cite at least 2 signs and or symptoms.

For **nutrition**, 36% of the children aged between 11 and 23 months were malnourished with 7% of them being severely malnourished. This rate is slightly below the one that was observed in the mid-term evaluation of the project (38%), but this prevalence of malnutrition has exceed the original target of the project which was to attain at least 45% of children with chronic malnutrition. This rate is higher than the national average which is estimated at 22% in 2005 (6, 9). Big improvement in immunization of children was done, and the proportion of children who are fully immunized rose from 64% in 2001 to 80% in 2006. (6, 10). The Vitamin A supplement has remained relatively high at 62% in

2006 versus 63% in 2001. Growth monitoring of children also improved and the proportion of children who were weighted in the previous 3 months rose from 49% in 2001 to 65% in 2006.

The proportion of deliveries at a health facility increased from 19% to 48% from 2001 to 2006. This improvement could have been greater but financial accessibility to modern health services remains a principle reason for home deliveries. Participation in mutuelles is an important solution to explore.

For **maternal and child health**, it is noted that more than 50% of deliveries are attended by skilled personnel as compared to only 8% in 2001. 40% of the women received at least 2 doses of TT vaccine during their last pregnancy as compared to 24% in 2001. Preventive treatment against malaria and anemia during pregnancy rose from 33% to 43%. Deliveries at health facilities rose has doubled raising from 19% in 2001 to 55% in 2006. This proportion can be improved but it is hampered by the lack of financial means of the population to access health care services. Enrolment into health mutual is one of the solutions that need to be explored.

Diarrhea disease prevalence is still high which is due mainly to poor hygiene of the population. Only few households (6%) have adequate hand washing systems at point of latrines.

VI. CONCLUSION & RECOMMENDATIONS

In **conclusion**, the "Child Survival" program in Gisagara district attained and even exceeded its objectives. The knowledge of the population, with regard to the four interventions, has considerably improved; however the practice remains a challenge. This study will provide CONCERN/RWANDA and the Gisagara district health staff with relevant information on the success and/or failure of the strategies and actions that were carried out, and will allow them to set up new strategies, in order to solve the remaining problems and future challenges.

With regard to results obtained and constraints encountered, the following recommendations are made:

- Bed net use, though satisfactory, needs to be improved in order to increasing its usage especially among children
- PMTCT services use has increased but has not reached the level of other centers and this requires to increase the sensitization and the extension of PMTCT services to all the health facilities in Gisagara district
- Delivery at health facilities has increased significantly during these last years but there is still extra effort to make so that the adequate level is attained. Enrolment in health mutual which increases health service utilization is one of the strategies to explore.
- Prenatal care service utilizations is still low and will require collaborative efforts from health staff and community volunteers in order to increase awareness of the population
- Prevalence of diarrhea disease remains high and requires new strategies especially in improving the hygiene practices of the population.

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VIII. ANNEXES

Annex 1: Sampling Framework of Sectors and Villages

SECTEURS	Cellules	Population	Team
1. Kansi			**Day 1**
	- Agatare	2.429	*Team 1*
	- Rugarama		*Team 2*
	- Kanserege		*Team 3*
2. Kibilizi			**Day 2**
	- Gisororo	2.503	*Team 1*
	- Burashi		*Team 2*
	- Gitwa		*Team 3*
	- Henene		**Day 4** Team 1
3. Nyaruhengeri			**Day 3**
	- Gitwa	3.972	*Team 1*
	- Mudoboli		*Team 2*
	- Bucyo		*Team 3*
	- Murambi		J4 Team 2
4. Kibingo			**Day 5**
	- Impinga	2.503	*Team 1*
	- Gisozi		*Team 2*
5. Nyanza			**Day 6**
	- Ruvugizo	4.660	*Team 1*
	- Nyamihatsi		*Team 2*
	- Akagarama		*Team 3*
6. Kivuru			***Day 7***
	- Mbuye	4.235	*Team 1*
	- Akabuye		*Team 2*
	- Mujahu		*Team 3*
	- Mugobe		*Day 4 Team 3*
7. Cyumba		4.774	**Day 8**
	- Musatsi		*Team 1*
	- Gitwa		*Team 2*
8. Kibayi			
	- Rwahambi	3.143	***Day 5*** *Team 3*
	- Kibayi		***Day 8*** *Team 3*
9. Mukindo			**Day 9**
	- Nyabisagara	6.602	*Team 1*
	- Rususa		*Team 2*
	- Kanage		*Team 3*
10. Nyabitare			**Day 10**
	- Nyirakanywero	3.984	*Team 1*
	- Mutobo		*Team 2*
	- Hemba		*Team 3*

Annex 2: Questionnaire

République Rwandaise	**Concern Worldwide**	**CLUSTER N^{O}|____| |____|**
Ministère de la Santé	**Kibilizi Child Survival**	
Gisagara District	**Program**	**QUESTIONNAIRE N^{O}|____| |____||____|**

CHILDREN 0-23 MONTHS (AMEZI: 0 – 23)

	ITALIKI Jour	UKWEZI Mois	UMWAKA Annee
ITARIKI Y'IBAZWA DATE D'INTERVIEW	|____|	|____|	|____|

IZINA RY'UBAZA (Nom de l'enquêteur): …….	
IZINA RY'UMUGENZUZI (Nom du Superviseur): ……..	
IBITARO BYA KIBILIZI (Hôpital de Kibilizi) : ……	
IVURIRO (CS): …….	AKARERE KA GISAGARA *(District administratif)*
UMURENGE (Secteur) : ……..	AKAGARI (Cellule) : …….

UBWUMVIKANE

Muraho, Nitwa _____ nkaba nkora ----------. Tura kora ubushakashatsi k'ubuzima bw'ababyeyi n'abana. Twabasabaga kudufasha muri ubwo bushakashatsi. Nashakaga kubabaza ibibazo bijyanye n'ubuzima bwanyu hamwe n'ubwabana banyu. Ibizavamo bizafasha inzego z'ubuzima, hamwe n'abaterankunga kurushaho gukemura ibibazo by'ubuzima muhura nabyo. Ntabwo mbafata igihe kirekire. Ibyo mutubwira byose biraba ibanga hagati yacu.

Kudusubiza ni ubushake bwanyu, kandi mufite uburenganzira bwo kudasubiza ikibazo mwasanga kibabangamiye. Gusa turizera ko ntakibazo bibatera

Hari ikibazo mwaba mufite kubyo mbabwiye?

IYO USUBIZA YANZE, MUSHIMIRE, UMUSEZERE, UGENDE. MUGIHE YEMEYE, MUBAZE NIBA AFITE UMWANA URI HAGATI Y'AMEZI 0—23. NIBA ARI NTAWE, MUSHIMIRE, UMUSEZERE, UGENDE. NIBA AHARI, TANGIRA IBIBAZO KUVA KURI NOMERO YA MBERE.

IBIBAZO BYEREKEYE UMUBYEYI/ *QUESTIONS SUR LA MERE ELLE-MEME*

1	MWITWA BANDE? *Quel est votre nom?* ……	
2	NYIRI URUGO NI NDE? Quel *est le nom du chef de menage ?*……	
3	MUFITE IMYAKA INGAHE ? *Quel âge avez-vous ?*	UMUBARE |____| |____| A*ns*
4	MUZI GUSOMA? *Savez-vous lire?*	0. OYA/ *Non* 1. YEGO/*Oui*
5.	MUBYO MUTUNZE HABA HARIMO IBI BIKURIKIRA? (*Lequel* de ce *matériel disposez vous, dans votre ménage*)	a. Inyakiramajwi/Radio Oui / Non b. Igare/Bicycle Oui / Non c. Telefone/ou cellulaire Oui / Non d. Television Oui / Non e. Frigo Oui / Non f. I pikipiki/ Motorcycle Oui / Non g. Imodoka/ Voiture/camion Oui / Non h. Amashanyarazi/ Electricité Oui / Non
6.	MU RUGO RWANYU MUKORESHA UMUSARANE BWOKO KI? (*Quel type de toilette principale disposez-vous ?)*	1. Umwobo usanzwe wubakiye /*Une fosse arabe couverte de poutres* 2. Umusarane wa Kijyambere / *Une fosse améliorée couverte de dalle bétonnée* 3. Umusarane bakoresha amazi / *Toilette avec chasse d'eau* 4. Ubundi bwoko (bivuge / préciser) /*Autre type, préciser.* _____ 5. Ntawuhari, mu rutoki cg mu gihuru / *Inexistante, se débrouille dans la nature.*
7.	AMAZI MUNYWA N'AYO MUKORESHA MUYAVOMA HE? (*Avez-vous une source principale d'eau potable ?)*	1. Umugezi utemba/ *Eau de rivière courante* 2. Amazi y'imvura /*Eau de pluie* 3. Ivomo rusange rya Robine /*Robinet public* 4. Iliba rusange ritunganijwe neza(Kano) /*Une fontaine publique bien aménagée*

		5. Iliba rusange rititaweho neza / *Une fontaine publique non aménagée* 6. Iliba bwite ritunganijwe neza / *Une fontaine privée bien aménagée* 7. Iriba bwite ridatunganijwe neza. /*Une fontaine privée non aménagée* 8. Amazi meza azanwa ni tiyo mu kigo /*Eau potable dans la résidence dans un tuyeau* *9.* Amazi meza azanwa ni tiyo mu rugo /*Eau potable dans l'habitation par un tuteau* *10. If has bottled water for drinking water/Eau embouteillee* *11. if gets water from a tanker truck/Eau du camion citerne* 12. Indi soko y'amazi / *Autre source d'eau*_____
8a.	IMYUBAKIRE YO MU NZU IMBERE (AHA, NI BYIZA KUHAREBA NIBA BISHOBOKA, NIBA BIDASHOBOKA UKABAZA) (le type de pavement principal de la maison principale)	1. Ni ibyondo / *Le sol non pavé* 2. Hahomesheje amase / *lissé avec la bouse* 3. Harimo isima /*pavé avec ciment* 4. Harimo ama Karo / *sol carrelé* 5. Hakoreshejwe imigano cyangwa urubingo/ *fait avec des bambous ou autre branchage* 6. Imbaho z'ibiti / *fait avec les planches de bois* 7. Ibindi/ *autre, préciser*_____
8b.	MUKORESHA IKI MURI URU RUGO MU GUTEKA IBIRIBWA? (Quelle est votre source d'énergie principale dans la cuisson des aliments ?)	1. Inkwi / *Bois de chauffe* 2. Biogaz 3. Nyiramugengeri / *la turbe* 4. Rechaud Kerosene / 5. Gaz 6. Amashanyarazi / *Electricité* 7. Amakara y'ibiti. / *charbon de bois* 8. Ibindi / (bivuge) *Autre, préciser* _____

IBIBAZO BYEREKEYE ABANA/ *QUESTIONS SUR LA SANTE DES ENFANTS*

9.	HARI ABANDI BANA MUFITE BARI MUNSI Y'IMYAKA ITANU? *Avez-vous d'autres enfants ages de moins de 5 ans* *NB : Mettre leurs dates de naissance et souligner l'enfant sélectionné pour l'enquête âgé de 0-23 mois? Si deux enfants ages de 0-23 mois, sélectionner un par hasard (utiliser une pièce de monnaie)-*			IGIHE YAVUKIYE/*Date de naissance*							
				ITALIKI Jour		UKWEZI Mois		UMWAK Année			
			1.								
			2.								
			3.								
			4.								
10.	UMWANA URI HAGATI Y'AMEZI 0 -23 YITWA NDE ? *Comment s'appelle votre enfant age de 0 -23 mois ……*										
11.	IGITSINA *Le sexe de l'enfant séléctionné*	F. UMUKOBWA/ *Fille* M. UMUHUNGU/*Garçon*									
12a	Umuryango wawe wigeze uba mu bw'isungane mu kwivuza bita mitiweli? Niba ari Yego ni ryari? (*Votre ménage a-t-elle déjà fait partie d'une mutuelle de santé)* *Encercler toutes les années ou l ménage était membres d'une mutuelle.*	0. OYA/ *Non* 1. YEGO/*Oui* *(Niba ari yego, garagaza umwaka aho hepfo) :* ***2002 2003*** ***2004 2005 2006***									
12b	If yes, please ask to see the card/ si oui , verifier la carte de mutuelle	1. Card verified for all years stated above/carte verifiee pour toutes les années 2. Card verified but not for all periods indicated above./carte verifiee mais pas pour toutes les périodes 0. no card available /carte non disponible									

IBIBAZO BYEREKEYE MALARIA /*QUESTIONS SUR LE PALUDISME)*

13.	MURAYIFITE ? Avez-vous une moustiquaire dans votre maison ?	0. OYA Non → 1. YEGO Oui
14.	Where did you get the net ? Ou l'avez vous acheter?	1. Market 2. FOSA 3. Neighbor/friend 88. IBINDI/Autre _____
15.	How long ago did you get your net ? pendant combien de temps possedez vous la moustiquaire?	__ __ ans __ ___ mois

16.	IRAKARIHIJE? NI UBUHE BWOKO ? *Est-t-elle traitee?*	0. OYA/ *Non* → 18 1. YEGO*/Oui* 2. Ubwoko buza bukarihije*/Long lasting* → 18 99. NTABIZI */Ne sait pas* → 18
17.	MUHERUKA KU YIKARISHYA RYARI? *Quand est-ce qu'elle a été traitée pour la dernière fois?*	1. MBERE Y'AMEZI 6 *<6 mois* 2. HAGATI Y'AMEZI 7 NA 12 3. HEJURU Y'UMWAKA 99. NTABIZI /*Ne sait pas*
18.	(KANAKA) YARAYE MU NZITIRAMIBU IRI JORO? *(Nom de l'enfant) a-t-il dormi sous la moustiquaire cette nuit?*	0. OYA/*Non* 1. YEGO/*Oui*
19.	MUTWITE (KANAKA) MWIGEZE MURWARA MALARIA? *Avez-vous attrape le paludisme au cours de la grossesse de (Nom de l'enfant)?*	0. OYA *Non* 1. YEGO *Oui* 99. NTABIZI
20.	MUTWITE (KANAKA) MWARARAGA MU NZITIRAMIBU *Quand vous etiez enceinte de (Nom de l'enfant), dormiez-vous sous une moustiquaire ?*	0. OYA *Non* → 27 1. YEGO *Oui*
21.	MWAYIRAYEMO IGIHE KINGANA IKI? *Pendant Combien de temps avez-vous dormi sous cette moustiquaire (pendant la grossesse)*	|____| Amezi /*Mois*
22.	May I see the net ? /Puis je le voir?	OYA, not acceptable/ YEGO /Oui – net verified

GENDER QUESTIONS (Established in 2nd annual report) *Les questions relatives au genre. Ibibazo bijyane n'uburinganire bw'ibitsina.*

23.	NINDE UFATA IBYEMZO CY'IMKORESHEREZE UMUTUNGO W'URUGO*?* *Qui décide de l'utilisation de l'argent qui provient de la production familiale?*	1. Umugabo/ *L'homme* 2. umugore/ *La femme* 3. Bombi/*Les deux* 88. Ibindi (bivuge) *Autres préciser)*_____ 99. Ne sait pas/*Simbizi*

24.	NINDE ICYEMEZO CY'AHO UMUGORE AGOMBA KUBYARIRA ? *Qui décide l'endroit pour l'accouchement dans votre famille?*	1. Umugabo/*Le mari* 2. Umugore ubwe/*La femme enceinte* 3.Bombi Les deux *(mari et la femme enceinte)* 4.Umujyanama w'ubuzima/ *L'animateur de santé* 5. Umubyaza wa Gihanga/*L'accoucheuse traditionnelle* 6. Nyirabukwe/*La belle-mère* 88. Ikindi/ *Autres* _____ 99. Simbizi/ *Ne sait pas*

IBIBAZO BYEREKEYE INDWARA ZIFATA MU MYANYA NDANGA BITSINA NA SIDA. *QUESTIONS SUR LES MST ET VIH/SIDA*

25	ESE WATUBWIRA UBURYO UMUNTU YAKWIRINDA KWANDURA AGAKOKO GATERA SIDA? *Comment peut-on éviter d'attraper le virus du VIH?*	a.Kwifata/*Abstinence* b. Kudaca inyuma uwo mwashakanye*/ Fidélité* c.Agakingirizo/*Condom* d.Kudasangira ibikoresho bikomeretsa /*Eviter de partager les objets tranchants* e.Kwirinda magendu/ *Eviter les charlatans* f.Kwirinda ubusambanyi/ *Eviter le vagabondage sexuel.* x. Ibindi (bivuge)/ *Autres (préciser*) _____ y. Simbizi/ *Ne sait pas*
26	SINSHISHIKAJWE NO KUMENYA IGISUBIZO WABONYE, ARIKO NKENEYE KUMENYA NIBA MWABA MWARIPIMISHIJE UBWANDU BW'AGAKOKO KA SIDA? *Avez-vous été testé sur le VIH/ SIDA*	1. YEGO/ *Oui* 2. OYA/ *Non* → Jya kuri **29**
27	MWIPIMISHIRIJE HE ? *Où avez-vous été testé?*	1. Mu Kigo gitanga inama kikanapima ubwandu bwa Sida muri rusange cyo muri Gisagara (VCT) / *Dans un des Centres VCT de Gisagara(préciser le quel)* _____ 2 . Ahandi, havuge / Ailleurs, préciser _____

28	NI RYARI MWIPIMISHIJE? /*Quand est ce que vous etes vous fait testé*	1. Uyu mwaka (2006)/ *cette année* 2. Ushize (2005)/ *l'année passé* 3. Mu myaka yashize 2-5 years/ *Dans 2 -5 ans passés* 4. Imyaka itanu irarenga/ *plus de 5 ans* 5.Ntabwo nibuka/ *Je me rappelle pas*
29	NI IKI WAKORERA UMUTURANYI WAWE MU GIHE YABA AFITE UBWANDU BW'AGAKOKO KA SIDA? *Quelle aide apporteriez-vous à votre voisin porteur du VIH/SIDA?*	a. Kumugaburira/ *Lui donner à manger* b.Kumukarabya/ *Le laver* c.Kumumesera/*Lessiver ses habits.* d. Kumujyana kwa muganga/ *Le conduire à la FOSA.* e. Kumuhumuriza/ *Le réconforter.* f. Ntanakimwe/*Rien* x. Ibindi (bivuge)/ *Autres (préciser*)_____
30	MWABA MWARIGEZE KUMVA INDWARA ZANDURIRA MU MIBONANO MPUZA BITSINA? *Avez-vous déjà entendu parler des M.S.T.?*	0. OYA/ Non 1. Yego/ Oui
31	NI IBIHE BIMENYETSO BY'INDWARA ZIFATIRA MU MYANYA NDANGA BITSINA WABA UZI ? *Quels sont les signes des M.S.T. que vous connaissez?*	a. Kubabara mu kiziba cy'inda / *Douleurs pelviennes* b. Udusebe ku myanya ndanga bitsina / *Lésions sur les organes génitaux.* c. Uruzi runuka ruva mu gitstina / *Pertes vaginales* d. Amashyira ava mu gitsina / *Pertes purilentes* e. Kunyara ukababara/ *Douleurs à la miction* f. Kunyara inkari zirimo amaraso/Sang dans les urines (*Hématurie)* x. Ibindi(bivuge) / *Autres(préciser)* _____ _____ y. Ntabizi /*Ne sait pas*

IBIBAZO BYEREKEYE IGIHE UMUBYEYI YARI ATWITE (KANAKA)
QUESTIONS SUR LA PERIODE D'AVANT LA NAISSANCE DE ((NOM DE L'ENFANT)?

32.	MUGITWITE (KANAKA) MWIGEZE MWIPIMISHA? *Avez-vous reçue une consultation prénatale pendant la grossesse de (Nom de l'enfant) ?*	0. OYA *Non* → 48 1. YEGO *Oui*
33.	MWIPIMISHIJE INSHURO ZINGAHE? *Combien de consultations prenatales avez-vous reçues?*	|__. __|
34.	MUGITWITE (KANAKA) MWIGEZE MUTERWA URUSHINGE RW' URUKINGO RWA (ˊAGAKWEGA) TETANOSI KU KUBOKO ? *Avant la naissance de (Nom de l'enfant), avez-vous recue une injection dans le bras pour vous vacciner contre le tetanos?*	0. OYA *Non* →36 1. YEGO *Oui* 2. NARAZIRANGIJE/ J*e les ai terminé*
35.	MWAZITEWE KANGAHE? *Combien de ces injections avez-vous reçues ?*	|____||____|
36.	MWABA MUZI IKIGO GITANGA INAMA KIKANAPIMA UBWANDU BW' AGAKOKO KA SIDA, KIKANIBANDA KU BAGORE BATWITE? *Connaissez-vous les centres de PMTCT?*	0. OYA *Non* →38 1. YEGO *Oui*
37.	MWABA MWARA KIGANNYE? *Avez-vous fréquenté ce centre (PMTCT)?*	0. OYA *Non* 1. YEGO *Oui*
38.	MUGITWITE (KANAKA) MWAFASHE IBININI BYONGERA AMARASO ? (byerekane) *Quand vous étiez enceinte de (Nom de l'enfant), avez-vous pris du fer ? (MONTRER L'EXEMPLAIRE)*	0. OYA *Non* → 40 1. YEGO *Oui* 99. NTABIZI →40
39.	MWABIFASHE IGIHE KINGANA IKI? *Pendant combien de temps avez-vous pris du fer?*	MUNSI Y'UKWEZI |____| AMEZI/*Mois* 99. NTABIZI/ *Ne sait pas*
40.	MUGITWITE (KANAKA) MWANYOYE IBININI BYA MALARIA ? *Avez-vous reçue des comprimes pour lutter contre le paludisme pendant la grossesse de (Nom de l'enfant) ?*	0. OYA *Non* → 42 1. YEGO *Oui* 99. NTABIZI → 42 Ne sait pas
41.	MWABIFASHE INSHURO ZINGAHE? *Combien de fois avez-vous pris des comprimes antipaludéens?*	|____|
42.	MUFITE IFISHI MWIPIMISHIRIJEHO? *Possedez-vous la fiche de consultations prenatales?*	0. OYA *Non* → 48 1. YEGO *Oui*

43.	MUSHOBORA KUYINYEREKA? *Puis-je la voir?*	0. NTIBONETSE / pas disponible→ 48 1. YEGO/ *Oui*
IBIBAZO BYO KURI NOMERO 44 BYEREKEYE INKINGO ZOSE UMUBYEYI YABA YARABONYE MUBUZIMA BWE		
44.	*REBA KU IFISHI UMUBARE W'INKINGO ZOSE Z'AGAKWEGA (Tétanos) YABONYE Regarder le nombre de VAT*	UMUBARE |____|
IBIBAZO BYO KURI NOMERO 45-47 BYEREKEYE INKINGO UMUBYEYI YABONYE ATWITE KANAKA/ *relatif aux vaccinations de la mère lors de la grossesse.*		
45.	*REBA KU IFISHI INSHURO Y'IPIMISHIJE IGIHE YARATWITE KANAKA Regarder le nombre de CPN*	UMUBARE |____|
46.	*REBA KU IFISHI IGIHE YAMAZE AFATA UTUNINI TWONGERA AMARASO/ Regarder le temps de prise du fer*	UMUBARE |____||____|
47.	*REBA KU IFISHI INSHURO YAFASHE IBININI BYA MALARIA Regarder les prises des antipaludéens*	UMUBARE |____|

IBIBAZO BYEREKEYE IVUKA RYA (KANAKA) ***QUESTIONS SUR LA NAISSANCE DE (NOM DE L'ENFANT)***

48.	UMWANA YAVUKIYE HE? *Le lieu de naissance ?*	1. I Muhira /*A la maison* 2. Ikigo nderabuzima cya Leta/ *Centre de santé public* 3. Ikigo nderabuzima cy'igenga/*Centre de santé agrée* 4. Ku bitaro bikuru/ *Hôpital de reference* 88. Ahandi /Ailleurs_____
49.	NINDE WAGUFASHIJE MU KUBYARA (KANAKA)? *Qui vous a aide pendant l'accouchement de (Nom de l'enfant age) ?*	0. YARIBYAJE *Elle même*→51 1. UMUBYEYI (nyina, nyirabukwe) *Parent* →51 2. UMUGABO WE *Mari*→51 3. UMUGANGA *Infirmier/Docteur* →51 4. UMUBYAZA WA GIHANGA *Acc. traditionnelle* 5. UNDI (muvuge) /*Autre* _____ → 51

50.	NIBA ARI UMUBYAZA WA GIHANGA, YITWA NDE_____ AKAGARI ATUYEMO _____ *Si c'est l'accoucheuse traditionnelle, quel est son nom, et sa cellule ?* YARAHUGUWE ----------→ *A-t-elle ete Formee?*	0. OYA/ *Non* 1. YEGO/*Oui* 8. NTABIZI/*Ne sait pas*
51.	YAKORESHEJE IBIKORESHO MUKURA KU IVULIRO AKUBYAZA? *Avez-vous utilise le Kit d'accouchement a domicile lors de l'accouchement de(Nom de l'enfant) ?*	0. OYA/ *Non* 1. YEGO/*Oui*
52.	MUGIHE CYO KUBYARA, NIBIHE BIMENYETSO BYAGARAGAZA INGORANE ZATUMA UMUBYEYI AJYANWA BYIHUTIRWA KWA MUGANGA? (Reka umubyeyi abyivugire) *Pendant l'accouchement, quels sont les signes qui montrent qu'il y a un probleme et que la femme doit aller au centre de sante ou a l'hôpital (Laissez la femme enumerer ces signes)*	A. UMUBYEYI UFITE UMURIRO *fievre* B. UMUBYEYI UFITE IGITENGO *frissons* C. GUTINDA KUNDA BIRENZE AMASAHA 8 *Si le travail dure plus de 8 heures* D. UMUBYEYI UHWERA *Si la femme a des convulsions* E. UMUBYEYI UVA CYANE *Si la femme perd beaucoup de sang* F. UMUBYEYI URIBWA CYANE MU IKIZIBA CY'INDA *Si la femme a des douleurs abdominales basses severes* G. IYANYUMA IRENGEJE IMINOTA 30 ITARAVUKA *Si le placenta est retenu plus de 30 minutes* H. UMUBYEYI UBYIMBAGATANYE MU MASO N'IBIKONJO *Si la femme a des* o*edemes a la face et aux mains* I. IBINDI (bivuge) *Autres (préciser*)
53.	MUMAZE KUBYARA (KANAKA) MWAMUSHYIZE KW'IBERE HASHIZE UMWANYA UNGANA NI IKI? *Apres la naissance de (Nom de l'enfant), quand est-ce que vous l'avez mis au sein pour la premiere fois?*	0. MUNSI Y'ISAHA/*Moins d'une heure* 1. AMASAHA 1- 24 / *1-24 heures* 2. HEJURU Y' AMASAHA 24 */ Plus de 24 heures*

IBIBAZO BYEREKEYE UBUZIMA BW'UMUBYEYI NA (KANAKA)
QUESTIONS SUR LA SANTE DE LA MERE ET DE (NOM DE L'ENFANT AGE DE 0-23 MOIS)

54.	MU GIHE CY'IMINSI 2 YA MBERE IKURIKIYE IVUKA RYA KANAKA HARI UWABA YARAJE KUBAKURIKIRANA, [NK'URUGERO KUREBA KO MUFITE UMURIRO CYANGWA MUVA CYANE] ? *Dans 48 HEURES suivant la naissance de (Nom de l'enfant), est-ce que quelqu'un est venu voir votre sante-par exemple pour verifiersi vous aviez de la fievre ou si vous aviez perdu beaucoup de sang ?*	0. OYA/ *Non* → 58 1. YEGO/*Oui*
55.	NI INDE ? *Qui a fait la consultation?*	1. UMUVUZI WA GIHANGA *Guerisseur traditionnel* 2. UMUBYAZA WA GIHANGA *Accoucheuse traditionnelle* 3. UMUJYANAMA W'UBUZIMA *Animateur de sante* 4. UWO MURI FORUMASIYO *Agent de la pharmacie* 5. UMUGANGA *personnel de FOSA* 6. UNDI (muvuge) *Autres (préciser)* _____ _____
56.	NIBA ARI 2 cg 3, YITWA NDE_____ AKAGARI ATUYEMO _____ *Si c'est 2 ou 3, quel est son nom, et sa cellule ?* YARAHUGUWE ? ----------→ *A-t-il ete Forme?*	0. OYA/ *Non* 1. YEGO/*Oui* 8. NTABIZI/*Ne sait pas*
57.	YAKOZE IKI (K'UMUBYEYI) ? *Qu'est ce qu'il a fait pendant cette consultation*?	A. KUREBA KO AVA CYANE *Verifier l'hemorragie* B. KUREBA KO AFITE UMURIRO *Verifier la fievre* C. KUREBA KO AFITE AMARASO AHAGIJE *Verifier l'anemie* D. KUREBA KO AFITE IGISANZA KINUKA *Verifier a un ecoulement vaginal nauseabond* E. NTACYO / *Rien* F. IBINDI (bivuge) *Autres(préciser)* _____ _____
58.	MU CYUMWERU CYAKURIKIYE IVUKA RYA KANAKA HARI UWABA YARAJE KUREBA KO AMEZE NEZA (NK'URUGERO KUREBA UMUKONDO CYANGWA KO YONKA NEZA)? *Dans la semaine suivant la naissance de (nom de l'enfant) est ce que quelqu'un est venu pour verifier sa sante, par exemple regarder le cordon ombilical*	0. OYA/ *Non* → 64 1. YEGO/*Oui*
59.	NINDE? *Qui a fait la consultation?*	1. UMUVUZI WA GIHANGA *Guerisseur traditionnel* 2. UMUBYAZA WA GIHANGA *Accoucheuse traditionnelle*

		3. UMUJYANAMA W'UBUZIMA *Animateur de sante* 4. UWO MURI FORUMASIYO *Agent de la pharmacie* 5. UMUGANGA *Infirmier/Docteur* 6. UNDI (bivuge) *Autres(préciser)* _____
60.	NIBA ARI 2 cg 3, YITWA NDE_____ AKAGARI ATUYEMO _____ *Si c'est 2 ou 3, quel est son nom, et sa cellule ?* YARAHUGUWE ? ----------→ *A-t-il ete Forme?*	0. OYA/ *Non* 1. YEGO/*Oui* 8. NTABIZI/Ne ne *sait pas*
61.	YAKOZE IKI (KURI KANAKA)? *Qu'est ce qu'il a fait pendant cette consultation*?	A. KUREBA KO YONKA NEZA *Verifier s'il tete bien* B. KUMUPIMA IBIRO/ *Peser* C. KUREBA UMUKONDO *Verifier l'ombilic* D. KURE BA UKO AHUMEKA *Verifier comment il respire* E. KUREBA KO AFITE UMURIRO *Verifier la fievre* F. NTACYO / *Rien* G. IBINDI (bivuge) / *Autres (préciser)* _____
62.	MWAFASHE AKANINI KA VITAMINE **A** HASHIZE IGIHE KINGANA IKI MUMAZE KUBYARA (KANAKA)? (byerekane) *Combien de temps apres la naissance de --- avez-vous pris une dose de vitamine A*	0. NTABYO NAFASHE/*pas* 1. MU KWEZI KUMWE/*1 mois* 2. MU MEZI ABIRI /*2 mois* 8. NTABIZI/Ne ne *sait pas*
63.	NYUMA YO KUBYARA N'IBIHE BIMENYETSO BYEREKANA INGORANE ZATUMA UMUBYEYI AJYA KWA MUGANGA *Apres l'accouchement, quels sont les signes qui montrent qu'il ya un probleme et que la femme doit aller au centre de sante ou a l'hopital ?*	A. UMUBYEYI UFITE UMURIRO *Si la femme a une fievre* B. UMUBYEYI UFITE IGITENGO *Si la femme a des frissons* C. UMUBYEYI UZANA IGISANZA KINUKA /*Si la femme a une decharge vaginale nauseabonde* D. KWANGIRIKA KW'IMYANYA MYIBARUKIRO /*Si la femme a une dechirure des organs genitaux* E. UMUBYEYI UVA CYANE *Si la femme perd beaucoup de sang* F. NTABIZI/ *Ne sait pas* G. IBINDI (bivuge)/ *Autre* _____
64.	NYUMA YO KUVUKA NI IBIHE BIMENYETSO BYEREKANA INGORANE ZATUMA UMWANA AGOMBA KUJYANWA KWA MUGANGA	A. UTONKA *Ne tete pas* B. UHONDOBERA *Difficile a reveiller* C. UMURIRO f*ievre*

	Apres la naissance, quels sont les signes qui montrent qu'il ya un probleme et que l'enfant doit aller au centre de sante ou a l'hopital?	D. GUHUMEKA INSIGANE *Respiration rapide et ou difficile* E. KURUKA IBYO AFASHE BYOSE *Vomit tout ce qu'on lui donne* F. GUHWERA *Convulsion* G. GUHITWA *Diarrhee* H. UWAVUTSE AFITE IBIRO BIRI MUNSI 2,5 KG *Nait avec moins de 2.5 Kg* I. UMWUMA *Deshydratation* J. NTABIZI *ne sait pas* K. IBINDI (bivuge)/*Autres (preciser)*_____ _____

IBIBAZO BYEREKEYE INDYO N'IPIMISHA RY'IBIRO BYA KANAKA*QUESTIONS SUR L'ALIMENTATION ET SURVAILLANCE NUTRITIONNELLE DE (NOM DE L'ENFANT)*

65.	(KANAKA) ARONKA? *Est-ce que (Nom de l'enfant) est allaite actuellement*	0. OYA/ *Non* 1. YEGO/*Oui*
66.	(KANAKA) YARIYE IKI EJO (umunsi n'ijoro)? *Qu'est-ce que (Nom de l'enfant) a recu comme alimentation hier (jour et nuit)?*	A. YARONSE GUSA/ *Allaitement seul* B. AMAZI E*au* *<u>Ibinyamisogwe</u> Legumineuses* C. IBISHYIMBO *Haricot* D. AMASHAZA *Petit pois* E. UBUNYOBWA *Arachide* *<u>Ibinyamafufu</u> Feculants* F. UBUGARI CYANGWA IMYUMBATI *Pate de manioc ou Manioc* G. IGITOKI *Banane* H. IGIKOMA *Bouillie* *<u>Imboga rwatsi</u> Legumes verts* I. ISOMBE J. IZNDI IMBOGA/ *Autres légumes* *<u>Intunga mubili zikomoka ku matungo</u> Proteines animales* K. INJANGA *Petits poissons seches* L. IFI *Poisson*

		M. AMAGI *Œuf* N. INYAMA *Viande* O. AMATA Y'INKA *Lait de vache* *<u>Imbu</u>to Fruits* P. AVOKA *Avocat* Q. IMYEMBE *Mangue* R. IPAPAYI *Papaye* S. IBINYOMORO *Prune du Japon* T. MARAKUJA *Maracouja* U. INANASI *Ananas* V. IMINEKE *Banane mure* W. IBINDI (bivuge) *Autres* _____ _____
67.	MURI AYA MEZI ATATU ASHIZE (KANAKA) YABA YARAPIMWE IBIRO? Est-ce que (Nom de l'enfant) a été pesé dans les 3 derniers mois ?	0. OYA Non 1. YEGO Oui
68.	KANAKA AHERUKA KUBONA AKANINI KA VITAMINI A RYARI? Est –ce que (Nom de l'enfant) a reçu la vit A dans les 6 derniers mois (MONTRER UN EXEMPLAIRE DE VIT A) ?	0. NTAKO YAFASHE / N'en a pas récu 1. MU MEZI 4 ASHIZE/ Dans 4mois passés MU MEZI 6 ASHIZE/ Dans 6 mois passés 2. Autre, préciser _____ 88. NTABIZI/ Ne sait pas

IBINDI BIBAZO BYEREKEYE (KANAKA) ***AUTRES QUESTIONS SUR (NOM DE L'ENFANT)***

69.	UMWANA WANYU ARAMUTSE AGIZE UMURIRO, WAMUKORERA IKI ? Qu'est ce que vous faites pour votre enfant en cas de la fièvre ?	1. NDAMUVUZA/ Je le fais soigner 2. IKINDI/ Autre _____

70.	UMUVUZA HASHIZE IGIHE KINGANA IKI AFASHWE ? Quand le faites-vous soigner ?	1. MU MASAHA 24 AFASHWE Dans les 24 heures 2. NYUMA Y'AMASAHA 24 AFASHWE Apres 24 heures 7. NTABIZI Ne sait pas
71.	NI IBIHE BIMENYETSO BIGARAGAZA UBUREMBE BW'UMWANA WAFASHWE N'UMURIRO ? Quelles sont les signes de gravite d'un enfant présentant de la fièvre ?	A. KUTONKA/ incapacité de boire-téter B. GUCIKA INTEGE/ Asthénie C. COMA/GUTA UBWENGE D. GUHWERA/ Convulsions E. KWERERUKA/Pâleur extrême/anémie F. IBINDI/ Autre _____
72.	NIBIHE BIMENYETSO BYEREKANA INGORANE ZATUMA UMWANA AGOMBA KUJYANWA KWA MUGANGA? *Quels sont les signes qui montrent qu'il y a un problème et que l'enfant doit aller au centre de santé ou a l'hôpital?*	A. NTABIZI Ne sait pas B. GUCIKA INTEGE Asthénie C. KUTARYA Ne pas manger D. KUTANYWA Ne pas boire E. GUHONDOBERA BIDASANZWE Difficile a réveiller F. UMURIRO Fièvre G. GUHUMEKA INSIGANE Respiration rapide ou difficile H. KURUKA ICYAFASHE CYOSE Vomit tout ce qu'on lui donne I. GUHWERA Convulsions J. IBINDI (bivuge) Autre (préciser)_____
73.	MU BYUMWERU BIBIRI BISHIZE, KANAKA YABA YARA RWAYE? *(Nom de l'enfant) a-–t-il ete malade pendant les 2 dernières semaines?*	0. OYA/ *Non* → ***83*** 1. YEGO/*Oui*
74.	NINDE WAMUVUYE UBWAMBERE? *Qui a traité l'enfant en premier?*	A. NTAWE */personne* B. K'UMUVUZI WA GIHANGA *Guerisseur traditionnel* C. K'UMUBYAZA WA GIHANGA *Acc traditionnelle* D. K'UMUJYANAMA W'UBUZIMA WA MALARIYA

		Animateur de sante E. UMUKOZI WO MURI FORUMASI *Agent de la pharmacie* F. KWA MUGANGA *Fosa* X. Ahandi (havuge) (p*réciser*_____
75.	YARI YAFASHWE ATE ? *De quoi etait-il malade?*	a. UMURIRO f*ievre* A. INKORORA *Toux* -→ ***79*** B. GUHUMEKA INSIGANE *Respiration rapide et difficile* → ***79*** C. KURUKA *Vomissements* --→ ***79*** D. IMPISWI *Diarrhée* --→ ***78*** E. KWITUMA AMARASO *Diarrhee sanglante* -→ ***79*** X. IBINDI (bivuge*) Autres (preciser)* _____

76. **[FIEVRE]** YABA SE YARAHAWE IYIHE MITI? *Qu'est ce qu'il a reçu comme médicament?*

Traitement reçu (encercler)	No des jours que le médicament a ete pris par l'enfant	Source du médicament utilise: 1 – Distributeur 2 – Pharmacie 3 – FOCA/Hôpital 4 – Guérisseur 88 – Autre (Préciser) 99 – Ne sait pas
0. Ntayo/ *Rien recu*	[___] [___]	[___][___]
1. Fansidar et Amodiaquin	[___] [___]	[___][___]
2. Fansidar	[___] [___]	[___][___]
3. Amodiaquin	[___] [___]	[___][___]
4. Aspirine	[___] [___]	[___][___]
5. Simbizi/ *Ne sait pas*	[___] [___]	[___][___]
6. Quinine	[___] [___]	[___][___]
88. Ikindi/*autres*_____	[___] [___]	[___][___]

77.	**[FIEVRE]** NIBA YARI AFITE UMULIRO, YATANGIYE GUHABWA IMITI NYUMA Y'IGIHE KINGANA IKI AFASHWE? *Si il avait la fièvre, le début de traitement a commence après combien d'heures de début de la fièvre*.	1. MU MASAHA 24 AFASHWE *Dans les 24 heures* 2 NYUMA Y'AMASAHA 24 AFASHWE *Apres 24 heures* 88. NTABIZI *Ne sait pas* **——> Aller au no 79 si pas de diarrhée dans les semaines passées**
78.	**[DIARHEE]** IYO (KANAKA) ARWAYE IMPISWI, MUMUHA IKI? *Qu'est-ce que vous donnez a (Nom de l'enfant) lorsqu'il a de la diarrhee?*	A. NTACYO *Rien* B. AMAZI *De l'eau* C. SRO/ SERUMU/ DARUZI *SRO* D. AMAZI ARIMO ISUKARI N' UMUNYU *Solution sucrée salee* E. AMAZI Y'UMUCERI *Eau de riz* F. IBININI *Comprimés* G. NTAYO YIGEZE ARWARA N'a pas encore eu la diarrhée X. IBINDI (bivuge) *Autre (préciser)……*
79.	**[TOUTE MALADIE]**KANAKA ARWAYE, MWAMUHAYE IBYO KUNYWA NO KONKA INCURO ZINGANA IKI MUGERERANIJE N'UBUSANZWE ? *<u>Pendant</u> la maladie de (Nom de l'enfant), lui avez-vous donne en liquide?*	1. NTABYO/*Rien* 2. NKEYA/ *Moins que d'habitude* 3. NK'UBUSANZWE/ *Comme d'habitude* 4. ZIRUSHIJEHO/*Plus que d'habitude* 5. NTABIZI/ *Ne sait pas*
80.	**[TOUTE MALADIE]** KANAKA ARWAYE, MWAMUHAYE IBYO KURYA INCURO ZINGANA IKI MUGERERANIJE N'UBUSANZWE ? *<u>Pendant</u> la maladie de (Nom de l'enfant),lui avez-vous donne en alimentation?*	1. ARONKA GUSA *Allaitemnt exclusif* 2. NTABYO/*Rien* 3. NKEYA/ *Moins que d'habitude* 4. NK'UBUSANZWE/ *Comme d'habitude* 5. ZIRUSHIJEHO/*Plus que d'habitude* 6. NTABIZI/ Ne sait pas
81.	**[TOUTE MALADIE]**KANAKA AKIRUTSE MWAMUHAYE IBIRYO INCURO ZINGAHE MUGERERANIJE N'UBUSANZWE ? *<u>Apres</u> la maladie de (Nom de l'enfant),lui avez-vous donne en*	1. ARONKA GUSA *Allaitement exclusif* 2. NTABYO/*Rien* 3. NKEYA/ *Moins que d'habitude* 4. NK'UBUSANZWE/ *Comme d'habitude*

	alimentation?	5. ZIRUSHIJEHO/*Plus que d'habitude* 6. NTABIZI/ *Ne sait pas*

UMUSARANE N'ISABUNE (*la latrine et du savon)*

83.	MUGIRA AGASABUNE HANO MURUGO? *Avez vous un savon?*	**0.** OYA / Non 1. YEGO / Oui
84.	WIGEZE UKARABA N' AGASABUNE EJO CYANGWA NONE ? *Depuis hier vous etes vous laver avec le savon?*	0. OYA / Non 1. YEGO / Oui
85	NI RYARI MUKARABA INTOKI N'ISABUNE ? *Quand est ce que vous utilisez le savon en vous lavant les mains?*	A. MBERE YO GUTEGURA IBYO KURYA *Avant la préparation du repas* B. MBERE YO KONSA UMWANA *Avant d'allaiter un enfant* **C.** MBERE YO KUGABURIRA UMWANA *Avant de nourrir un enfant* D. AMAZE GUHEHA UMWANA *Apres avoir nettoyer un enfant qui vient de déféquer* E. AVUYE KWITUMA *Apres avoir déféqué* F. SINKARABA ISABUNE / *Ne se lave jamais les mains avec du savon* G. IBINDI (bivuge) / *Autres (préciser)* :_____
86.	NSHOBORA KUREBA UMUSARANE URUGO RUKORESHA?/ *Je peux voir la toilette que dispose votre ménage*	0. OYA / Non -→ Fin d'enquête 1. YEGO / Oui
87.	[MUKIRI AHO BITUMA, MUBAZE] "MUSHOBORA KUNYEREKA AHO MUKARABIRA INTOKE NIBYO MWABA MUKORESHA MUKARABA?"*Etant encore sur les lieux,*	1. YEGO / OUI 5. Si AHABUGENEWE , *pas commode*-→ 89 0. NTA RUHUSHYA, *pas de permission* -→ 89

	cherchez a savoir s'ils ont un systeme commode de se laver les mains après avoir fait les selles?	
88.	ISABUNE YABA SE IHARI? Le savon est-il disponible	0. OYA / *Non* 1. YEGO / *Oui*

IFISHI MUPIMISHIRIZAHO KANAKA / La fiche de l'enfant
Seulement pour les enfants de 12 a 23 mois
→Si l'enfant a moins de 12 mois allez y à la question n° 92

89.	MWABA MUFITE IFISHI MUPIMISHIRIZAHO KANAKA Avez-vous une fiche de santé de (nom de l'enfant)	0. Non, L'enfant n'a pas de carte 1. La carte se trouve au FOSA 2. La carte est perdu 3. Oui

90.	REBA KU IFISHI INKINGO YABONYE (*Vaccins recus*) UZANDUKURE	*Jour Mois Année* ITALIKI UKWEZI UMWAKA
	BCG	|____| |____| /|____| |____| /|____||____|
	POLIO 0	|____| |____| /|____| |____| /|____||____|
	POLIO 1	|____| |____| /|____| |____| /|____||____|
	POLIO 2	|____| |____| /|____| |____| /|____||____|
	POLIO 3	|____| |____| /|____| |____| /|____||____|
	PENT 1	|____| |____| /|____| |____| /|____||____|
	PENT 2	|____| |____| /|____| |____| /|____||____|
	PENT 3	|____| |____| /|____| |____| /|____||____|
	ISERU/ *Rougeole*	|____| |____| /|____| |____| /|____||____|
	VIT.A	|____| |____| /|____| |____| /|____||____|
	Mebendazole	|____| |____| /|____| |____| /|____||____|
91.	REBA KU IFISHI INSHURO YAPIMWE MU MEZI ATATU ASHIZE/*Nombre de fois que (Nom de l'enfant) a été pese selon la fiche*	|____| Umubare *Nombre*

IMILIRE Y'UMWANA *(Etat nutritionnel de l'enfant [TOUS LES ENFANTS DE 0 a 23 MOIS)*

92.	NSHOBORA GUPIMA IBIRO BYA (KANAKA)*? Puis-je peser (Nom de l'enfant)?*	IBIRO |____||____| , |____| *Poids Kg grammes*
93.	PIMA UMUZENGURUKO W'AKABOKO. Taille Bras PB / Périmètre brachial de l'enfant	IBIRO |____||____||____| *Mm*
94.	REBA NIBA HARI AHO ABYIMBAGANYE PRESENCE DE L'OEDEME	0. OYA / Non (pas d'oedeme) 1. YEGO / Oui (Oedeme present)

NTA BIBAZO MWABA MUFITE MWAMBAZA?
Avez-vous des questions a me poser ou quelques choses a ajouter?

REBA NIBA IBIBAZO BYOSE BYABAJIJWE
Vérifiez si toutes les questions ont été posées

MURAKOZE CYANE. TWIZEYE KO IBYO MWATUBWIYE BIZADUFASHA KURUSHAHO GUKEMURA IBIBAZO BY'ABANA N'ABABYEYI MU KAGARI KANYU K'UBUZIMA. TUZABAGEZAHO IBYAVUYE MURI UBU BUSHAKASHATSI MU GIHE KITARAMBIRANYE.
Merci beaucoup. Nous espérons que vos réponses vont nous aider a trouver des solutions aux problèmes de sante des enfants et des femmes dans votre district. Nous vous communiquerons les résultats de cette enquête dans les meilleurs délais.

ANNEX 3: RAPID CATCH INDICATORS: Baseline survey (2002), Midterm survey (2005) and Final survey (2006)

			Baseline Survey (Jan 02) (Cluster) N=422			Midterm Survey (Jan 04) - LQAS N=133			Final Evaluation (June 06) (Cluster) N=420		
INDICATOR AND DEFINITION			**Total**	**%**	**Remarks**	**Total**	**%**	**Remarks**	**Total**	**%**	**Remarks**
UNDERWEIGHT CHILDREN	Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**Numerator** No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age	**0**	**n/a**		**51**	**38%**	**12-23 months**	**59**	**36%**	**12-23 months**
		Denominator Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)	**0**			**133**			**164**		
BIRTH SPACING	Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**Numerator** No. of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth (Rapid CATCH Question	**261**	**74%**	**0-23 months**	**0**	**n/a**		**110**	**79%**	
		Denominator Number of children age 0-23 months in the survey who have an older sibling	**354**			**0**			**139**		
DELIVERY ASSISTANCE	Percentage of children age 0-23 months whose births were attended by skilled health personnel	**Numerator** No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D	**29**	**8%**		**37**	**28%**	**all facility deliveries with skilled attendant**	**230**	**55%**	
		Denominator Number of children age 0-23 months in the survey	**365**			**133**			**420**		
MATERNAL TT	Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**Numerator** Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9	**100**	**45%**		**90**	**68%**	**0-11 months**	**262**	**62%**	**0-23 months**
		Denominator Number of mothers of children age 0-23 months in the survey Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9 Denominator Numerator: Number of mothers of children a	**220**			**132**			**420**		

			Baseline Survey (Jan 02) (Cluster) N=422			Midterm Survey (Jan 04) - LQAS N=133			Final Evaluation (June 06) (Cluster) N=420		
INDICATOR AND DEFINITION			**Total**	**%**	**Remarks**	**Total**	**%**	**Remarks**	**Total**	**%**	**Remarks**
EXCLUSIVE BREASTFEEDING	Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	**Numerator** Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13	75	74%			n/a		151	97%	
		Denominator Number of infants age 0-5 months in the survey	102						155		
COMPLEMENTARY FEEDING	Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**Numerator** Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13	66	94%		61	86%	6-11 months	35	49%	
		Denominator Number of infants age 6--9 months in the survey	70			71			71		
FULL VACCINATION	Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**Numerator** Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)	132	64%		96	72%		108	76%	
		Denominator Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)	205			133			143		
MEASLES	Percentage of children age 12-23 months who received a measles vaccine	**Numerator** Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16	159	78%		96	72%		137	82%	
		Denominator Number of children age 12-23 months in the survey	205			133			168		
BEDNETS	Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**Numerator** Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19	3	1%		56	21%		195	46%	
		Denominator Number of children age 0-23 months in the survey	422			266			420		

INDICATOR AND DEFINITION			Baseline Survey (Jan 02) (Cluster) N=422			Midterm Survey (Jan 04) - LQAS N=133			Final Evaluation (June 06) (Cluster) N=420		
			Total	%	Remarks	Total	%	Remarks	Total	%	Remarks
DANGER SIGNS	Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**Numerator** Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20	305	72%		22	17%	Malaria signs among WRA	317	75%	
		Denominator Number of mothers of children age 0-23 months in the survey	422			133			420		
SICK CHILD	Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**Numerator** Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23	11	8%			n/a		24	16%	
		Denominator Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)	131						147		
HIV & AIDS	Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**Numerator** Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25	103	24%		98	74%		338	80%	
		Denominator Number of mothers of children age 0-23 months in the survey	422			133			420		
HANDWASHING	Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**Numerator** Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26	0	n/a		37	28%	One activity	56	13%	5 activités
		Denominator Number of mothers of children age 0-23 months in the survey	0			133			420		

ANNEX F HFA REPORT

(insert as separate document)

CONCERN WORLDWIDE

Gisagara Health District, Rwanda

CHILD SURVIVAL PROGRAM

Capacity Assessment of the Health Facilities & Community Based Associations
- Final Report -

Sept. 2006

Prepared by: Dr Jean Kagubare, Consultant

SUMMARY

The overall objective of this study is to evaluate the capacity as well as the performance of the health facilities (HF) and community associations (community health workers associations (CHW), traditional birth attendant associations (TBA) and associations of people living with HIV (PLWHA), operating in the Gisagara (formerly Kibilizi) District.

This is a descriptive study, combining the quantitative and qualitative methods, based on the focus group discussion technique and individual interviews. All the health care centers are targeted as well as a sample of patients who benefited from the Antenatal Clinic (ANC) services, child consultation, and community based associations.

The main results of the analysis show that:

- The health infrastructures of Gisagara are old, with an average age of 37 years; the average number of beds per Health Center (HC) being of 32 beds, with an average of 23,000 inhabitants per HC, which is in the average recommended by the Ministry of Health.
- Each health center has an average health staff number of 17 people; but there is a lack of the professional staff A1 and A2 nurses.
- The number of community health workers in Gisagara district are sufficient number (1300) and have grown rapidly these last years, thanks to the support of the CSP Concern project.
- All health centers have health functional committees and the overall management of services has improved.
- The number of the curative and preventive consultations in all health centers has increased tremendously (almost by three times) during these 5 last years. Almost all services (including HIV/AIDS) are now functional, except some health centers which do not have the VCT and PMTCT services yet.
- Efforts were made to organise the training of health staff, in several priority areas of which malaria, HIV/AIDS, respiratory infections and nutrition.

- The supervision of health staff and the community volunteers have been organised regularly and especially more often in the years 2004-2005. Information concerning the organised training and supervisions is not always available.
- Community Health Workers (CHWs) are referring more and more patients towards health facilities. The main reasons of transfers are primarily due to complicated childbirth and complicated malaria cases. On the other hand, counter-referral and feed back from health facilities is almost inexistent, which is a nationwide common practice.
- The analysis of the capacity and quality of the VCT services reveals that almost all FOSA have a functional VCT service, except for Kirarambogo. The knowledge and experience of the VCT health staff are of medium quality. Most of the interviewed agents who have given good spontaneous answers reached a rather low level (20% - 40%).
- The clients perception of the quality of ANC and consultation of children services is very good, however there is some issues of dissatisfaction in particular with regard to the time spent waiting at the Health facility, which is very long (an average of almost 4 hours to a maximum time of 8 hours for some), the high cost of drugs, and the lack of patient follow-up.
- The clinical practice of personnel of VCT and children consultation services is not very satisfactory, because some basic processes are not systematically used such as measuring patients' pulse, or advising the patients with regard to the follow-up.
- The knowledge of patients, with regard to the danger signs related to pregnancy and children diseases, is rather at a medium level because the majority of patients was unable to quote all major danger signs.
- The head of Health Centre and the district management health team (DMHT) state to have noticed positive changes since the CSP Project Concern started to operate in the district of Gisagara, especially in the projects' 4 intervention areas: Malaria, Nutrition, HIV/AIDS, as well as maternal and child Health. The

management services, the meetings related to the planning and supervisions became more regular, whereas the relation with the partners more constant.

- CHWs, Traditional Birth Attendants (TBAs) and People Living With HIV/AIDS (PLWHAs) have formed associations; they all unanimously state that the CSP ***Concern*** project has contributed a lot to their initial training but also helped them to fulfil their daily duty in the community.
- After the end of the CSP ***Concern*** project, the head of Health Centres, the DMHT, and members community associations state to be willing to continue the activities initiated by the CSP project. This would be possible thanks to the acquired technical skills of the health staff and volunteers but also by reinforcing local and national leaders support. The creation of income generating projects for the volunteers is one of the ways to enable them to become financially independent.

In **conclusion**, the capacity assessment of health facilities and Community based associations, operating in Gisagara district revealed that the level of management and services performance as well as the level of activities has significantly increased since the beginning of the CSP ***Concern*** project. However, the quality of the provided services is not yet satisfactory in general; particular efforts are necessary in order to reach the desired quality level. Though all the stakeholders of the district seem to be willing to continue the activities initiated by the CSP project, their sustainability remains a challenge, therefore, transition strategies and support will still be necessary.

Acknowledgements

The present study has been carried out in collaboration with the Team of CONCERN-Rwanda, and more particularly with Dr. Luz Rose and Mr. Christophe Habyambere. We wish to thank Rozalin Davoonida for sharing with us the questionnaires of community actors.

The field data collection was done by a team of 4 investigators, under the supervision of the principal investigator:

Investigators:

- *Dr Vedaste NDAHINDWA*
- *Joseph GUMUYIRE*
- *Florent RUTAGARAMA*
- *Jean Paul MFIZI*

Our sincere thanks go to all the health facility staff as well as to the members of community based associations (CHW, TBAs, PLWHA) operating in Gisagara district (Southern Region) whose support was very important for the realisation of this study.

This study was financed by CONCERN RWANDA.

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ABREVIATIONS

AIDS:	Acquired Immuno Deficiency Syndrome
ANC:	Antenatal Clinic
ARI :	Acute respiratory infections (ARI)
CA:	Catchment Area
CHW:	Community Health Worker
COSA :	Health Committee
CSP :	Child Survival Program
DHS:	Demographic and Health Survey
DMHT:	District Management Health Team
EPI:	Expanded Program of Immunization
FARN :	French acronym for Hearth
FP:	Family Planning
HBM:	Home Based Malaria Treatment
HC :	Health Centre
HF:	Health Facility
HIS:	Health Information System
HIV:	Humane Immunodeficiency Virus
KPC :	Knowledge, Practice, and Coverage
Minisanté:	Ministry of Health
PLWHA:	People Living with HIV/AIDS
PMTCT:	Prevention of Mother To Child Transmission
STD:	Sexually Transmitted Diseases
TBA:	Traditional Birth Attendant
TT:	Tetanus Toxoid
USAID :	United States Agency for International Development
VCT :	Voluntary Testing Center
WHO:	World Health Organization

I. INTRODUCTION

CONCERN/RWANDA has set up a project entitled "CHILD SURVIVAL" in Gisagara District (former Kibilizi district), in the Southern Province of Rwanda, since October 2001, for 5 years period, financed by the USAID. This project has as overall objective to contribute to the reduction in maternal and child mortality and morbidity, and increased life expectancy in Kibilizi District, Butare Province of Rwanda.

Concern Worldwide US, Inc. is an affiliate of Concern Worldwide which began activities in Rwanda in 1994. It is in 1998 that CONCERN/RWANDA started its technical assistance programme to the health district of Kibilizi (now Gisagara).

To achieve its goal, the project worked out an action plan with strategies based on the objectives of the Ministry of Health as well as those of the USAID in Rwanda. The main strategies are primarily based on the staff capacity building in health services and of community based organizations in order to encourage them to participate in the prevention of health problems and addressing the local population health issues.

The present study evaluates the capacity and performance of the health facilities and community based associations, compared to the objectives of the Child Survival Project conducted in June 2006.

II. BACKGROUND

The former Kibilizi Health District (now a part of Gisagara District) is located in the Southern province and includes seven Health centres which provide a minimum package of health activities to the population. The district hospital is not functioning yet. The district of Kibilizi covers two administrative districts (Mugombwa and Kibingo), with 43 sectors and 142 cells (the smallest administrative unit). In 2006, the total population is estimated at 178,502 inhabitants. The former health district of Kibilizi was characterised by high child and maternal morbidity and mortality due mainly to poor access and quality of health services.

The ***CONCERN*** programme entitled Kibilizi Child Survival Partnership Program used three main strategies to achieve its goal: (1) building the management capacity of the district health staff and supervisors; (2) developing the capacities of the health staff of the district in the four program fields of intervention; and, (3) strengthening the district's community outreach approach.

The four major fields of interventions of the program are:

1. HIV/AIDS prevention
2. Malaria Control
3. Nutrition and prevention of chronic malnutrition
4. Mother and Newborn care.

The expected program outputs are:

1) Improved district health management systems
2) Improved quality of services on the four selected interventions
3) Increased health care coverage
4) Decentralized and institutionalized health services
5) Sensitized District Health Team and population on gender health issues
6) Empowered population for disease prevention and risk reduction
7) Improved Concern-CSP planning, design, and management capacity

The overall objective of this study aims at evaluating the capacity as well as the performance of the health facilities and Community based associations (Community health workers associations (CWH), associations of traditional birth attendants (TBA) and associations of the people living with HIV/AIDS (PLWHA) operating in the district of Gisagara.

This study aims specifically at : (i) evaluating the general level of performance of the Health Centres (HC) in terms of achieved activities and health staff general point of view especially with regard to the project 4 major interventions (Malaria, nutrition, maternal and child health and HIV/AIDS); (ii) evaluating the knowledge and the technical skills of the health staff with regard to the HIV voluntary testing; (iii) evaluating the satisfaction and performance level of the health staff in connection with the antenatal consultation and children care; and, (iv) evaluating the management and technical capacity of associations, and the way they are perceived at the community level, compared to the objectives of the project.

This study will give CONCERN/RWANDA and the health staff, and the community based associations, the impact of their interventions and also the challenges which still remain ahead.

III. METHODOLOGY

This is a descriptive study which used quantitative as well as the qualitative methods. Focus group discussion and individual interview were used. The target populations of the study are all health centers and community based associations based in Gisagara district.

1. Sampling

This study surveyed all health centers of the district of Gisagara (7 health centers), 14 patients who attended antenatal consultation services (7 patients) and external children consultation (7 patients), and 12 community based associations. A sample of 12 community based associations has selected by taking into account their activities (CWH, TBAs, and PLWHA) and their performance criteria (See appendix 3).

2. Questionnaires

Four questionnaires have been developed by the Child Survival team; these are: 1) questionnaire for the head of health centers, 2) questionnaire concerning the VCT service, 3) "exit interview" questionnaire of patients attending antenatal clinic and children outpatient consultation, and 4) questionnaire for focus group discussion with community based associations and the district management health team. All questionnaires have been pre-tested on field and corrected accordingly before the field work (see appendix 1).

The questionnaire for head of health centers contains information on the number and the qualification of the health personnel, the use of health services, the type and number of training and supervision performed.

The questionnaire concerning the VCT evaluates the knowledge and practice of the health staff working in this service. It also covers staff qualifications, the type and number of trainings received, the knowledge and attitude with regard to counselling patients before and after an HIV test.

The exit interview questionnaire targets those who attended antenatal clinic and children outpatient consultation. The questionnaire seeks to evaluate the patient opinion on the

time spent at health center, the services costs, the consultation quality, and the patient's knowledge with regard to danger signs related to pregnancy and childhood diseases which require an urgent medical consultation.

The focus group discussion questionnaire for community based associations inquire about their activities, trainings received, support received from the CSP project, and the sustainability plans. As for the district management health team (DMHT) questionnaire, it focuses on the management capacity (meetings, supervision, reports, relations with MINISANTE and other stakeholders) and the technical capacity of the DMHT in the project's four intervention areas.

3. Training of investigators and field data collection

Four investigators were recruited and trained during two days in interview and "focus-group" discussion techniques. The training courses related primarily to: 1) the objectives of the assessment, 2) the objectives and indicators of the project 3) interview and focus-group discussion techniques, 4) data quality control and data collection 5) member's role and responsibilities.

After the training, a pre-test was carried out at CUSP health center in the district of Huye, Southern province. This site was selected because it is located close to the training site and also because it does not belong to the survey area.

For field data collection, the investigators were assigned in 2 teams of 2 people and each team was assigned a specific number of health centers and community associations to survey. The field investigation was carried out from June 12-16, 2006 (see appendix 2). A total of 7 health centres, 14 patients of ANC (7 patients) and children outpatient consultation (7 patients), 12 community based associations, and the Gisagara DMHT team were successfully surveyed as planned.

Two approaches were used to collect information on field, namely the quantitative approach and the qualitative approach. The *quantitative approach* used structured

questionnaires for data collection from head of health centers, the in charge of the VCT service, and the users of the ANC and children outpatient consultation.

The *qualitative approach* used focus-groups discussion technique (FGD) with members of community associations and the district management health team as well as individual interviews with the head of health centers.

Each focus group discussion was comprised with an average of 10 people from the association. The FDG guide was divided in major themes and each theme had several questions from a more general question to detailed and specific sub-questions which would allow the facilitator to lead the discussion and cover all the aspect of the theme. Moreover, the facilitator encouraged participants to give more details. Before the end of the discussion the facilitator asked the participants if they still had questions and/or additional topics before the conclusion of the meeting.

A verbal consent of the participants was always obtained before the beginning of each interview.

4. Data entry and Analysis

The data entry was carried out by the investigators, using MS WORD and EPIDATA software. The internal coherence of the answers was checked before the analysis of the data. The statistical analyses were done MS EXCELL and STATA (version 7) software.

IV. RESULTS

A. QUANTITATIVE RESULTS

1. Health Facilities

Infrastructure

All the seven health centres of the Gisagara District (3 public and 4 private) were surveyed. As indicated in table1, the population benefiting from the health centre amounts to an average of 23,322 inhabitants, varying from 17,503 to 28,000. The health centres have been operational for several decades, with an average of 37 years, with large variations, going from 20 to 73 years and have an average hospitalization capacity of 32 beds.

Table 1: Characteristic of the Health Centers

Characteristic	Average	Min	Max
Age of the FOSA	37	20	73
Population benefiting from the FOSA	23,322	17,503	28,000
Numbers of beds	32	24	39

Human Resources

Health staff

The analysis of human resources shows that the total number of the personnel working in the health centres of the Gisagara district amounts to 121 people, with an average of 17 people per health centre. Table 2A shows that there are 4% of A1 nurses, 304% of A2 nurses, 1.7% of A3 nurses, 7.4% of auxiliary nurses, and 6.6% of laboratory technicians. The social workers and nutritionists respectively constitute 5% and 1.7% of the total number of workers. The support staff (workers and others) represent 43.4 % of the total staff.

Table 2A: Staff distribution by Health Center in Gisagara district

Health Center	A1	A2	A3	A4	Social Assistant	Nutrition	Labo	Workers	Total
KIBAYI	0	8	0	1	0	1	0	7	**17**
KIBILIZI	4	2	0	0	0	0	1	9	**16**
KIRARAMBONGO	4	1	1	0	2	0	0	11	**19**
KANSI	0	5	0	0	1	0	1	7	**14**
MUGOMBWA	2	3	0	4	2	1	1	4	**17**
KIGEMBE	0	5	0	2	1	0	3	8	**19**
GIKORE	1	5	1	2	1	0	2	7	**19**
Total	**11**	**29**	**2**	**9**	**7**	**2**	**8**	**53**	**121**
% Total	**9,1%**	**26,4%**	**1,7%**	**7,4%**	**5,8%**	**1,7%**	**6,6%**	**33,4%**	**100%**
Average per HC	**1.6**	**4.6**	**0.3**	**1.3**	**1.0**	**0.3**	**1.1**	**5.4**	**17.3**

Table 2B below shows the distribution of staff by sex and the majority of the health staff is female, since 62% of them are women.

Table 3B: Staff distribution by sex in Gisagara district

Sex	A1	A2	A3	Auxil	Ass Sociale	Nutrit	Tech lab	Trav	Autre	Total	%
Male	0	14	1	2	2	0	3	21	3	**46**	**38%**
Female	11	18	1	7	5	2	5	17	9	**75**	**62%**
Total	**11**	**32**	**2**	**9**	**7**	**2**	**8**	**38**	**12**	**121**	**100%**

Community Volunteers

Gisagara district has a total of 1308 Community volunteers (in 2006) with an average of 187 volunteers per health center. As shown in table 3 below, the distribution per category of community volunteers is as follow: 259 traditional birth attendants (TBA), 161 community health workers (CWH), 449 community based anti-malaria drug distributors, 320 people living with HIV/AIDS, and 119 other volunteers. Women represent 47% of the total staff but they have almost the total majority of TBAs and a slight majority among people living with HIV/AIDS.

Table 3: Distribution of community volunteers in Gisagara district

Health Center	TBA	CWH	Malaria distributor	PLWHA	Others	Total
KIBAYI	64	27	110	48	54	**303**
KIBILIZI	40	21	-	32	0	**93**
KIRARAMBONGO	10	21	68	0	0	**99**
KANSI	30	19	82	32	0	**163**
MUGOMBWA	50	22	59	35	52	**218**
KIGEMBE	20	19	60	47	13	**159**
GIKORE	45	32	70	126	0	**273**
Total	**259**	**161**	**449**	**320**	**119**	**1308**
Average by HC	**37**	**23**	**64**	**46**	**17**	**187**
Male	**2**	**133**	**317**	**149**	**92**	**693**
Female	**257**	**28**	**132**	**171**	**27**	**615**

Health services management

All health centres of the district of Gisagara have a functional management committee, 71% of which meet monthly and 29% meet on quarterly basis. As shown in table 4 below, the majority of health centers (85.7%) have introduced some form of exemption payment system for the poorest. 43% of health centers apply a total exemption of fees payment , 57% grant reduced tariffs and 29% distribute gifts in kind to the poor.

Table 4: Health Services Management

Category	Numbers	Percentage
Health Management Committee (HMC)	7	100%
HMC meeting		
Monthly	5	71.4%
Quarterly	2	28.6%
System of exemption for the poorest	6	85.7%
Type of exemption		
Free health care	3	42.9%
Tariff Reduction	4	57.1%
In kind	2	28.6%

Use of the services

As summarised in table 5 below, the total number of people who have benefited from health services in the district of Gisagara during the last six months (from December 2005 to May 2006), is estimated at 42,433 patients with a monthly average of 7 079 cases. Hospitalisation cases are estimated at 2840 with a monthly average of 473 patients during the same period. Children growth monitoring (18,485 cases), malaria (7,227 cases), and antenatal consultations (6,299 cases) constitute the majority of the consultations. We also note that over the same period there is a monthly average of 30 cases of STD (syndromic approach), 313 cases of VCT and 259 cases of PMTCT. Cases of transfer by ambulance amounts to 207 patients but this number is underestimated as most of the health centres do not record these data.

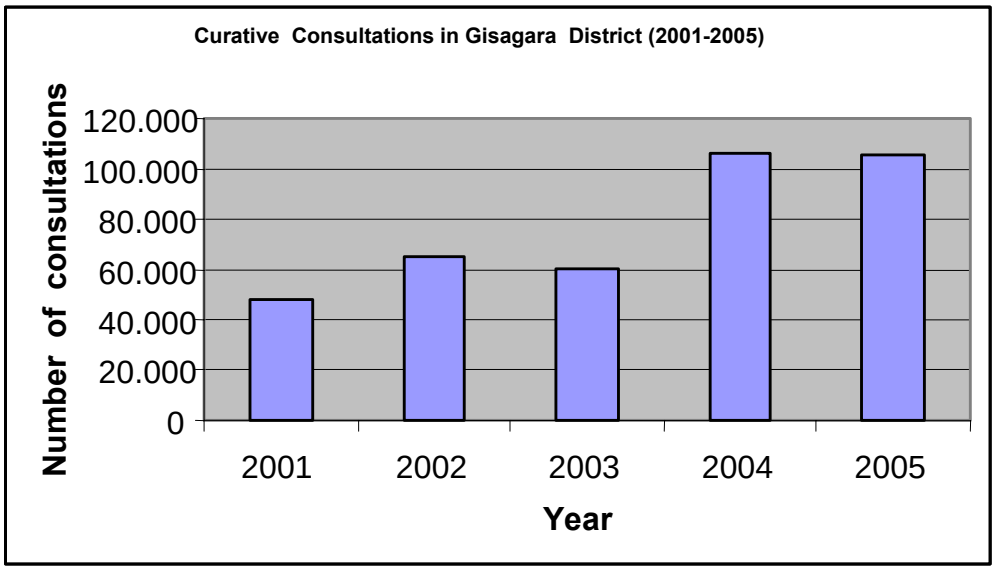
Table 5: Use of the Health care services (December 2005 to May 2006)

Categories	Kanzi	Mugombwa	Kirarambogo	Kibiliz	Kibayi	Gikore	Kigembe	Total: 6 months	Average per month
Malaria	1 408	1 982	959	786	974	614	504	**7 227**	**1 205**
Children Growth Monitoring	3 389	473	6 597	3 211	401	2 381	2 033	**18 485**	**3 081**
CPN	1 263	730	1 703	913	368	586	736	**6 299**	**1 050**
Post-natal Care	-	-	-	-	-	-	-	-	-
Normal delivery	264	192	136	88	130	129	209	**1 148**	**191**
Assisted childbirth	0	0	0	0	0	0	0	**0**	**0**
Blood transfer	0	0	0	0	0	0	0	**0**	**0**
STD Diagnosis									
Etiological	0	0	0	0	0	0	0	**0**	**0**
Syndromic approach	20	-	11	18	12	73	45	**179**	**30**
STD Treatment	20	-	11	18	12	73	45	**179**	**30**
STD Counselling	20	-	11	18	12	73	45	**179**	**30**
HIV/AIDS									
VCT	0	62	0	285	630	82	819	**1 878**	**313**
ART	0	0	0	0	0	0	0	**0**	**0**
PMTCT	0	0	0	373	443	0	736	**1 552**	**259**
External consultations	7 475	8 911	3 396	5 955	6 958	3 330	6 448	**42,473**	**7 079**
Hospitalizations	578	438	440	197	280	615	292	**2 840**	**473**
References (ambulance)	37	150	-	-	20	-	-	**207**	**35**

Post natal care service is not established yet as a distinctive unit from the children general consultation service; this is the reason why this rubric does not contain data. The anti-retroviral drugs (ARV) service dedicated to HIV/AIDS patients was not yet functional in any of the health centers of Gisagara district during the above mentioned period.

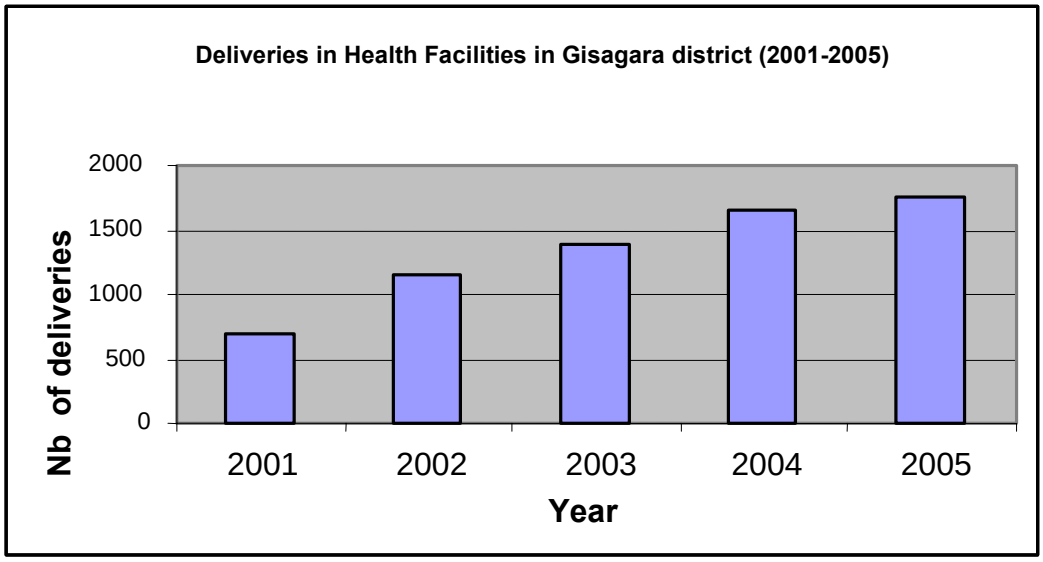
There is a very sharp increase of the number of curative consultations in all health centers in Gisagara district over the last past five years (2001-2005). As shown in figure 1, the number of consultations raised from 42 000 cases in 2001, to more than 100 000 cases in 2005.

Figure 1: Curative consultations in Gisagara District (2001-2005)



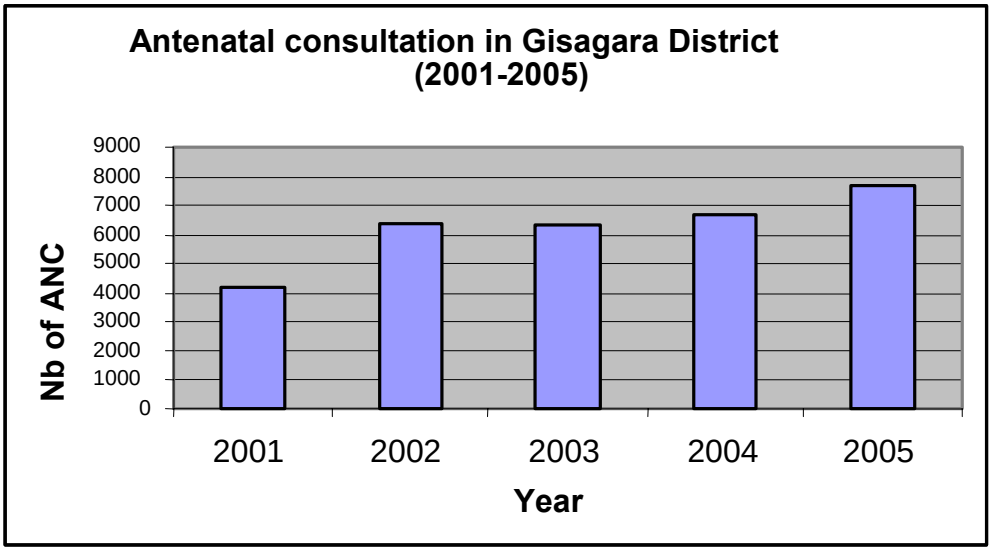
As indicated in figure 2, deliveries in health facilities increased almost our times during the five year period raising from 600 in 2001 to 1800 cases in 2005.

Figure 2: Deliveries in Health Facilities in Gisagara District (2001-2005)



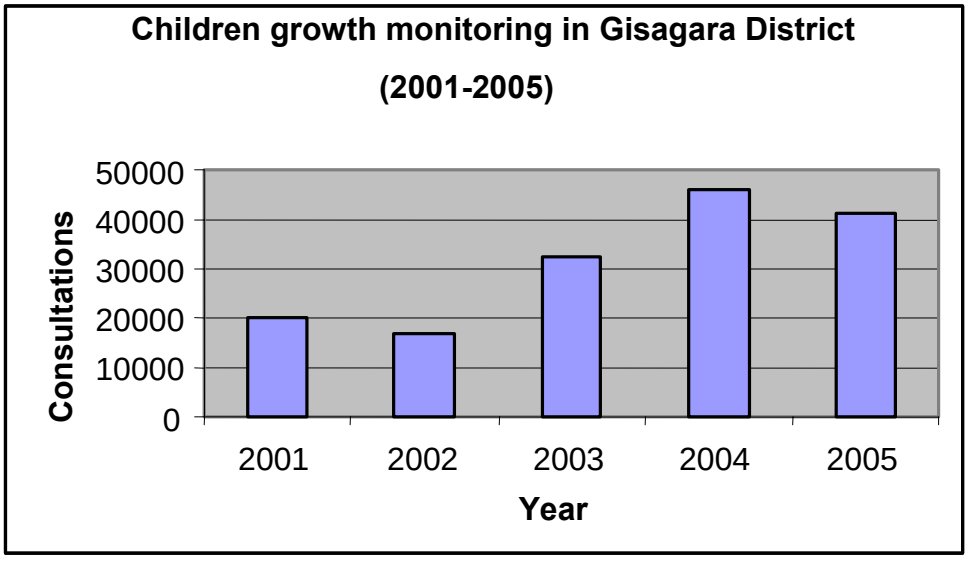
The preventive activities such as antenatal consultations also experienced a significant increase during the last 5 years in Gisagara district. As shown in figure 3 below, antenatal consultations rose from 4 000 cases in 2001 to almost 8 000 cases in 2005.

Figure 3: Antenatal consultations in the Gisagara District (2001-2005)



There is also a significant increase with regard to the children growth monitoring, consultations rose from 20,000 cases in 2001 to more than 40,000 cases in 2005 as shown in figure 4 below.

Figure 4: **Children growth monitoring in Gisagara District (2001-2005)**



Training, supervision and transfer

Training

The total number of type of trainings conducted and the number of health staff trained in Gisagara district during the last 5 years (2001-2005) is estimated respectively at 95 trainings and 186 people trained. The majority of trainings (75%) and staff trained (65%) were done during the year 2005 only. Some of the health centers did not always have the necessary information, especially during the first years of the project, thus introducing an underestimation of these trainings. As shown in table 6, the types of training cover several conditions and diseases, the most frequent of which being malaria, STD/AIDS and nutrition.

Table 6: Categories of training and trained people (2001-2005)

Categories	2001	2002	2003	2004	2005	Total
Pathologies						
Deliveries	0	0	0	0	6	**6**
ANC	1	0	0	0	4	**5**
VCT	0	0	0	0	5	**5**
PMTCT	0	0	0	0	5	**5**
Nutrition	0	0	1	1	8	**10**
Diarrhoea	0	0	0	0	0	**0**
Malaria	0	3	0	1	9	**13**
STD	0	2	0	2	3	**7**
Postnatal consultation	0	0	0	0	1	**1**
Health Mutuelle	0	0	0	0	6	**6**
Family planning	1	0	0	1	4	**6**
Gender	0	0	0	0	1	**1**
HIV/AIDS	0	2	0	0	8	**10**
IEC	1	3	0	0	1	**5**
Respiratory infections	0	0	1	0	0	**1**
Others	2	0	1	0	11	**14**
Total pathologies	**5**	**10**	**3**	**5**	**72**	**95**
Staff Trained	**16**	**12**	**14**	**24**	**120**	**186**

Supervisions

During the period between 2001 and 2005, there were 186 supervisions of the health center personnel in Gisagara district, with an average of 37 supervisions per annum. The supervision experienced had a sharp increase from 2004. We noticed that some health centers did not have complete information about the supervisions, especially in Gikore and Kibilizi health centres.

Table 7: Number of supervisions conducted in Gisagara district (2001-2005)

Health Centre	2001	2002	2003	2004	2005	Total
KIGEMBE	3	11	-	10	16	**40**
KIBAYI	-	2	5	13	20	**40**
MUGOMBWA	5	3	5	8	12	**33**
KIRARAMBONGO	12	4	4	11	15	**46**
GIKORE	-	-	-	-	-	-
KIBILIZI	-	-	-	-	-	-
KANSI	4	3	2	9	9	**27**
Total	**24**	**23**	**16**	**51**	**72**	**186**

The types and number of supervisions from December 2005 to May 2006 are summarised in table 8 below. There were a total of 61 supervisions conducted during these six months, and these ANC (3), Immunization (19), HIV/AIDS (12) and malaria (27). The average number of supervisions per health center is estimated at 9, varying from 3 supervisions in Kibilizi to 13 supervisions in Kansi.

Table 8: Type and number of supervisions conducted (Dec. 2005 – May 2006)

Health Centres	CPN	Vaccination	VIH	Malaria	Total
KIGEMBE	2	3	4	2	**11**
KIBAYI	1	1	3	5	**10**
MUGOMBWA	0	4	0	1	**5**
KIRARAMBONGO		4		6	**10**
GIKORE		3		6	**9**
KIBILIZI		1	1	1	**3**
KANSI		3	4	6	**13**
Total	**3**	**19**	**12**	**27**	**61**

The health staff also carried out supervisions of community based associations comprised by community health workers, TBAs, anti-malaria drugs distributors, the "mamans lumières" (Positive deviant mothers who are poor but have well nourished children) and health committees. Table 9 summarises the types and number of supervisions conducted. There were a total of 295 supervisions over a 6 months period from Dec 2005 to May 2006 (note that there was missing information in some health centers), the majority of which focused on "mamans lumières" and anti-malaria drug distributors.

Table 9: Type of supervisions conducted at the community level (Dec.2005-May 2006)

Health Centres	CHW	TBA	Malaria Distributors	"Mamans Lumières"	Health Mutual	Total
KIGEMBE	11	11	-	50	1	**73**
KIBAYI	9	0	81	48	0	**138**
MUGOMBWA	6	0	24	0		**30**
KIRARAMBONGO	-	-	-	-	-	**-**
GIKORE	6	6	-	6	-	**18**
KIBILIZI	-	-	-	-	-	**-**
KANSI	6	6	-	18	6	**36**
Total	**38**	**23**	**105**	**122**	**7**	**295**

Referrals

The total number of referrals, transfers and counter-referrals is estimated at 1 588 cases during from December 2005 to May 2006, as indicated in table 10 below. The referrals made by Community agents amounts to 1,386 cases, whereas transfers made by the health staff amounts to 197 cases. Counter-referrals are almost non-existent and are estimated at 3 cases only, for the whole period. Malaria cases, deliveries and respiratory infections cases constitute the majority of the referrals. The only cases of counter-reference (3 cases) are related to deliveries.

Table 10: Transfers, referrals and counter- referrals (Dec. 2005-May 2006)

Health Centres	Referrals	Transfers	Counter references	Total
Deliveries	522	154	3	**679**
Malnutrition	0	5	0	**5**
Respiratory Infection	95	2	0	**97**
Malaria	739	24	0	**763**
Diarrhoeal Diseases	0	0	0	**0**
Immunizations	30	0	0	**30**
HIV/AIDS	0	12	0	**12**
Total	**1 386**	**197**	**3**	**1 586**

Meeting

Table 11 below presents the period during which the last meeting took place, together with the head of health facilities and the community agents. Most meetings took place on monthly basis, except for the meeting with the health insurance committee which was held every three months. Only Kigembe health center never organised any meeting with the Community volunteers.

Table 11: Meeting of head of health facilities with other partners

Health Centers	Health Center staff	CHW	TBA	Volunteers	Other HC	DMHT	HMC	Anti-Malaria drugs Distr.	Mutual Com
KIGEMBE	1	1	2	4	1	1	1	1	3
KIBAYI	1	1	2	-	1	1	1	1	2
MUGOMBWA	1	1	1	1	1	1	2	2	1
KIRARAMBONGO	1	1	1	1	1	1	3	2	3
GIKORE	2	1	1	1	1	1	2	1	2
KIBILIZI	2	2	1	1	1	1	3	1	3
KANSI	1	2	1	1	1	1	1	1	2

NB: 1: <= 1month; 2: 1-3 month; 3: > 3month; 4: Never

Common pathologies

According to head of health facilities interviewed at the time of this study, the three most frequent pathologies in the health centers among children under 5 years are malaria, respiratory infections and diarrhoeal diseases, whereas among pregnant women, the most frequent diseases are malaria, respiratory infections, and pregnancy complications, as described in table 12 below.

Table 12: The most frequent pathologies among children (<5years) and pregnant women

	Children < 5 years			Pregnant woman		
Health Centres	**Malaria**	**Respiratory Infections**	**Diarrhoeal Diseases**	**Malaria**	**Respiratory infections**	**Childbirth Complications**
KIGEMBE	X	X	X	X		X
KIBAYI	X	X	X	X	X	
MUGOMBWA	X	X	X	X	X	
KIRARAMBONGO	X	X	X	X	X	
GIKORE	X	X	X	X		X
KIBILIZI	X	X	X	X	X	
KANSI	X	X	X	X	X	

2. VCT Service

The voluntary counselling and testing service (VCT) is established in six out of seven health centers of the Gisagara district, only the Kirarambogo HC did not have a VCT service by the time of the survey, as indicated in table 13 . The health staff in charge of VCT was mainly constituted by A2 nurses and A2 laboratory technicians. All of the VCT staff interviewed stated that they had additional training courses since the end of their study.

Table 13: VCT health staff: qualification and training

Health Centre	**VCT Service**	**Qualification**	**Training**
KANSI	Yes	A2 Nurse	Yes
KIBILIZI	Yes	A2 Nurse	Yes
GIKORE	Yes	A3 Lab	Yes
KIBAYI	Yes	A2 Nurse	Yes
MUGOMBWA	Yes	A3 Lab	Yes
KIGEMBE	Yes	A2 Nurse	Yes
KIRARAMBOGO	Non	-	-

Table 14 below shows the type of trainings followed by the VCT staff, as well as the agencies which organised these training courses. One notes that all agents were trained in VCT, 5 agents out of 6 were also trained in PMTCT (except for the Gikore Health Center), the agent of the Kansi Health Center was the only one to have been trained in ART, half of the agents were trained in STD treatment, according to the syndromic approach; only one agent was trained in STD etiological diagnosis, and 2 agents out of 5 were trained in counselling patients with regard to STD. The agencies and institutions which have organised these training courses are: Concern, the Ministry of health, and Caritas.

Table 14: Type of trainings conducted in HIV and STD

Health Centre	PMTCT	ART	VCT	STD (HO)	STD (ED)	STD Counselling
KANSI	Yes	Yes	Yes	No	No	No
KIBILIZI	Yes	No	Yes	Yes	-	-
GIKORE	No	No	Yes	Yes	Yes	Yes
KIBAYI	Yes	No	Yes	No	No	Yes
MUGOMBWA	Yes	No	Yes	Yes	No	Yes
KIGEMBE	Yes	No	Yes	No	No	No
Trainers	Concern	MINISANTÉ	Concern	Caritas Concern MINISANTÉ	Concern	MINISANTÉ

NB: SA : Syndromic Approach; ED: Etiological Diagnostic

An assessment of competence of the VCT staff was conducted in regard to a hypothetical case of a patient at a VCT service. The agent's knowledge was evaluated based on three possible scenarios: 1) patient who comes to get general information on VCT service, 2) patient who comes to have an HIV test, and 3) patient who comes to get his HIV test result. There are three possible scores for each answer: score 1: answered yes without prompting, score 2: had to prompt but answered yes, and score 3: had to prompt but answered no (see appendix 1).

Table 15 summarises the VCT staff scores for the first scenario. There are 14 possible answers and one note that in general only 25% of the VCT staff properly answered

spontaneously, and 63% answered "yes" but had to prompt and 12% did answer "no" after prompting. The agent of the Kansi Health Centre obtained the best score.

Table 15: Average score of the evaluation of the VCT staff (information)

Health centre	Score 1	Score 2	Score 3	Total
KANSI	7	5	2	**14**
KIBILIZI	5	7	2	**14**
GIKORE	4	9	1	**14**
KIBAYI	3	8	3	**14**
MUGOMBWA	1	12	1	**14**
KIGEMBE	1	12	1	**14**
Total	**21**	**53**	**10**	**84**
Percentage	**25%**	**63%**	**12%**	**100%**

NB: Score1: correct and spontaneous answers , Score 2: answered "yes" after prompting; Score3: answered "no" after prompting

Concerning the second scenario (HIV pre-test), there are 11 answers. Table 16 summarises the results of the scores obtained by the VCT staff: 21% of the VCT agents answered correctly in a spontaneous way, 73% answered "yes" after prompting and 6% did answer "no" after prompting. The agent of the Kansi HC obtained the highest score.

Table 16: Average of scores of the evaluation of VCT staff (pre-test)

Health Centre	Score 1	Score 2	Score 3	Total
KANSI	5	6	0	**11**
KIBILIZI	1	9	1	**11**
GIKORE	0	9	2	**11**
KIBAYI	2	9	0	**11**
MUGOMBWA	4	7	0	**11**
KIGEMBE	2	8	1	**11**
Total	14	48	4	**66**
Percentage	21%	73%	6%	**100%**

NB: Score1: correct and spontaneous answers , Score 2: answered "yes" after prompting; Score3: answered "no" after prompting

The third scenario is related to the HIV post test and table 17 below presents the score of the VCT agents in each health centre. Ten answers are possible, and one notices that on the total of all agents, 40% answered spontaneously yes, 48% answered "yes" but after

prompting and 12% did answer “no” after prompting. The agent of the Kigembe Health center obtained the highest score.

Table 17: Average scores of the evaluation of VCT staff (post-test)

Health Centre	Score 1	Score 2	Score 3	Total
KANSI	3	6	1	**10**
KIBILIZI	4	3	3	**10**
GIKORE	3	7	0	**10**
KIBAYI	5	4	1	**10**
MUGOMBWA	2	6	2	**10**
KIGEMBE	7	3	0	**10**
Total	**24**	**29**	**7**	**60**
Percentage	**40%**	**48%**	**12%**	**100%**

NB: Score1: correct and spontaneous answers , Score 2: answered “yes” after prompting; Score3: answered “no” after prompting

3. Antenatal Clinic (ANC) and children consultation services

General Characteristics

In total, 14 beneficiaries were interviewed during an exit interview about their opinion about the ANC services and children consultation, particularly concerning the transport duration and the time spent in the Health Center, the quality of the service provided, the diagnostic and therapeutic process, and about their knowledge of the danger signs.

All patients who were interviewed stated that the average time of walk from their homes to the health facility was about 40 minutes, varying from 10 to 60 minutes. As indicated in table 18, the average time spent at the health center from the arrival to the departure, amounts to a minimum of three hours and half. The shortest time spent at health center was one hour and the longest time was 7 hours and 30 minutes.

Table 18: Time spent in the health centre

Health Centre	ANC	Child Cons.	Average (Minutes)	Average (Hours)
KIRARAMBOGO	180	230	205	3,4
GIKORE	224	337	281	4,7
KIBILIZI	139	200	170	2,8
KANSI	168	128	148	2,5
KIGEMBE	*60*	150	105	1,8
MUGOMBWA	460	245	353	5,9
KIBAYI	*450*	240	345	5,8
Average	**240**	**219**	**229**	**3,8**

Patient satisfaction

The patients were questioned on their level of satisfaction concerning several aspects of the services provided during their visit, and as summarised in table 19 below, it was noted that, in general, an average of 64% of the patients were satisfied with the services provided. 86% of the patients declared that they were satisfied with the antenatal consultation service, whereas only 43% were satisfied with the children consultation service. The patients estimated that the quality of the time spent with health care staff

was very good (> 85%), in regard to their respect and attitude. The hygiene, the cost, the drugs availability and the explanations provided by the health personnel were ranked as of good quality in over 70%. Half of the patients stated that they were not satisfied with the quality of the follow-up and the counselling provided by the health personnel, with the price of the drugs and the time spent waiting in the Health Center.

Table 19: Patient satisfaction of the health services

Category	% satisfaction: ANC	% satisfaction: children Consultation	% total satisfaction
Time spent waiting in the HC	71%	57%	**64%**
Time spent with the Health personnel	86%	100%	**93%**
Hygiene	100%	57%	**79%**
Respect of private life	86%	86%	**86%**
Staff attitude	100%	71%	**86%**
Cost of Services	71%	71%	**71%**
Drugs price	57%	57%	**57%**
Drugs Availability	71%	71%	**71%**
Explanation given by health personal	86%	57%	**71%**
Follow-up and counselling	71%	29%	**50%**
Total services provided	**86%**	**43%**	**64%**

Cost of health services, performance, and patients profile.

As indicated in table 20, the average amount paid for the consultation is 200 Rwf but the real cost of the services could not be calculated, since the majority of the patients interviewed were members of a health mutual because their co-payment is only a fraction of the full cost.

Concerning the performance of health services, we noticed that the prescribed drugs were available in all health centers and that none of the patients interviewed had received a prescription to go and buy drugs elsewhere, only 14% of children consultation had to process their laboratory test outside of the health centre.

The average age of the patients interviewed is 28 years, the large majority of the patients are women (93%); and that 72% of the interviewed patients were members of health mutual.

Table 20: Costs, performance and patient's profile

Categories	ANC	children Consultation	All
Amount paid for the consultation (Rwf)	150	250	**200**
% prescriptions to be purchased elsewhere	0%	0%	**0%**
% laboratory examinations to be made elsewhere	0%	14%	**7%**
Average age of the patients (years)	26	29	**28**
% female	86%	100%	**93%**
% member of a health mutual	43%	100%	**72%**

Antenatal consultation

The average of age of the pregnancy of patients attending the ANC were about 6 months old (varying from 3 to 8 months), and 43% of women had come for the first time. During this interview, patients were asked if some actions have been taken by the health care provider (as mentioned in table 21 below) during the antenatal consultation. It was noticed that only half of recommended actions (53%) were performed during the antenatal consultation. Weight control and abdomen examination were systematically done. Blood pressure control and foetal auscultation were done in 86% of the cases. The other actions were seldom done, such as measuring the size, gynaecological examination, and oedema examination, or HIV testing. Urine sample was never taken.

Table 21: Percentage of actions taken during the PN Consultation

Category	Actions taken (%)
Growth monitoring	14%
Weight control	100%
Blood Pressure Control	86%
Abdomen examination	100%
Gynaecological examination	29%
Foetal examination	86%
Oedema examination	57%
Blood sample	43%
Urine sample	0%
TT Vaccine	29%
HIV Test	43%
The nutritional counselling	57%
Average	**53%**

At the end of the interview, a knowledge assessment was carried out among the ANC clients in regard to pregnancy danger signs that require an urgent medical consultation. As shown in table 22, an average of 53% of the interviewed women declared that they knew danger signs related to pregnancy. 75% of the women spontaneously quoted as danger signs haemorrhage, fever (57%), and the presence of an oedema, dyspnoea and paleness (43%).

Table 22: Knowledge of the danger signs during pregnancy

Category	**Percentage**
Haemorrhage	75%
Fever	57%
Oedema	43%
Dyspnoea	43%
Paleness	43%
Total	**53%**

Children curative consultation Service

Most of the children (71%) who came for curative consultation were less than 36 months old, as indicated in table 23 below. 57% of the patients had with them their health card and 71 % had their vaccination cards. 71% of the children were weighed during the consultation. When examining the growth follow-up card, one notices that 60% of the children were within the green colour area (good nutrition) while 40% were in the yellow colour area (malnutrition). None of the children were in the red category (severe malnutrition).

Table 23: Characteristics of the patients seen at the curative consultation service.

Category	Percentage
Child age: < 36 months	71%
Health card	57%
Weight	71%
Vaccination card	71%
Growth follow-up Card	
Green	60%
Yellow	40%
Red	0%

The most frequent reasons for children consultation (see table 24) are fever and/or malaria (71%), respiratory problems (29%), and less significantly, diarrhoeas and vomiting (14%).

Table 24: Reasons for children consultation

Category	Percentage
Reason for consultation	
Diarrhoea / vomiting	14%
Fever /malaria	71%
Respiratory problems	29%
ENT problems	0%
Growth follow-up	0%

During this interview, patients were asked if specific actions were performed by the health care provider during the curative consultation of their child, as described in table

25 below. We notice that some of these actions were done frequently such as the physical examination (86%), and the pulse and stools control (57%), while other actions have been less performed such as weight and growth control (29%), hands and nails examination and abdomen palpation (14%). Eyes and oedema examination, and nutrition counselling were not performed for any of the child during the consultation. At the end of the consultation, 71% of the children had received anti-malaria and antibiotics prescriptions.

Table 25 : Percentage of the actions performed during the curative consultation

	Percentage
History taking	43%
Physical examination	86%
Temperature control	43%
Pulse control	57%
Weight control	29%
Growth measuring	29%
Eyes examination	0%
Hands and nails examination	14%
Palpation of the abdomen	14%
Stools Sample	57%
Blood Sample	29%
Oedema examination	0%
Nutrition Counselling	0%
Anti-malaria prescription	57%
Antibiotics prescription	57%

A knowledge assessment was done among parents of sick children who came for curative children consultation service, concerning the knowledge of danger signs of a sick child which require an urgent medical consultation. As shown in table 26 below, 100% of parents interviewed stated that they knew the danger signs. 43% of parents mentioned difficulties to drink and/or breast feed and vomiting, and 14% cited dyspnoea, convulsion, and diarrhoea with blood or a worsening disease. Nobody mentioned lethargy and/or unconsciousness as being a danger signs in children.

Table 26: Knowledge of the danger signs of a sick child

Categories	**Percentage**
Knowledge of the warning signals	*100%*
Difficulty in drinking / breast feeding	43%
Vomiting	43%
Lethargy / unconsciousness	0%
Dyspnoea	14%
Convulsions	14%
Becomes increasingly ill	14%
Diarrhoea with blood	14%

B. QUALITATIVE RESULTS

1. Head of health centers

Individualised interviews with head of each one of the health centers of district of Gisagara were conducted in order to inquire about their general impression about the impact of the CSP Concern project, on the performance of the Health Center, and also on the sustainability of the activities at the end of the CSP project.

Activities

The head of the health centers stated that they have noted positive changes since the CSP Concern Project started to operate in the district of Gisagara, especially in the 4 fields of interventions of the project: Malaria, Nutrition, HIV/AIDS, maternal and child health.

Concerning **malaria**, the head of health centers noted that since the beginning of the community based malaria treatment, children death rates have decreased, because children were treated at home before the disease worsens. Impregnated mosquito nets have become available at low prices and also that they are free of charge for pregnant women. Access to the mosquito nets allowed an increase in ANC attendance. They declare that the community understands better the advantage of sleeping under an impregnated mosquito net.

As for **nutrition**, thanks to the introduction of the Nutritional Training and Rehabilitation Centre (FARN) and the Community based weight control (PNBC) of the Concern project, heads of health centers noticed a better follow up of children nutrition in the community. The community health workers were trained to weight and follow-up children and have received the necessary materials to this effect. The PNBC revealed the major nutrition problem in the community and the need to adopt new behaviours with regard to good nutrition. Children growth monitoring is done at the community level, and “role model mothers” played a key role in the nutritional rehabilitation of the malnourished children. The FARN and the PNBC are well accepted by the community

and have made it possible to transfer in time severely malnourished children to health centres.

For **Maternal and Child Health**, the training and distribution of delivery kits to mothers have allowed an improvement of delivery at home, but also increasing transfers towards the health facilities. The net increase in deliveries rate at health facilities is the consequence of that change.

In the field of HIV/AIDS, one notes that many of the health centers which did not have functional VCT and PMTCT services, could now afford one, thanks to the support of the CSP Concern project. At the beginning, the CSP project contributed to transport of blood samples to Kibilizi HC for laboratory analyses and also provided consumables and material for blood samples. Anti-AIDS clubs were created and organised as well as several associations of PLWHA. HIV test acceptance in VCT and PMTCT services increased in a significant way.

It is also necessary to highlight a strong and steady enrolment of the population into health mutual thanks to the promotional activities organised by Community volunteers and local leaders, and the training health committees and health personnel.

Challenges

Even though the use of modern health services by the population has appreciably increased these last years, access to care still remains a problem, especially for the poorest. The increased enrolment in health mutual partially solves this problem. The other remaining challenge is the low rate of HIV tests, in spite of strong community sensitisation campaigns. The reinforcement of community based training, public testimonies, and sensitisation by volunteers must be maintained. Until now the health centres do not have nutritional centres. The introduction of nutritional rehabilitation unit at the health center level remains a priority, since the prescribed 12 days for FARN at community level are not sufficient to solve complicated cases of malnutrition.

Among the specific issues or constraints that the CSP Concern project helped to solve, one can particularly mention the distribution of mosquito nets to pregnant women, the Community volunteers training and health staff training, and the help in setting up of health mutual. In one of the health center, it was mentioned the CSP project helped in the construction of a water tank which allows now to have water even during the dry season.

Constraints and difficulties which existed before the beginning of the CSP Concern project and that are persisting today are the weak health mutual enrolment rate due to population poverty level and the management of the lack of nutritional center at the health facilities. In spite of the numerous trainings of TBAs and sensitisation of mothers to deliver at health facilities, the rate of those who deliver at home is still high. The VCT and PMTCT services are not yet established in all health centers, and in addition, transportation of blood samples still poses a problem.

Suggested Solutions

It is urgent to look for financial support in favour of the poor, in order to help them to enrol into health mutual which would give them access to health services. It will also be necessary to reinforce TBA associations and sensitise ANC clients to deliver at health facility level. Thanks to the help of the Global Fund and the Ministry of Health, all of VCT and PMTCT services are now technically and financially supported. The Ministry of Health is in the course of setting up a food support programme in favour of people living with HIV/AIDS which will solve some of the above mentioned problems

Gender

Although the CSP Concern project has organised gender trainings, no notable changes were yet noticed at the ground level. However, we noticed that women actively participate in Community associations and some women were elected as presidents of these associations.

Relation between the Health Centre and associations

The relationship of health centers and Community based associations has become more cordial and professional. Professional meetings and supervisions are more regular. The Community volunteers continues health activities in the community by sensitising and visiting sick people at home, and refer sick patients to health facilities before the disease worsens.

Sustainability

The head of Health Centers are committed to ensure that most of the current activities be maintained even after the end of the CSP Concern project. However, they are worried that delivery kits, mosquito nets, training courses and FARN will be difficult to maintain because of the limited resources at their disposal at the health center level. They suggested having transitional funds that would help the Health centers in maintaining some of these activities.

2. District Management Health Team (DMHT)

A focused group discussion was held with the district management health team (DMHT) of Gisagara district, in order to have their opinion on the management of the health services, their relation with partners and the way they intend to sustain their activities in the district.

Management

Thanks to the support of the Concern project, the management of the health services has improved a lot. Service meetings are more regular and held at least once a week. All members of the DMHT actively participate in these meetings, namely the hospital director, the Administrator, the Supervisors, the Accountant, the Secretary of the District, and the Manager of the Pharmacy. The meetings proceed according to a well defined agenda and the reports are presented and discussed in order to share the research of solutions to the existing problems. It also should be noted that the whole CSP project Team, together with as well as activists regularly participate in meetings with the DMHT and head of health centers.

Each position has a job description, with clear and well defined roles and responsibilities. The activity descriptions of each position were done by the district director in collaboration with all DMHT staff**.**

Supervisions are planned on a monthly basis and re-examined each week. Field visits allow the DMHT to directly observe activities of the Health Centers, to discuss and find solutions to the problems that are facing the health center staff. The performance evaluation system was established for all DMHT staff. Each staff knows his/her obligations and his/her responsibilities. The performance bonus is based on pre-established indicators and when the performance target is not reached, financial penalties are applied.

Decisions are made in the DMHT meeting, on proposal of the person in charge of the activity. This depends on the importance of the decision. Major decisions are made by

the team. Some decisions are made by the district director or the Administrator in case of emergency.

There is an annual written activity plan, except for the year 2006, due to the territorial changes in terms of demarcation.

Based on the activities to be carried out, the DMHT prepares an annual **plan,** with an implementation plan and budget. This plan is done in collaboration with Concern project team, the Head of health centers, and Health Center representatives, such as priests, nuns and pastors. A self-evaluation is organised each quarter, to assess the progress that has been made.

Several reports are compiled by the DMHT at various intervals. There reports that are made each month (SIS, EPI, FP), or each quarter (PNLIT). At the end of each quarter, a report is submitted to the head of the District in charge of health, Gender and Social Affairs. There is no specific time report for the Ministry of Health.
The Head of Health Centers share and discuss the monthly reports with the DMHT, during the monthly meetings.

Gender
The CSP project organised training in regard of gender issues for all health personnel of the health centers and the District team. The district has a policy that prohibits sex discrimination at work and staff recruitment and promotion is solely based on merit. Generally, in the Health facility there more women than men (for example, there are 5 women on a total of 8 heads of health centers).

Relation with partners
DMHT organises regular meetings (each month) with the provincial health authorities, but also at the central level of the Ministry of health. Several vertical programs and projects regularly meet with the DMHT of Gisagara district in order to evaluate the activities, but also to inform the DMHT of new directives and approaches recommended by the Ministry of Health.

CSP Project helped creating and training Health Committees as well as health mutual committees. Concern Activists are involved in the activity planning with the health center staff and help sensitising the population to subscribe to the health mutual. The CSP project helped to create the District Management Committee, but it is still not yet now functional. The CSP Project helped the District in particular with regard to:

- *Supervision*: Concern availed a vehicle for supervision twice a week. Concern project also helped providing drugs from Kigali. Thanks to that help, no vaccines or drugs went out-of-stock.
- *Immunization campaign*: Concern helped in providing a permanent vehicle during the immunization campaign (Vitamin A, Mebendazole, and Meningitis).
- *Transport*: Each Concern activist has a motor bike and whenever urgent need for transport arose at the Health Center level, the Concern activist was available to help. The CSP project granted a new ambulance to the District. CSP also availed motor bikes which were used during supervisions.
- *Training*: Several trainings were conducted and financed by the CSP project in several fields: Malaria, Nutrition, HIV/AIDS, Communication for a behaviour change, Family planning, antenatal care etc.

All this support has been very useful to the District. The District played a crucial role in the improvement of the quality of health services by regular monthly supervision activities at least once a month and the CSP project helped in the organising and facilitating these supervisions.

Sustainability

At the end of the CSP project, the DMHT envisages continuing most of the current activities, thanks to the following reasons:

- The availability of a vehicle offered by the government and which will be able to help in organising supervision

- Several people from the health staff and volunteers have already been trained, therefore, there will be a limited need for further trainings; and for future trainings government and other projects support is assured
- Home based malaria treatment will be financed by the MOH (Malaria program)
- VCT activities are already financed by the Global Fund project

Achievements, challenges and suggested solutions

Patients' transportation and health services supervision are among the key achievements accomplished by CSP Concern project since its beginning, which is now properly done thanks to the ambulance offered by the CSP project. The remaining constraints are related to the staff motivation and the lack of communication mean between Health facilities. In the future, the improvement can be focused on establishing of communication network between health facilities and establishing a contractual approach.

Technical support of the CSP Concern project

The CSP Concern project brought a technical support in several fields, the most important ones being:

1. *HIV/AIDS*: The CSP project supported two VCT services (Kansi and Kibilizi HC) at the beginning of their activities, by providing all the necessary material, but by now the Global Fund project has taken over its full financing.
2. *Maternal and Child health (MCH)*: the CSP Project organised training courses for TBAs, with emphasis of transferring pregnant women to health centres. It also trained the health personnel as regards family planning and antenatal care. CSP gave delivery kits which helped women a lot to prepare for childbirth. Efforts are made to continue the provision of these delivery kits, but the problem related to its high cost need to be resolved.
3. *Nutrition*: Malnutrition remains the major health problem in the District. The CSP Project implemented the Training and Nutritional Rehabilitation Center (FARN) which helps the community to deal with malnutrition issues. It is an approach to be recommended to other communities, for it is an efficient way of encouraging the community to fight against malnutrition.

4. *Malaria*: The home based malaria treatment (HBM) is one of the successful strategies at the level of District, since the results are remarkable and it is well accepted by the community. The CSP Project supported the HBM together with the support from the Minisanté (PNLIT). In collaboration with the PNILP, it is envisaged to implement HBM activities in all Gisagara sectors. In order to continue the mosquito nets distribution, a contact has been established with PSI which will continue to help the community health workers to provide mosquito nets to the population through sales with small benefit.

3. Community based associations

Focus group discussions were held with each of the 12 associations (4 CHW associations, 4 PLWHA associations and 4 TBA associations) on the several topics, and particularly concerning the activities and achievements made, the relation between the Health facilities and the community, about gender issues, and the issues related to the sustainability of activities after the end of the CSP Concern project.

Description of Community Based associations

The general and common goal of Community based health associations is to promote public health at the community level and also to improve the social and economic development of its members. As shown in table 27 below, most of the associations which we met were established between 2002 and 2004; the average number of members by association amounts to fifty people, ranging from 17 to 120 members. All associations are recognised by the administrative district and have legal representatives. The sources of income are primarily based on the members' contributions and all of them have bank accounts.

Table 27: Community based associations

Name	Start date	Representative	Members	Source of income	Category
Urumuli rw'abaturage (Kirarambogo HC)	2004	10	17	members and Concern Contribution	CHW
Duharanire ubuzima bwiza (HC)	2002	5	22	Members and MINISANTE contribution	CHW
Turwanye Sida (Kibayi HC)	2002	4	23	Members contribution	CHW
Twite ku buzima (Kigembe HC)	2002	8	33	Members and MINISANTE contribution	CHW
Abatanyurwa (Kansi HC)	2002	8	120	members and Concern Contribution	PLWHA
Abashyizehamwe (Kibilizi HC)	2004	4	46	Members contribution	PLWHA
Hora munyarwanda (Mugobwa HC)	2001	6	50	members and Concern Contribution	PLWHA

Akabando ki minsi (Kigembe HC)	2004	5	47	Members contribution	PLWHA
Abatabaranumwete (Kirarambogo HC)	2002	4	30	Members and Concern Contribution	TBA
Abagirimpuhwe (Gikore HC)	2003	3	32	Members and Concern Contribution	TBA
Abatabazi (Mugobwa HC)	2003	5	38	Members and Concern Contribution	TBA
Abakorerabushake (Kibilizi HC)	2003	3	21	Members contribution	TBA

Activities

The main activities of Community health worker associations aim at sensitising the population to support the Ministry of health policy and participate in various programs set up by the health centre such as: national immunization campaign, distribution of mosquito nets and anti-malaria drugs, family planning activities, prevention and voluntary HIV testing, the fight against malnutrition, and the promotion of hygiene.

The associations of People living with HIV/AIDS do a lot of anti-stigmatisation campaigns and educate the population by making public testimonies about HIV. The members help patients at home to do the housework, wash their clothes, cook their food, and accompany them to the health centre when they are very ill.

The traditional birth attendant associations do help mothers and their children by visiting women during pregnancy and after childbirth. They sensitise women for antenatal consultation and to deliver at the health facility, and also when necessary do help in delivery and or transfer them to the Health center.

The CSP Concern Project organised several training courses in favour of community based associations. There were training courses on tuberculosis, nutrition, and health mutual; on how to live positively with HIV/AIDS and also on reproductive health which were very helpful to community volunteers. The members of community associations are

now able to recognise several health conditions and particularly: children with growth and nutrition problems, malaria signs and respiratory diseases, and pregnancy complications. And they can now advise the population with regard to: children growth, , HIV infection transmission means, HIV voluntary testing, malaria prevention and treatment, preparing healthy food, and advising pregnant women.

The most recent referred cases (last 3 months) by community volunteers to health facilities were patients with malaria, persistent cough, persistent diarrhoea, and patients suffering from tuberculosis, children who did not respect their vaccine calendar, and abortions. All these cases were transferred to the nearest health centre because of its proximity to the population of community association.

The most important changes brought by the CSP concern project, which have been useful to the associations, consist mainly in trainings conducted that help them to acquire new scientific knowledge and prevention methods against the most current diseases in their community, and also the reinforcement of team spirit and help among members. The traditional birth attendants do not perform delivery at home any longer, except in emergency cases.

Motivation

The motivation of community volunteers in joining an association is mainly due to the desire to help others, and also for personnel gains that the association provides to its members, especially with regard to acquiring new scientific knowledge but also credits granted to members, and an easy access to ARV drugs for PLWHA.

Community associations held several and regular meetings, and generally on a monthly basis together with the health center staff. These meetings were useful since they allowed people to establish monthly programs and tackle health problems encountered at the community level. During these meetings, HIV/AIDS issues are almost always mentioned and several topics were usually discussed such as: HIV prevention, HIV testing, and sensitisation of those who tested positive to join the associations.

The problems that were encountered during theses meetings are absenteeism, which sometimes leads to the cancellation of the meeting when the quorum is not reached.

Relation with the Health Facilities

Each association has a special day to meet with the Health Centre which is usually attended by the head of the health center, and when he is not available, he is represented by a member of his team. The relationship with the Health Center has become more cordial and many changes were noticed, such as referral of patients from the community to the health facility: in the past, a patient transferred by a community volunteer used to pay cash up front before getting treatment but currently a referral note of the community volunteer is enough to get treatment. The Concern project team helped a lot in the improvement of this relationship, by serving as intermediary between the health centre and the associations.

Issues that need to be improved are the motivation (allowances and other incentives) and the lack of necessary material and equipment of community volunteers in order to allow them to achieve their goals.

Programs that were conducted by CSP Concern project and health centre towards associations were very beneficial to community associations especially the trainings which allowed community volunteers to acquire new knowledge on epidemic diseases, the creation of small income generating projects, a support for good financial management of grants received, and the development of internal cohesion among members of the association.

Relationship to the community

At Community level, association members visit patients at home; they also organise health training courses on hygiene, prevention against common diseases and on health mutual. They distribute mosquito nets, anti-malaria and anti-tuberculosis drugs at home, and give public testimonies on HIV/AIDS.

Community based associations are well accepted by the population because the volunteers are rendering many services which are generally free of charge, and also because volunteers are members and are part of the community. There are few formal meetings with other associations, except for few events at national level such as the international day against HIV/AIDS.

Achievements

Associations organised very few co-operative activities for their members except granting few and small credits for income generating activities and this is primarily due to the lack of financial means and materials because the association' main source of income is from meagre members' contribution and sometimes from donor' small grants. Nevertheless, associations have managed to organise notable activities such as: reducing severe malnutrition cases at community level, improving the population knowledge on the common diseases such as malaria and HIV/AIDS, reducing the stigmatisation of People Living with HIV, increasing enrolment into health mutual, and reducing the rate of deliveries at home and consequently reducing the rate of mothers' death. These achievements are primarily due to the training courses received from CSP Concern project, the support from health centre and from local administration authorities, and the members' personal commitment.

Gender

PLWHA members had received trainings on gender issues from CSP Concern project especially on how to take decisions as a couple with regard to sex intercourse and how couples facing difficulties should live together. On the other hand, community health workers and TBAs declared that they had not received any training on gender issues from CSP project.

Community volunteers interviewed stated that they learned a lot of things since they joined their association, as for instance, the respect and unity among association members, management and savings skills. PLWHA especially learned how to live positively with HIV/AIDS, to have a good nutrition, and to protect and avoid infecting

others. TBAs learned how to recognize danger signs of pregnancy and to transfer pregnant women to health center ahead of time and avoid practicing dangerous traditional treatment.

Community volunteers helped their association by paying their contributions regularly, and in caring out several activities of the association activities.

Sustainability issues

After the end of the CSP Concern project, members of the community associations stated that they were willing to continue the activities initiated by the CSP project. They can continue carrying out these activities because they had already acquired the necessary technical skills and also from the income from small income generating projects that they intend to start in the near future in order to enable them to become financially self-sufficient. TBAs, however, demanded to be helped to gain the same status and benefits as community health workers (incentives and other materials such as radios and bicycles) to enable them to perform efficiently their duties. TBAs also stated that they have difficulties to find people to train because the profession has become less attractive to young people.

People living with HIV/AIDS gave several public testimonies, especially during official ceremonies such as the international day against HIV/AIDS and during local elections. These testimonies helped in reducing stigmatisation and in encouraging people to be tested and also encouraged people who were tested HIV positive to enrol into the PLWHA association. In spite of the limitation of accessing anti-retroviral treatments, PLWHAs intend to continue and even intensify these public testimonies in the future.

V. DISCUSSION

The results of the analysis show that the health infrastructures of Gisagara district are old, the majority of the health centers were built in the 1970s and some of them need urgent rehabilitation in order to maintain their status. The number of beds is sufficient and the population served by health center is in the recommended range of the Ministry of health, which are about 20,000 inhabitants per health centre catchment's area.

The number of health personnel by health center amounts to 17 people and this number seems to be sufficient but the number of qualified health professionals such as A1 nurses are still low while the majority of the staff is rather constituted by a lesser qualified staff such A3 and A4 nurses and support staff.

There are sufficient community volunteers in Gisagara district (about 1 300 volunteers) and their number has significantly increased over these last years, undoubtedly due to the support from CSP Concern project.

All health centers have now a functional health committee and the management of health services has satisfactory improved. Some health centers do provide subsidies and discounted tariffs for the very poor people but the exact amount is not well accounted and known. Health centers will not be able alone, at long run, to help all the very poor people and there is a need for targeting the free enrolment of the very poor people into health mutual which is the best alternative solution.

The number of the curative and preventive consultations in all health centers sharply increased (almost three times) during these last 5 years. All health services are functional, except for some health centers for which VCT and PMTCT services are not yet in place. This gap is in the process of being filled thanks to the support of the Global Fund project. The post-natal care service is integrated in the routine consultations and

not a separated unit; this makes difficult to obtain specific data about the post natal care utilization, but still it seems that post natal care consultations are not frequently done.

Efforts have been made to organise health staff training, in the several priority fields, namely malaria, HIV/AIDS, ARI (Acute respiratory infections) and nutrition. Most of the trainings were organised during the last 2 years of the project. The supervisions of the health personnel and Community volunteers have also been regular and much more were conducted during the years 2004-2005. Information concerning the trainings and supervisions made especially in the first years of the project was not always available, because not recorded.

Community volunteers referred more and more patients to health facilities especially complicated malaria and delivery cases, while the counter-referrals were almost non-existent, which seems to be a common practice country wide.

Capacity and quality assessment of VCT services reveals that almost all health centers in Gisagara district FOSA have an operational VCT service, except for in Kirarambogo health center, but the knowledge and experience of the VCT service staff is still not adequate. The majority of the VCT staff obtained low scores during the evaluation, thus advocating for further training and supervision.

Patients' perception of the quality of ANC and children consultation services is very good, however there are some poor quality issues particularly those related to the long time spent at the health facility (between 4-8 hours), the high cost of the drugs and the lack of patients' follow-up. Some of these shortcomings can undoubtedly be improved without additional costs to the health center, and the establishment of good quality assurance strategy can be enough to tackle these issues as recommended by the Ministry of Health.

The clinical practice of VCT and children Consultation services staff was evaluated and it was observed that overall performance was just adequate. We noticed that several key

practices were not systematically performed such as: taking pulse, or give advice for the further follow-up of the patient. Additional trainings and close supervision are necessary. The level of knowledge of some of the patients, during the exit interview, concerning the danger signs of pregnancy or illnesses of sick child was not satisfactory; most of the patients could not cite major danger signs spontaneously.

The heads of centers and the DMHT acknowledged that they have noticed positive changes since CSP Concern Project started to work in the Gisagara district, especially in the 4 major intervention areas: malaria, Nutrition, HIV/AIDS, and maternal and child. The management as well as planning and supervisions of health services have improved and the relationship and meetings with other stakeholders became more regular. However, there are still challenges especially in regard to the lack of access of health services by the poorest people and the slow behaviour change of the population particularly with regard to HIV/AIDS and nutrition. Development of community health insurance schemes and the participation of local authorities, as well as the reinforcement of public awareness campaigns remain among the strategies to be maintained and strengthened.

Community volunteers have organized themselves in associations; they all are unanimous to state that CSP Concern project contributed much in setting up these associations and also helped them to fulfil their duties in the community. Though their associations are still young, the volunteers have been able to carry out noticeable achievements and had positive impacts on their community. Most of volunteers are now able to recognise major signs of the most common diseases in their community and are since referring many cases to the health facilities. The relationship between the community and the health facilities has become more cordial and meetings are more regular.

After the end of the CSP Concern project, heads of health centers, the district management health team and members of the community associations in Gisagara district stated that they are all committed to continue the activities initiated by the CSP project. This will be possible thanks to the technical skills they acquired from the CSP project and

also through the committed support from the national and local authorities. The creation of income generating projects for the volunteers is a way to enable them to become financially independent.

VI. RECOMMENDATIONS AND CONCLUSION

At the end of this study and in regard to the obtained results and constraints noticed, several recommendations can be made:

- Ensure infrastructure renovation of health centers, especially the very old ones, in order to maintain their status
- Recruit additional health personnel, especially qualified A1 and A2 nurses in order to improve the quality and performance of the health services.
- Establish a quality assurance team in all health facilities in order to guarantee a better quality of services to the community.
- Establish VCT and PMTCT services in all health centers in collaboration with the Ministry of Health
- Establish a performance monitoring system and motivation of the health personnel, as it is done in other health (contractual approach).
- Continue to encourage enrolment of the population into health mutual and envisage subsidies for the poorest.
- Reinforce community based associations and envisage establishing a follow-up and evaluation system, and also a contractual approach.

In **conclusion**, the evaluation of the health facility and Community based associations capacity operating in Gisagara district showed that the management and performance of health services have significantly increased since the beginning of the CSP Concern project. However, the quality of the services provided is not yet very satisfactory; specific efforts are necessary to reach the desired level. Although all the health players of the district (heads of health centers, DMHT, and community volunteers) are committed to continue the activities initiated by the CSP project, the sustainability issues remain a challenge which will require, in the short term, transitional support strategies.

VII. APPENDIXES

1. Questionnaires

1. **Health Facility Questionnaire**
2. **VCT Questionnaire**
3. **VCT and children consultation services Questionnaire**
4. **Community associations and DMHT Questionnaire**

Part 1 : Questionnaire for Health Facility

EVALUATION OF HEALTH FACILITY IN KIBILIZI DISTRICT

NAME OF INTERVIEWER CODE:

DATE OF INTERVIEW DAY: MONTH: YEAR:

TIME INTERVIEW BEGAN:

TIME INTERVIEW COMPLETED:

CONSENT TO INTERVIEW

INTERVIEWER: Hello: My name is _____. I am from _____.

We would like to know about the types of services you provide in this facility so that we can seek ways to improve the quality care. Any information you give us will remain strictly confidential. Whether or not you participate in this interview, there will be no negative effect on the facility or respondent. No information will be linked to you or this facility. You may refuse to reply to certain questions, or end this interview at any time.

Do you agree to participate in this interview?

YES, the respondent accepts.....1
NO, the respondent refuses .....2 | **→STOP**

NAME OF RESPONDENT

POSITION OF RESPONDENT_____

TITULAIRE…….....1
SUPERVISOR.....2
ADMINISTRATOR.....3
NURSE.....4
OTHER (SPECIFY_____).....5

COMMENTS:

	SUPERVISED BY	EVALUATED BY	ENTERED BY
NAME			
DATE	DAY MONTH	DAY MONTH	DAY MONTH

SURVEY QUESTIONNAIRE

I. General Information

N°	Variables/ Questions	Responses	Code
Q1	Name of Health Facility (HF)		☐
Q2	Location of HF	Sector _____ Cell :_____	
Q3	Category of HF	1. Public 2. Agrée	☐
Q4	In what year did this facility open?	Month _____ Year _____	
Q5	Approximately how many people does this facility serve?	n=	
Q6	Total number of beds of the HF (in good state)	n=	
Q7	Number of health personnel	Male Female 1. A1 n= 2. A2 n = 3. A3 n = 4. Auxiliaires de Santé n= 5. Assistantes sociales n= 6. Nutritionniste n= 7. Lab Technicien n = 8. Travailleur n= 99. Others (give details) _____ n= _____ n=	

Q8	Number of community volunteers	**Male** **Female** Traditional Birth Attendants n= Health Animators n= Drug Distributors (malaria) n= PLWHA n= Others (specify): _____n = _____n=	
Q9	Does this health facility have a Health management committee (COSA) with members outside of the facility?	1. yes 2. no	
Q10	How often does this committee usually meet?	Weekly Twice per year Monthly Every 3 months Annualy Others (specify)_____	☐ ☐ ☐ ☐ ☐ ☐
Q11	Is there a system of exemption for the poor or those who can not afford to pay?	1. oui 2. non	
Q12	What is the type of these exemptions?	Total free service Reduction in cost of service Provision of in kind service	☐ ☐ ☐
Q13	Services, Utilization	Does this facility provide this service? For each service can you please record the total number of patients listed in the register for the last 6 months, starting Dec 2005 to May 2006 Malaria treatment for children 1. oui 2. non ☐☐ Child growth monitoring 1. oui 2. non ☐☐ Prenatal care 1. oui 2. non ☐☐ Post natal care (mother) 1. oui 2. non ☐☐	

		Facility based delivery - Normal 1. oui 2. non ☐☐ - Assisted (forceps, vacuum) 1. oui 2. non ☐☐ Blood transfusion 1. oui 2. non ☐☐ **STI services** -Etiologic diagnosis 1. oui 2. non ☐☐ -Syndromic approach 1. oui 2. non ☐☐ -Treatment 1. oui 2. non ☐☐ -Counselling 1. oui 2. non ☐☐ **HIV/AIDS services** -VCT 1. oui 2. non ☐☐ -ART 1. oui 2. non ☐☐ -PMTCT 1. oui 2. non ☐☐ 24 –hour emergency care 1. oui 2. non ☐☐ outpatient clinic 1. oui 2. non ☐☐ Inpatient stay 1. oui 2. non ☐☐ Referral services (ambulance) 1. oui 2. non ☐☐	
Q14	a. Number of training received during years 2001-2005	2001 2002 2003 2004 2005 Deliveries : CPN : VCT PMTCT Nutrition CC Diarrhea Malaria STI post natal cons Mutuelle Family Planning Gender HIV/ SIDA IEC Respiratory diseases Other Autres (give details) _____ _____ _____	
	b. Number of people trained per year 2001-2005	2001 2002 2003 2004 2005	

Q15	Number of supervisions received per year 2001-2005	2001 2002 2003 2004 2005	
Q16	Types et number of supervisions received by health personnel of the HF from Dec.2005 - May 2006	- Deliveries n= - Prenatal cons. n= - Immunization n= - AIDS n= - Nutrition n= - **Curative Consultations** Malaria n= STI n= Diarrhea n=	
Q17	Type et number of supervisions done by health personnel of HF from Dec.05 - May 2006. (see supervision book)	- Animateurs de santé n= - TBA n= - Distributors of anti malaria n= - Mamans lumières n= - Comités de mutuelle n= - Volontaires n= - Others n=	
Q18	Number of transfers and contre références from Dec.05 - may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q19	Deliveries from Dec.05 -may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q20	Malnutrition from Dec.05 - may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q21	Respiratory Infections from Dec.05 -may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q22	Malaria from Dec.05- may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q23	Diarrhea diseases from Dec.05 - may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q24	New born from Dec.05 -may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	

Q25	Immunizations from Dec.05 - may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q26	AIDS from Dec.05 - may 2006	Refered by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n=	
Q27	Total number of activities (year 2005)	1. Deeliveries performed n= 2. Confirmed malaria n= 3. VCT n= 4. PMTCT n= 5. STI n= 6. Nutrition n= 7. Prenatal consultations n= 8. Post natal Consultations n=	
Q28	When was the last meeting of the titulaire/health personnel with: 1. <= 1 month 2. 1- 3 month 3. > 3 Month 4. Never met	1. Health personnel 2. health animators 3. TBA 4. Community Volonteers 5. Les titulaires of other FOSA 6. DHMT 7. COSA 8. anti-malaria Distributors 9. Mutuelle committee 10. Others (give details) _____ _____ _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Q29	Three most important common diseases relating to children and pregnant women. Place a tick in the appropriate square	Children <5 yrs / Women Malaria ☐ ☐ Respiratory Diseases ☐ ☐ Diarrhea ☐ ☐ Acute Resp Infections ☐ ☐ Malnutrition ☐ ☐ Complications of pregnancy & postpartum ☐ ☐ Accidents & Injuries ☐ ☐ Hepatitis ☐ ☐ AIDS ☐ ☐ Tuberculosis ☐ ☐ Leprosy ☐ ☐ OTHERS (SPECIFY)	

II. General Impressions

A. What positif chnages have you noticed since concern started working with you *? (malaria, Nutrition, AIDS/HIV, Maternel and child health)*

Malaria : (HBM, ITNs)
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Nutrition : (FARN, PNBC)……
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Maternel and child health : (TBAs)
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HIV/AIDS: (PMCTC etc.
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Others (give details) : (Mutuelle etc.)
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B. Which have been the most helpful or made the most difference? Why?

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……

C. Give your opinion on health services offered in your health facility (strengths, weaknesses, and suggestions for improvements).

What was the big challenge and why ?.....

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What constraints have encountered that Concern help to solve ?

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What are the constraints that were present before Concern started but that are still not solved ?.……...……

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Solutions proposed?

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D. How did the CSP project activities changed your attitude towards men's and women's roles and responsibilities?What made the most difference.

E. What and how is the working relationship between the health centre and the community volunteers

……
……

……
……

F. The project is ending in September, do you think the CSP activités implemented in your health centre will continue after that? Why? If NO, what can be done to make it sustainable?

G. Any other comments that you wish to make?……
……
……
……
……
……
……
……

Thank you for your collaboration and your help.

HEALTH FACILITY ASSESSMENT

PART 2 – Health staff skills' assessment
Name of the health center:_____

VCT SERVICES - Interviewer administered VCT protocol

1. Does this health facility provide voluntary counselling and testing for HIV?

YES..1
NO...2 (»next section)

2. Can you please identify a staff person present today who provides VCT?

NAME_____

The following questions should be directed to this person.

3. Can you please tell me your qualifications?

a. Nurse A2 1
b. Nurse A3 2
c. Auxiliary staff, > 1 yr of training . . . 3
d. Auxiliary staff, < 1 yr of training . . . 4
e. Laboratory technician 5
f. Counsellor 6
g. Other (SPECIFY_____) 7

4 In what year did you complete your studies? **YEAR:** ____

5 Have you received additional training since you graduated?

YES..1
NO...2 (»7)

Can you tell me, for each of the following areas, whether you received additional training and, if so, who organized this training??	**6.Did you receive training in [--]? YES..1 NO...2 (»NEXT)**	**6.a.By Whom Concern …1 MOH/District…2 Caritas….3 Others…4**
PMTCT		
ART		
VCT		
STI syndromic approach		
STI etiologic diagnosis		
STI (non-HIV) treatment		
STI (non-HIV) counselling		
OTHERS (_____)		

We would like to understand the process by which you provide voluntary counseling and testing for an adult person who may be HIV positive. We would like to know about everything you do, beginning with the arrival of the patient and ending when the patient goes home. I shall describe a clinical case, and I will ask you a series of questions about activities that you would regularly do for such a case. Are you ready? Now I will read out the case (READ OUT 2 TIMES):

Mrs. Baribwira, a married woman of 32 years, came to this facility alone to find out more information about voluntary counseling and testing for HIV. She does not appear to be pregnant and has no symptoms of any opportunistic infections.

7. What questions do you ask Mrs. Baribwara about her medical and personal history?

FIRST LISTEN TO THE RESPONDENT. ANY QUESTION THAT HE OR SHE MENTIONS SHOULD BE MARKED WITH CODE 1. AFTER THE RESPONDENT IS FINISHED, FOR ANY QUESTION THAT HE OR SHE DOES NOT MENTION, ASK EXPLICITLY IF THIS QUESTION WOULD BE ASKED, AND CODE THE APPROPRIATE RESPONSE:

RESPONSE CODES:
MENTIONED WITHOUT PROMPTING....1
HAD TO PROMPT, ANSWERED YES....2
HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

a. Any current illnesses? ☐

b. Any current or previous STI? ☐

c. Understanding about how HIV is transmitted? ☐

d. Age at first sexual intercourse? ☐

e. Number of sexual partners in last 12 months? ☐

f. Had sex under the influence of drugs or alcohol? ☐

g. Condom use during last sexual encounter? ☐

h. Ever had unprotected sex? ☐

i. Has been tested for HIV before? ☐

j. Other exposure to blood products? ☐

k. Existing knowledge about HIV testing? ☐

i. Recent pregnancy test? ☐

j. Partner's HIV status? ☐

k. Ex-refugee/returnee status? ☐

l. autres:…….

8. l. Mrs. Baribwara states that she wants to be tested for HIV. What do you explain to her before she takes the test?

AGAIN, FIRST LET THE RESPONDENT ANSWER. AFTER HE OR SHE IS FINISHED, ASK EXPLICITLY ABOUT ANYTHING NOT MENTIONED BY THE RESPONDENT.

RESPONSE CODES:
MENTIONED WITHOUT PROMPTING....1
HAD TO PROMPT, ANSWERED YES....2
HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

a. Meaning of HIV+, HIV-, and indeterminate results ☐

b. Meaning of the "window period" ☐

c. When the results will be ready ☐

d. How the results are given/post-counseling period ☐

e. Confidentiality of testing and results ☐

f. Cost of the test ☐

g. Voluntary nature of testing ☐

h. Referral and support services available

i. Availability of ART

l. PMTCT

m. Husband to be tested with counselling

n. Autres:…….

9. Mrs. Baribwara returns to the facility to obtain the results of the test. The test results are negative. How do you proceed with the patient's counselling?

AGAIN, FIRST LET THE RESPONDENT ANSWER. AFTER HE OR SHE IS FINISHED, ASK EXPLICITLY ABOUT ANYTHING NOT MENTIONED BY THE RESPONDENT.

RESPONSE CODES:
MENTIONED WITHOUT PROMPTING....1
HAD TO PROMPT, ANSWERED YES....2
HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

a. Ask her how she feels since taking the test

b. Ask her is she is ready for the results

c. Discuss the meaning of the results

d. Discuss repeating the test if exposed to HIV w/in 3 months

e. Discuss reducing risk/ preventing exposure to HIV in future

f. Discuss condom use

g. Discuss partner's HIV status

h. Discuss sharing the results with partner

i. Encourage partner to get HIV test

j. Provide condoms

K. Others:

THIS IS THE END OF THE VCT CASE SCENARIO.

Thank you for your participation.

2. Survey Schedule

HF and Association Kibilizi Evaluation: Field visits: Timetable: 12-16 June 2006

Hours	Monday	Tuesday	Wed	Thursday	Friday
From 8a.m. to 12	Kirarambogo HC (T1)	Gikore HC (T1)	DMHT-Kibilizi (T1)	Kansi HC (T1)	Kibilizi HC (T1)
From 8 to 12	Kigembe HC (T2)	Mugombwa HC (T2)	Kibayi HC (T2) PLWHA - Kansi (T1)	TBA-Kibilizi (T2) PLWHA-Kibilizi (T2)	
From 2 to 3 p.m.	CHW -Kirarambogo (T1)	CHW -Gikore (T1)	CHW-Kibay (T2)		
From 3 to 4 p.m.	TBA-Kirarambogo (T1)	TBA-Gikore (T1)			
From 2 to 3 p.m.	PLWHAKigembe (T2)	PLWHA - Mugombwa (T2)			
From 3 to 4 p.m.	CHW-Kigembe (T2)	TBA-Mugombwa (T2)			

3. Selection Criteria for Community based associations

LIST OF HEALTH FACILITIES /INSTITUTIONS/ASSOCIATIONS FOR THE CONCERN RWANDA QUALITATIVE SURVEYS

1. HEALTH FACILITIES (7) :

Kibilizi HC
Kansi HC
Mugombwa HC
Kigembe HC
Kibayi HC
Gikore HC
Kirarambogo HC

2. PLHWA Associations (4) in:

Kansi – strong association group
Kibilizi – medium group
Mugombwa – medium group
Kigembe – nascent group

3. Health Organisers (CHW associations (4)

Kibayi – attached to govt
Kigembe – attached to govt
Gikore – semi-private/private (Caritas)
Kirarambogo – semi-private/private (Caritas)

4. TBA association (4)

Kibilizi – training in 2003
Mugombwa – training in 2003
Gikore – training in 2006 (strong TBA assoc)
Kirarambogo – training in 2006 (strong TBA assoc)

5. Institution (1)

Kibilizi Health District Team

CSP evaluation steps

A. Evaluation of PLH associations. Some criteria have been identified in order to qualify an association as being strong, medium, nascent or weak.

These criteria are the following:
1. To have an income generating association (IGA)
3. Total Number of members
4. To have an official approval
5. Duration of the association
6. To have a bank account
7. Rate of Meetings
8. Testimony of People Living with HIV

This table gives more explanation on the choice of associations based on the above mentioned criteria :

	Mugombwa	Gikore	Kibilizi	Kansi	Kibayi	Kigembe	Kirarambogo
IGA	YES	YES	YES	YES	?	NO	YES
Number of members	70	42	46	120	32	46	38
Status	YES	DRAFT	YES	YES	?	YES	YES
Approval	YES	?	YES	YES	?	YES	YES
Duration	5 YEARS	3 YEARS	2 YEARS	5 YEARS	?	1 YEAR	4 YEARS
Bank Account	YES	YES	YES	YES	?	NO	NO
Meetings frequency	Weekly	Weekly	Weekly	Weekly	Monthly	Weekly	Weekly
Testimony	YES	YES	RARE	YES	RARE	YES	YES

Thus the PLH association of the Kansi Health Centre has been evaluated as strong, Mugombwa and Kibilizi as medium and Kigembe as nascent.

B As for the evaluation of health Organisers associations, it has been done according to the same process; the Kigembe and Kibayi associations have been evaluated as strong among the public health centres. Among the approved health centres, strong Health Organizers associations are found in the health centre of Gikore and Kirarambogo.

C. Evaluation of traditional midwives associations
The team has chosen 2 associations which had benefited from training courses in 2003, namely the traditional midwives of Kibilizi and Mugombwa. Among the remaining associations trained in 2006, we have evaluated Gikore and Kirarambogo as strong, once again according to the criteria chosen for associations of PLH.

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

(printed from PDF file from CSTS database)