WORLD RELIEF

WORLD RELIEF RWANDA
"UMUCYO" CHILD SURVIVAL PROGRAM

Fourth Annual Report
FY 2005

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Cooperative agreement: HFP-A-00-01-00029-00

Program Location: Kibogora Health District, Cyangugu Province, Rwanda

Program Dates: 30 September 2001- 29 September 2006

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ACRONYMS

ADRA	Adventist Development and Relief Agency
CBNP	Community-Based Nutrition Program
CDC	Community Development Committees
CG	Care Group
CSP	Child Survival Project
DIP	Detailed Implementation Plan
EOP	End of Project
FHI	Family Health International
FP	Family Planning
HBM	Home Based Management
HC	Health Center
HF	Health Facility
HIS	Health Information System
HMIS	Health Management Information System
IRC	International Rescue Committee
ITN	Insecticide Treated Net
KHD	Kibogora Health District
KPC	Knowledge, Practice, Coverage
LRA	Local Rapid Assessment
MFL	Mobilizing For Life
MIS	Management Inforrmation System
MOH	Ministry Of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
PD	Positive Deviance
PLWHA	People living with HIV/AIDS
PMTCT	Prevention Mother-to-Child Transmission
PSI	Population Services International
RPR	Rapid Plasma Reagin
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WR	World Relief
WRR	World Relief Rwanda

Child Survival and Health Grants Program Project Summary

Oct-28-2005

World Relief Corporation (Rwanda)

General Project Information:

Cooperative Agreement Number:	**HFP-A-00-01-00029-00**
Project Grant Cycle:	**17**
Project Dates:	**(9/30/2001 - 9/29/2006)**
Project Type:	**Standard**

WRC HQ Backstop: **Olubukola Ojuola**

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Funding Information:

USAID Funding:(US $): $1,300,000 **PVO match:(US $)** $433,333

Project Information:

Description:

Program goals are: 1) to reduce morbidity and mortality in children 0-5 and women 15-49, 2) to strengthen the capacity of the KHD to implement and sustain CS interventions, and 3) to empower communities to make decisions to improve their health. Toward the realization of these goals, primary areas of intervention include diarrheal diseases, vaccine-preventable diseases, malnutrition, HIV/AIDS and STIs. Project major strategies include community-wide education in HIV/STI prevention, promotion of voluntary counseling and testing, and home care; community-wide education in malaria prevention and treatment seeking behaviors; improved access to ITNs and re-treatment; community-wide education to promote improved infant and child feeding, community-based rehabilitation of malnourished children through Hearth, and VAC distribution at EPI clinics; education to improve hygiene and home treatment of diarrhea using ORT, improved access to ORS, and training of drug sellers to improve rational drug use; community-wide education and expansion of mobile EPI clinics to improve access to services; and promotion of safe delivery via TBA training, improvements in quality of care, and assisting communities to plan for obstetric emergencies.

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community

US HQ (CS unit) Field Office HQ CS Project Team	Local NGO	Pharmacists	Dist. Health System Health Facility Staff	Health CBOs

Interventions/Program Components:

Immunizations (15 %)

(CHW Training)
- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Mobilization

Nutrition (15 %)

(IMCI Integration)
(CHW Training)
- Comp. Feed. from 6 mos.
- Hearth
- Cont. BF up to 24 mos.
- Growth Monitoring

Control of Diarrheal Diseases (15 %)

(IMCI Integration)
(CHW Training)
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling
- POU Treatment of water

Malaria (20 %)

(IMCI Integration)
(CHW Training)
- ITN (Bednets)
- Care Seeking, Recog., Compliance

Maternal & Newborn Care (10 %)

(CHW Training)
- Recog. of Danger signs
- Emergency Transport

Breastfeeding (5 %)

(IMCI Integration)

(CHW Training)
- Promote Excl. BF to 6 Months

HIV/AIDS (20 %)

(CHW Training)
- OVC
- Behavior Change Strategy
- Access/Use of Condoms

Target Beneficiaries:

Children 0-59 months:	**24,021**
Women 15-49 years:	**34,066**

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
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)	43	272	15.8%	6.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	98	134	73.1%	16.3
Percentage of children age 0-23 months whose births were attended by skilled health personnel	125	289	43.3%	9.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	130	297	43.8%	9.4
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	32	53	60.4%	24.7

Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**51**	**210**	**24.3%**	**8.8**
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**101**	**214**	**47.2%**	**11.4**
Percentage of children age 12-23 months who received a measles vaccine	**164**	**214**	**76.6%**	**13.0**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**8**	**271**	**3.0%**	**2.9**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**277**	**300**	**92.3%**	**11.3**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**24**	**214**	**11.2%**	**6.2**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**240**	**300**	**80.0%**	**11.1**
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	**0**	**300**	**0.0%**	**0.0**

Comments for Rapid Catch Indicator

A. MAIN ACCOMPLISHMENTS

Umucyo has continued to make progress after the successful Mid-Term Evaluation conducted in August 2004; thanks to the hard work and commitment of volunteers, staff and partners.

Key achievements of the Umucyo CSP in year four are highlighted below. Refer Annex 1 for chart summarizing progress made towards CSP objectives.

1. VOLUNTEER DEVELOPMENT

233 Care Groups of 2998 committed volunteers form the foundation of the project. In 2005, the average attendance rate for all care groups was 85 % and the volunteer default rate did not exceed 4%. Such high rates of participation and commitment are attributable to the supportive supervision the volunteers receive, as well as the positive reinforcement given by the community and district team for the volunteers' valuable contribution to maternal and child health in Kibogora district. Umucyo acknowledges the importance of publically recognizing the contribution of volunteers in their communities and providing opportunities for personal development; and has promoted this.

Within the framework of sustainability of community-based activities in the domain of health, Umucyo volunteers' capacity building was considerably reinforced in order to accurately help them take responsibility for their tasks.

During the year 2005, all the volunteers received refresher training in the three main program interventions - Immunization, Maternal and Newborn Care, Nutrition and Breastfeeding; including home-based management of malaria,, growth monitoring, control of epidemics, data collection (HMIS) and community-based nutritional rehabilitation strategy. Every care group (CG) has at least two volunteers responsible for such community-based services as home-based management of malaria, growth monitoring,, and Hearth. Therefore, the quality of care provided by volunteers at the community level has improved tremendously.

This year Umucyo volunteers played a major role in health-related matters at the community level because Kibogora Health District (KHD) has more confidence in their work, and now places them at par with other health community agents in the district. A network of community health workers, including Health Animators and Maternal Health Animators and CG volunteers was created, and some of the volunteers were elected as representatives at HC level.

Umucyo volunteers got more involved in health center (HC) activities by informing mothers about the calendar of outreaches and mobilizing them for immunization. In those outreach sites, they align the mothers and take advantage of the occasion to carry out some CG activities such as weighing children, selling ITNs, 'Kalishya Force'; ORS and 'Sûr' Eau'. They communicate with the HCs through the referral/counter-referral system of immunization defaulters and through other events necessitating the community mobilization such as vitamin A supplementation campaigns.

All the CG leaders received technical support and supervision in participatory adult education

techniques, activity planning and coordination, and reporting guidelines. Thus, the CG leaders were empowered to take responsibility for leading volunteer meetings and trainings in the community, and to produce reports for the Community Development Committees (CDCs) and health centers. Their leadership skills have improved and they are sufficiently prepared to replace the promoters as the promoters progressively reduce their involvement in program activities.

The volunteers were sensitized about forming income-generating associations, and about 96.5% of them have accepted to work in associations.

Umucyo continues to provide regular training, supervision, and management tools (registers, store cards, registers for inputs & outputs, etc) to the management committees of 202 volunteers' associations. Umucyo assists these associations in assigning tasks to select volunteers or groups of volunteers. For example, 'Light Mothers' are assigned to lead Hearth programs; some volunteers take responsibility for growth monitoring, some are maternal health animators, and others are anti-malarial drug distributors. The project also helped the volunteers to get formal registration/ approval attestations given by administrative districts, and to open bank accounts locally. The project supports these associations by providing them some health promotion products which they sell in the community and save proceeds in the bank. The association receives a portion of money for items sold, e.g. 200frs ($0.35) on ITN, 100frs ($0.17) on Kalishya Force, 50frs ($0.09) on Sûr'Eau. Similarly, every family is sensitized about giving to the volunteer association 50frs every quarter per child as a contribution for the community-based nutrition program. Now, the assets of all the volunteer associations are 5,326,787francs ($9,426). Records of purchases and sales are well kept, and an association management committee has been set up, to ensure accountability and sustainability. Furthermore, Umucyo provided 836 sheep/goats to these associations, which have multiplied to 1,098 small ruminants; providing a source of income, manure, animal proteins, etc, to the volunteers.

The CSP initiated 5 volunteer associations of PLWHAs that currently include 54 members. This will help build social support for the PLWHAs, and also serve as a resource for delivering specific messages on HIV/AIDS prevention and care for other PLWHAs. In response to the advocacy efforts of the project World Relief Rwanda Micro Enterprise Development Program, awarded a grant of 705000francs ($1,250) to support small business/ income generating initiatives developed by the associations.

2. INTERVENTION HIGHLIGHTS

a. DIARRHEA DISEASE & HYGIENE

Within the context of prevention of diarrhea diseases, community-based education activities have continued through home visits and messages transmitted to the community during meetings.

The following key messages for care of children with diarrhea continue to be delivered to the community:

- Provide same quantity of food
- Ensure adequate levels of fluid intake and breastfeeding to reduce the risk of dehydration
- Develop the habit of washing hands
- Have adequate and functional latrines at home.

These messages have been continually planned and delivered in the community in collaboration with KHD, which already has a staff in charge of hygiene. The epidemic of typhoid fever that broke out was quickly suppressed because of the joint efforts of the program and KHD staff, and no case of cholera was identified in the community this year. This is contrary to the situation in previous years in the regions bordering Lake Kivu.

To reinforce the practice of drinking clean water, volunteers continue to sell a water purification product called Sur Eau within the community. The volunteer associations sold a total of 2,775 bottles to households within the community.

For the community to care for diarrhea cases, Umucyo in collaboration with UNICEF Rwanda made about 10,000 packages of ORS available through widespread distribution to households and promoting the use of home-prepared fluids in the absence of ORS packets.

b. IMMUNIZATION

The volunteers have continued to deliver to the households the following key messages on immunization:

- Have your child vaccinated prior to the first birthday.
- Have pregnant women receive at least two tetanus toxoid (TT) doses during pregnancy.

Umucyo surpassed the goals established for the immunization intervention in that 88% (EOP goal 85%) of all children of one year were immunized and 55% (EOP goal 50%) of all pregnant women within the community received tetanus vaccination prior to delivery. In addition, Umucyo volunteers have helped identify and trace 568 immunization defaulters through the existing referral system.

The program assists in outreach programs by transporting staff and materials to vaccination sites, and mobilizing the community to access immunization services. Umucyo supported 369 immunization outreaches at the HC level. The project support enabled the HCs to start eight new immunization outreach sites and the CSP staff contributed to improving the immunization data records kept by MOH staff, a major handicap for HCs in the past. Furthermore, activities such as deworming, Growth Monitoring, VIT A distribution, Antenatal check-up, ITNs, ORS and Sûr'Eau sales have been integrated into immunization outreach activities.

c. HIV/AIDS & STIs

Household members, associations caring for PLWHAs, and the community in general, have received key messages on the prevention of HIV/AIDS infection, and care of HIV/AIDS patients.

Sensitization for VCT and PMTCT were carried out in the community through various means, including home visits, community meetings, immunization sessions, antenatal check-up and churches. For the occasion of "Two-weeks AIDS", prepared at the national level, Umucyo mobilized the community for VCT. Umucyo provides ongoing transport and other logistical support to the mobile VCT campaigns of Kibogora Hospital, until the HC starts its VCT and PMTCT services in December 2005.

In FY 2005 a total of 9861 people were voluntarily tested for HIV and 10% of them tested positive to the virus. Through PMTCT services 2323 pregnant women were tested, and 6% were HIV positive. Sixty-three percent of HIV-positive pregnant women received Nevirapine during labor and 62% babies of HIV-positive mothers received Nevirapine.

In an attempt to reinforce the sensitization carried out in churches, Umucyo organized a training-of-trainers workshop where 224 trainers from nine local churches were equipped to train people in their respective churches about HIV/AIDS. Following these trainings, 4 Anti-AIDS Clubs, 11 PLWHAs and 2 PLWHA associations were initiated within these local churches.

To enhance the activities of the Nyamasheke administrative district Commission in Charge of the Fight against AIDS (CDLS), Umucyo provided both technical and financial support to the commission during a two-day training workshop, and another three-day planning workshop(for preparing its annual action plan for 2006).

Umucyo mobilized its HIV-positive volunteers to form associations/support groups in order to create vital social support for members and other PLWHAs. A total of five associations of 54 volunteers were formed, and have received financial support from World Relief Micro-Enterprise Development Program to establish small businesses where they sell beans, dried fish, juice, flour, etc.

STIs

The community has continued to receive education on the recognition of suspected symptoms, prevention, and early treatment of STIs through the year.

In collaboration with Kibogora Hospital, the project has compiled and analyzed the data from Kibogora HC on syphilis testing for pregnant women attending the antenatal clinics. Two percent of pregnant women tested positive for syphilis, using the Rapid Plasmid Reagin (RPR) test.

The collaboration with the grassroots level authorities, church leaders, Kibogora Hospital and other World Relief Rwanda programs are the key factors that enabled us to attain this level of success in our program activities and community-wide behavior change.

d. MALARIA

The two main messages delivered to households on malaria intervention are:

- Sleep under insecticide-treated mosquito nets, especially children under five and pregnant women
- Seek treatment within 24 hours at the health center or pharmacy for children with fever.

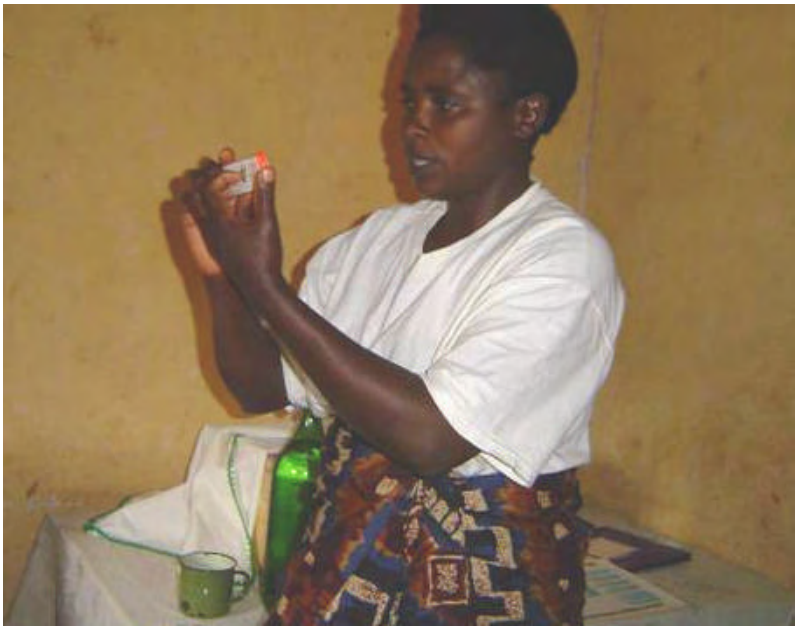
Umucyo purchases ITNs from PSI, and through a contract with Cordaid, provides the ITNs to the community at subsidized rates, through volunteer associations. .A total of 8,687 ITNs were sold to households with children under five years through the volunteers' associations. In collaboration with MOH, the project has promoted and supported the distribution of ITNs, (called *'Mamans nets'*) to pregnant women in KHD. The project provided regular supervision of ITN sales at HC level during antenatal clinics (ANC), and report back to the MOH every month. A total of 2,140 pregnant women received ITNs this year, and 83% of pregnant women sleep under ITNs, while 82% of children under 24 months sleep under treated bed nets.

Umucyo has reinforced the system of mosquito net re-treatment by selling 'Kalishya' the insecticide for bed net re-treatment through the same volunteers' associations. A total of 3,596 packets of Kalishya have been sold to households, and bed net re-treatment rates have risen to 76%.

The community has been mobilized to participate in the MOH *Mutuelles* Health Insurance Scheme, as part of an effort to promote seeking treatment for fever (suspected malaria) within. Sixty-two percent of the population currently subscribes to the *Mutuelles* Health Insurance Scheme in Kibogora Health District.

Umucyo's partnership with MOH has been an advantage in many ways, and this is evident in the implementation of the home-based management of malaria initiative. KHD was chosen as one of the six HC pilot sites for Malaria Home-Based Management (HBM) program. The setting up and follow up of this new strategy was jointly carried out by CSP UMUCYO and MOH. Thus, 496 malaria drug distributors elected by the community were trained and equipped with kits such as medicines registers and referral cards, for the community-based malaria management. They distribute the anti-malaria drugs to children aged between seven and fifty-nine months with fever. In the areas where the HBM strategy is operational, 85% of children under five are treated within 24 hours, and no death occurred after treatment by community drug distributors.

Umucyo participated in pre-implementation workshops, in preparation for launching the Intermittent Presumptive Treatment (IPT) against malaria strategy for pregnant women.



Euphrasie Nyiransabimana's witness about Vestine (pictured above), an anti-malaria1 drug distributor: "*My child had fever. I took him to Vestine. She gave me medicine and fever was no more. My other child was vomiting but Vestine's drugs healed him without going to 'Muganga Albert' (*referring to a health center*). My two children were healed here*." Euphrasie, like other women, had a suggestion: "*Why not also give other basic medicines to Vestine because we are in a great need of them in our neighborhood*?"

On the day of writing the current report, the KHD HMIS has indicated no malaria deaths among under fives during the whole year. This is a remarkable achievement compared with past years.

Year	2001	2002	2003*	2004	2004 (End of Sept 05)
#Deaths<5years due to malaria	32	25	22	4	0

***Start of ITNs distribution in the community by Umucyo*

e. NUTRITION

CSP volunteers have continued with the community-based nutrition program; and during this year the project has concentrated on this strategy. The nutrition intervention is considered as one of the most challenging interventions for the project because of the complexity of improving nutrition in the face of limited economic resources and food insecurity. Already, nutrition services provided by volunteers have improved, malnourished children are being followed up closely, and community groups receive continued encouragement to support optimal child feeding practices. To further tackle this problem, the project plans to reinforce the hearth program, conduct further qualitative research on reasons for the slow progress in overcoming malnutrition, and to advocate for the integration of agriculture and micro finance activities into child survival programming.

Improvement of the Growth Monitoring Quality

In FY 2005, CSP Umucyo initiated a growth-monitoring program in the communities in preparation for its emphasis on the nutrition intervention. A Growth Monitoring (GM) site was identified in each cell, and the vast majority of mothers have been in favor of the weighing sessions organized at these sites. There has been a dramatic increase from 29% in September 2004 to 78% in September 2005.

Umucyo prepared a proficiency session for the volunteer associations on growth monitoring in the community. A total of 517 volunteers, two volunteers per Care Group, were chosen by their associations to attend the training and they were made responsible for subsequent growth monitoring activities.

The main topics discussed in the training of these volunteers include weighing technique, filling in the individual card of the child and analyzing the data accurately; counseling the mother according to the weighing results.

The weighing results of September 05 compared with September 2004 indicate a decrease in under five malnutrition rates by 6% (from 33% to 27%). Table 2 below illustrates GM results for the last 12months:

Table 2: Growth Monitoring Data

Nutritional Status	**December 04**		**March 05**		**June 05**		**September 05**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Good nutritional status	6,963	67	8,757	69	11,854	70	12,804	73
Moderate malnutrition	3,398	32	3,782	31	4,541	27	4,065	23
Severe malnutrition	96	1	127	1	571	3	661	4
Total of children followed up	10,457	100	12,666	100	16,966	100	17,530	100

Deworming with mebendazole, VIT A supplementation

After an agreement with KHD, the volunteer associations received authorization to carry out VIT A capsule distribution and de-worming (with mebendazole) for children aged 6 to 59months. These distributions have been carried out at growth monitoring sites or during immunization outreaches prepared by HCs. Since this activity started in July 2005, a total of 4,394 children (17% of under-fives) have been de-wormed.

Umucyo supported KHD in the VIT A supplementation campaign of children aged 6 to 59months, and post-partum women. The coverage was 103% for the children of 6-11months, 122% for children 12-59 months and 169% for the women within 6 weeks of delivery

The nutritional rehabilitation of malnourished children using PD/ Hearth.

Within the framework of the Positive Deviance/Hearth approach, Umucyo followed up 4,078 children grouped into 533 Hearth groups. In July 2005, 81 hearth groups were successfully closed, and 34 new ones comprising 240 children started in August. At the end of the year, 3,484 children are still followed up in 483 hearth groups and 40% of children were recuperated and in good nutritional status.

Even though the 40% rehabilitation rate achieved falls short of the program objective for Hearth (80%), the project this year has allowed the community to own more this program, in the interest of sustainability, with the hope that the rates would be better next year. Mothers who participate in the PD/ Hearth sessions have started to form associations to carry out some income generating activities. They also cultivate common vegetable gardens and have started rearing rabbits and guinea pigs as sources of animal protein. Moreover, these mothers have taken the initiative to meet once a week to prepare nourishing food to feed their children together.

Mothers rehabilitating their children in hearth

In relation to this, the sector administrative authorities, the HC and certain individuals have lent their fields to the volunteers' associations or mothers who participate to PD/Hearth to promote food security.

Murwanashyaka Fidèle, a cultivator of Ngoma sector, Nyamasheke district witnesses:
«I have appreciated so much the work of UMUCYO volunteers and the effort they offer in the rehabilitation of malnourished children in my community, and I thought about the contribution that I could give towards this. It is for this reason that I have decided to give this field to the association of UMUCYO volunteers to exploit it temporarily to the profit of malnourished children in my community ».

In collaboration with WRR HIV/AIDS program, Mobilizing for Life, Umucyo facilitated the voluntary testing of 1574 malnourished children from PD/Hearth groups. This step was taken to determine HIV prevalence rate among these vulnerable population of children, and to access support for them according to their status. The test results reveal a low prevalence rate of 0.6%(10/1574) among this group, and the project provides additional nutritional counseling for mothers, and plans to link mothers with existing support groups, and to access antiretroviral therapy as it becomes available in the district HCs. These plans are evolving since the testing was only conducted in September 2005.

The importance of partnership in the CBNP

A system of referral/counter referral has been established between the CBNP and the nutritional service of Kibogora Hospital. The volunteers associations refer children with severe malnutrition to the nutritional service unit of the Hospital, and the latter refers them back to the associations for follow up in the community, after resuscitation and immediate clinical care. In addition, the project has provided food support to the nutritional service of the Hospital in the past, and has involved the KHD and Administrative Districts in the follow up activities of PNBC. The HC has visited 163 growth monitoring sites in the community, and the sector CDCs have visited 272. The HC and CDC have conducted 98 and 542 site visits respectively, to Hearth groups. Overall, CDCs of 33 administrative sectors have been trained on CBNP.

Quarterly Meetings that bring together volunteers' associations and sectoral CDCs have been organized, and used as occasions to present and analyze reports and facilitate decision making in relation to CBNP activities.

Promoters transmit reports on a regular basis to the CDC and the latter would meet once a quarter for discussion of the presented data. They then take measures to respond to the good functioning of the volunteers' associations and the project's activities at the community level.

At the Church level, following the mobilization of religious leaders on CBNP, local churches have decided to transmit these messages to their faithful members. In addition, they have taken the initiative to organize 'rehabilitation households' for children within the community. Seventeen of such households have already been established by local churches.

f. MATERNAL AND NEW BORN CARE

At the community level, the following key messages have been delivered about maternal and newborn care:

- Four standards antenatal visits during pregnancy
- Start antenatal visits in the first quarter of pregnancy
- Childbirth delivery plan in the family and birth in the health facility (HF), and
- Family planning.

Antenatal Check-up and Childbirth delivery in the HF:

Strategies to improve coverage of antenatal clinic attendance and HF delivery have been

promoted in collaboration with the KHD, except behavior change communication at the family level. To discourage home births, all community health workers (CHWs) have been mobilized to follow and accompany pregnant women to give birth in the FOSA. A network of maternal health animators have been put in place, and they consist of health animators, traditional midwives, and the 404 CSP volunteers chosen by association (2 per association) to follow up pregnant women within the 'action zone' of their respective associations. CHWs who accompany pregnant women to the FOSA for delivery receive an incentive from the HC. Another strategy adopted by the KHD is to make HC delivery free of cost to those women who have responded correctly to the ANC check ups.

Transport Plan:
The project promotes the use of traditional hammocks as means of transport for pregnant women in labor, and currently, there are 158 hammock associations in the community. A family pays between 100 and 200 RWF (0.2 to 0.4$ US) for renting a hammock for a pregnant woman in need of transportation.

Taking away churches' barrier to Family Planning (FP)
The opposition of many church leaders to the use of modern family planning methods has been a major barrier to the uptake of modern contraceptive method usage in KHD. In recognition of this fact, the project organized a FP training for religious leaders which was attended by 667 persons from 11 local churches. These leaders have begun to disseminate positive and useful information on birth spacing to their church members and in small group meetings.

Results:

1) Fifty-five percent of pregnant women deliver at HF (LRA September 05), compared with 23% at baseline (November 2001).
2) Contraceptive usage has increased to 18% (LRA September 05) from 3% (KPC Baseline November 2001). This places KHD at the top of all districts nationwide, in terms of FP coverage rates. In the course of the year, MOH delivered to KHD a certificate of merit in recognition of their achievement in promoting access to family planning.

It's noteworthy to highlight some positive events that enhanced Umucyo's performance:

- *A new HC was inaugurated in Karambi, which facilitated easy access to health care in the area*
- *Some roads have been rehabilitated by the government facilitating communication*
- *KHD expanded PMTCT and VCT services to its four HCs, which has reduced the challenge of access for pregnant women in the area*
- *The government invested much in strengthening the Mutuelles Health Insurance Schemes*

To complement the main accomplishments of the Umucyo program refer Annex 1 for table that highlights key activities for each program objective and overall estimation of progress made.

3. MONITORING AND EVALUATION SYSTEMS

The project up-dated its existing forms and created new ones to facilitate data collection. The compilation forms for MIS and HIS at Area/HC level, in particular, were reviewed. The forms are used to collect data on field activity and direct health related statistics. Also, forms for monthly report to CDCs and to HCs were introduced. See annex 2.
Data are compiled manually at the area level and then entered and analyzed by the administrative staff using MS Excel. Area coordinators transmit data on growth monitoring to HCs, and finally they are entered in KHD data base.

Project staff discuss these data during their monthly meetings and HCs and CGs receive appropriate feedback. During this year, the project conducted four internal evaluations (Local Rapid Assessments), and the results are shown in annex 3.

B. CHALLENGES

1. BEHAVIOR CHANGE OF TRADITIONAL BIRTH ATTENDANTS (TBAs)

Before Umucyo started in the community, the MOH had trained and equipped TBAs with delivery kits so that they could assist with some emergency deliveries in the community.
Thereafter the national policy changed and the only role of TBAs has become to follow up and accompany pregnant women to HF for delivery. In such a situation, it is hard to change the TBAs' old behavior.

RESPONSE: The project trained those TBAs on their new role, and reminded them of their new title of "Maternal Health Animators", recently proposed by the MOH at national level.

In addition, Umucyo encouraged the volunteers associations to select other two volunteers to follow up the pregnant women in their community. The Health Facilities have accepted to motivate them with an incentive of about 1$ when they accompany a pregnant women.

2. CULTURAL BARRIER TO ANTENATAL CHECK-UPS

In the Rwandan culture, women are not comfortable to reveal early pregnancies. Consequently, most of them delay attending ANC, thereby reducing overage rates in the first trimester.

RESPONSE:
Umucyo CSP has made mosquito nets available, to motivate the women attending ANC in the first trimester of pregnancy. On the other hand, KHD has allowed pregnant women who regularly attend ANC to deliver free of charge in health facilities.

3. REFERRAL OF PREGNANT WOMEN TO HOSPITAL

The ambulance of KHD is very old and can't reach the remote areas surrounding Nyungwe, the

National Park. This complicates the transfer of patients, especially pregnant women with complications requiring emergency services.

RESPONSE:
Umucyo advocated in favor of KHD to get another ambulance. Families were sensitized to make a delivery plan, including an emergency transport. Umucyo also encouraged the community to have hammocks in place as traditional ambulances and to help one another while transporting pregnant women.

4. MALNUTRITION RATE

The results of growth monitoring have indicated a decrease in malnutrition rates, from 33% to 27% over a one-year period (Sept 04- Sept 05).

There's been an increase in the price of food items (particularly legume and cereals) in the community, and the shortage of fruits, vegetables and animal protein. Many families cannot easily get enough food. Thus, malnutrition rates have decreased by only 6% using the Positive Deviance/Hearth strategy. Other factors that constitute a challenge to reducing malnutrition rates in the community include scarcity of land, overpopulation, polygamy, alcoholic husbands, migration of men to towns and cities for employment leaving the burden of family care to the women.

RESPONSE:
1) Umucyo sensitized families to the importance of regular child growth monitoring and family planning.
2) The women participating in the Positive Deviance/Hearth have been encouraged to continue to meet and feed their children together, even without food support from the project, and to join together in associations for income generating activities.
3) Umucyo encouraged sector CDCs to get involved in community education and the follow up activities of the community based nutrition program.
4) CSP prepared key messages on nutrition to deliver to husbands/fathers.
5) CSP started to promote the use of potato leaves as vegetables and guinea-pigs as a source of animal protein, especially in the families with malnourished children. Umucyo also plans to popularize the orange potatoes and the Molinga plant—a plant with edible leaves and fruits and higher nutritional value.

5. STAFF TURNOVER

In FY 2005, the CSP lost three employees - two promoters and one coordinator. They resigned for personal reasons; and this handicapped the work in their respective areas of work temporarily.

RESPONSE
Umucyo promoted one promoter to the position of coordinator and recruited two new staff for

replacements.

6. ADMINISTRATIVE RESTRUCTURING

The project's last year of operations would be affected considerably by the Government of Rwanda's major restructuring of its administrative provinces within the context of decentralization From available information, from January 2006 the current KHD will be a very small part of a vast heath district that will merge with the Nyamasheke new administrative district, including a part of the current neighboring province of Kibuye. The current provinces of Cyangugu, Kibuye and Gisenyi will constitute the west province, which will be one of five provinces in the country. Currently there are eleven provinces in the country.

This restructuring will also reach the grassroots structures in which Umucyo operates, such as sector CDCs. This means that the context of Umucyo's working conditions will change. For instance, most of the current grassroots authorities already trained by Umucyo to follow up the community health activities will be replaced by new ones, and this will require new efforts to mobilize them in order to continue with the plans already set.

7. SHORTAGE OF MOSQUITO NETS, KALISHYA AND SUR'EAU

Since January 2005, there's been periodic shortage of products procured at PSI Rwanda, including ITNs, Kalishya and Sûr'Eau. This has been a challenge because their lack implicates lower rates of products utilization, and consumption of treated water by households.

C. NEED FOR TECHNICAL ASSISTANCE

The project staff needs technical support in the implementing activities relating to the sustainability plan, mainly in the deployment of care groups in the community. There is no doubt that the staff will need technical support in the preparation for the final evaluation. Support from World Relief Headquarters and WR Rwanda Program Coordinator on sustainability drawing from lessons learned from other CSPs that have ended would be of great value.

D.CHANGES FROM DIP

Umucyo has extended its activities to two new administrative sectors of Kagarama and Bushekeri of Nyamasheke administrative district. Consequently, a ninth zone was formed, with 254 volunteers, three promoters and one coordinator.

Reasons: The MOH's delimitation of health districts that put the two sectors on the neighboring health district of Bushenge has had a repercussion of partial coverage of the area. On the other hand, the Nyamasheke district authorities expressed a need to have CSP interventions in that

zone. Since November 2004, CSP has operated in that area and now the community mobilization and transmission of health reports is conducted smoothly.

F. SUSTAINABILITY PLAN

From inception, the CSP Umucyo had a plan, set objectives and strategies for program sustainability, especially in the following areas: 1) accessibility and quality of health services, 2) reinforcement of the community to be self-sustaining in health-related matters, and 3) behavior change at the household level.

In particular, the mid-term evaluation of September 2004 proposed four main recommendations in the area of sustainability: 1) Support the volunteer associations, 2) involve the grassroots level authorities in the follow up of volunteer associations, 3) continue to share the results of the evaluations with different authorities and encourage them to discuss it, and 4) continue to involve the volunteers in Health Center activities.

The following paragraphs indicate how Umucyo responded on the above aspects:

a) Improvement of accessibility and quality of health services at KHD

In an attempt at improving mothers' access to health services, Umucyo increased the number of immunization outreach sites from 17 to 25, thereby shortening travel time between households and outreach facilities. The outreach sites also serve as ANC, consultation and basic treatment centers, and procurement centers for ITNs, Sur Eau, ORS and Kalishya Force. As described earlier, a system of identifying and recouping immunization and ANC defaulters was set up in the community.

To improve access to VCT services, the CSP supported the district hospital in preparing VCT outreaches in the very remote areas of the district. At present, VCT and PMTCT services are operational in 50% of HCs.

In collaboration with KHD, Umucyo has increased its activities on the community-based nutrition program, namely growth monitoring, Positive Deviance/Hearth approach, mebendazole de-worming, VIT A distribution, and referral of severe malnourished children. These activities are carried out by volunteer associations within the community.

Umucyo contributed to the Mutuelles Health Insurance Scheme initiative at start up in KHD, and facilitated a study visit of both administrative and health authorities to provinces that already initiated the scheme.

Umucyo has continued to support KHD in the setting up and follow up of malaria HBM strategy (discussed in point A.2.d above). The project provided training support for the HC staff on the appropriate management of malaria and STIs.

CSP Umucyo supported KHD in the Evaluation of Quality of Health Care in KHD. The evaluation was conducted jointly by the Public Health School of National University of Rwanda and Umucyo CSP and the results were shared with KHD managerial staff.

CSP Umucyo collaborated with KHD and Gatare Administrative District in advocating for the new HC at Karambi, which effectively started this year.

Finally, Umucyo continues to collaborate with Cordaid, an NGO that supports KHD in the same area of improving quality of health care services, through its performance-based approach,..

Some Results:
The KHD HIS has indicated that this year, only 1% of scheduled immunization outreach was missed by HCs personnel; mutuelle health insurance scheme utilization rate is 62%, and HC service utilization rate is 68%.
60% of CDCs and 80% of HC provided regular supervision for the PD/Hearth and GM sessions, as well as volunteer trainings in CG and household levels.

b) Reinforcement of the community messages on health care

Volunteers: See volunteers' development in A.1.

Administrative Leaders

Within the context of getting district administrative leaders more involved in CSP planning and evaluation activities, the project has invited mayors at regular intervals, to participate in the project's quarterly and annual planning/ evaluation meetings.

CDC members have been trained on community based nutrition program. Key points developed in these trainings include the presentation and discussion of GM data, the advancing state of Hearth, community contributions to CBNP, and the role of administrative leaders in the follow up of CBNP activities. In response to these trainings, CDC members suggested a report sheet on CBNP activities, which was subsequently developed for CG leaders to transmit monthly reports to CDCs. The CDC, volunteer association leaders, and promoters hold quarterly meetings to share data and review reports for appropriate decision making.

Sector CDCs have become more involved in the follow up of volunteer activities by paying visits to Hearth sessions, GM sites, and CG meetings. Finally, in the community meetings, they cooperate with volunteers in disseminating key messages on CSP interventions.

Kibogora Health District

The KHD recognizes and uses the CHIS data collected by volunteers. Regular meetings are set up to share ideas with all community health agents, and for HC follow up of community health agent activities.

Churches

All eleven local church denominations were mobilized in CSP interventions, and they receive regular training through their delegates who form the pastoral CG that meets once a month for training. The churches transmit health messages to their faithful members and follow up CG volunteer activities.

c) Behavior Change at household level

Home visits and the 'teaching by example' approach adopted by volunteers and CS staff, as well as availability of products for health promotion in volunteer associations have produced the behavior change observed at household level.
The collaboration with administrative leaders in promoting hygiene, malaria Home Based Management and mobilizing for mutuelle health insurance schemes have played a great role in household behavior change. To date, HC service attendance rate is 68%.

Plan for next year

Umucyo plans to prepare CDCs to replace promoters in supervising volunteer activities and in identifying community health needs. HCs will be more involved in the technical supervision of volunteer activities.

Umucyo will continue to give technical and financial support to volunteer associations in order to equip them to continue health message dissemination during home visits, data collection and preparing CDC reports.

The project will continue to share and discuss the results of assessments at all levels: KHD, local authorities, community health agents and the community itself.

The last activity of the project will be the evaluation of CGs and the closing ceremony in which they will be officially transferred to the community.

F. RECOMMENDATIONS ON MTE AND PHASE-OUT

MTE
Recommendation 1: Conduct a survey on prevalence of syphilis at KHD and encourage the HCs to test and treat syphilis at KHD for pregnant women from the first ANC contact.

Activities conducted and/or planned: The survey itself was not carried out due to lack of funds, but in collaboration with KHD, the project has compiled and analyzed existing KHD data for facilities that conduct the syphilis test within the framework of PMTCT. With the extension of the PMTCT/VCT service to HCs, access to the syphilis test has improved, and treatment for pregnant women is assured in KHD which has five operational centers. The project plans to continue to promote this screening and treatment.

Recommendation 2: Reinforce child spacing

Activities conducted and/or planned: The project targeted churches, which were barriers to the use of modern FP methods. Training for church leaders and their partners was carried out, who in turn trained different groups in their churches, especially husbands, women, and young fiancées about to get married. FP message dissemination was then expanded to the community health agents and HCs.

Recommendation 3: Reinforce the nutrition intervention within the framework of increasing the food availability.

Activities conducted and planned: Umucyo has continued to encourage the community to have vegetable gardens and fruit trees around their homes. It plans to promote the 'new' plant "Molinga".

Recommendation 4: Encourage the volunteers and prepare for the sustainability of their activities

Activities conducted and/or planned: Developed in A.1.

Recommendation 5: Study again the prevalence of malnutrition and diarrhea in the month of December 2004 and August and December 2006

Activities conducted and planned: Local Rapid Assessment (LRA) was conducted in December 2004 and indicators evaluated include those related to the nutritional status of

Recommendation 6: Reinforcement of community-based HIS and exploitation for monitoring and evaluation

Umucyo has a database for community-based HIS. Every month promoters collect data from CGs which they analyze during their coordination meetings. Data collected include vital events data for women of reproductive age and children under five. Promoters discuss these results among themselves and with the volunteers, and plan appropriate actions.

PHASE OUT

The project has begun to implement some activities relating to phase out. The role of the promoter is being phased out progressively, to empower CG leaders to take responsibility for

training and follow up of community activities. Coordinators, in turn, prepare the CDC and HCs for the supervision and follow up of volunteers' activities.

The volunteers make decisions relating to the state of their CGs, and some volunteers who were not good role models in health behavior/practices; or who misconduct themselves (<2% overall) were dismissed from the CGs and replaced by others. In addition, CGs provide regular reports to Umucyo on the state of their groups.

Healthy competition is promoted among volunteers, as they are encouraged to compare their output with other neighboring CGs and learn from them. Also, after a survey is conducted, volunteers are the first to ask about the results of their CGs in comparison with other CGs and other regions.

The volunteers perform well and many of them are selected to perform other responsibilities in the community. A volunteer has been recently elected Coordinator of the Nyakabingo sector in Nyamasheke district.

G. REPORT ON FAMILY PLANNING SUPPORT: not applicable for the project

H. MANAGMENT SYSTEMS

1. FINANCIAL MANAGEMENT

Budget design and implementation were conducted according to the procedures recognized by WRR. In mid-March, the accounting books were taken to WRR finance department for internal auditing, and in August 2005 WRR Finance Manager and Accountant visited CSP for management audit and financial system application according to WRR policy.

The monthly financial report justifying the use of funds is regularly submitted to the WRR Finance Department.

The year was closed without any debt. WRR CSP Umucyo has been awarded the Certificate of Merit by Rwanda Revenue Authority for having legally paid its taxes. This was possible thanks to the WRR Finance that carries out transfers 93.3% and 6.7% come from taxes on the products distributed in the community. Their recommendations have been very useful to us.

2. HUMAN RESOURCES

For the replacement of a staff who left Umucyo and for the new area of Gisakura, Umucyo recruited 9 promoters and promoted 3 promoters to the position of coordinator.
At the end of this year, the number of Umucyo staff stands at 53, including the Program Manager, Assistant Program Manager, Administrative Assistant, Accountant, 9 coordinators, 37 promoters, one driver and two guards.

3. COMMUNICATION SYSTEM AND STAFF DEVELOPMENT

Communication
The regular internal communication is assured through regular monthly staff meetings, for planning and evaluation of field activities.
Communication with Kigali or with the partners is carried out through cell phones and emails, since the installment of Internet at Kibogora Hospital, this year, by WRR.

Staff Development
The staff has continued to receive training during their monthly meetings: trainings on Umucyo interventions and follow up of community activities.

The promoters and coordinators were retrained on the Maternal and Newborn Care intervention and were trained on the Home Based Care of the PLWHAs by World Relief Rwanda Mobilizing For Life staff.

Thanks to the support of CORE group, the Program Manager and her Assistant participated in two workshops in USA: Workshop on the sustainability of CSP activities prepared by CSTS^{+} and workshop on Positive Deviance Beyond Hearth.
Three agents of Umucyo participated in a two-day meeting on Nutrition and HIV/AIDS prepared by WRR.

Together with Kibogora Health District, Umucyo staff carried out a study tour of the Reproductive Health Animators (former Traditional Birth Attendants) supported by IRC in Kibungo province in order to prepare them for helping the KHD in improving that program.

Training in English was organized for promoters and coordinators in their areas. At the end of the year, some of them are able to communicate with English speakers who visit the field.

For individual development, the project has facilitated staff to get loans from local banks

Twice a year, the field staff meet to conduct a self evaluation exercise. They select the champion in community activities, and the project awards him/her a certificate of merit and a gift.

Every trimester, the staff goes to Kibuye province for a three day spiritual retreat camp which allows them to also share field experiences with staff from other WRR programs.

4. RELATIONSHIP WITH LOCAL PARTNERS

The CG model used by the project is highly appreciated by partners including the MOH who has expressed the plan to scale up this approach to community-based health programming nationwide.

During this year, six NGOs visited the project to learn about the CG model and Positive Deviance/Hearth approach, including IRC from the Democratic Republic of Congo.

Umucyo has received positive feedback from many local partners, and recently the Provincial Association of Districts and Towns recognized Umucyo as an important actor in contributing to the high ITN utilization rate in KHD. Furthermore, Cordaid has expressed its appreciation for our partnership in distributing ITNs in the community.

5. COLLABORATION WITH LOCAL PARTNERS AND OTHER NGOs

a. Kibogora and Bushenge Health Districts

At the beginning of the year, CSP Umucyo presented the annual activity report for 2004 and its action plan for 2005 in its meeting with the KHD managerial team. Thus, the plan was discussed, amended and adapted.

At the beginning of every quarter, the CSP and KHD hold a joint planning/ evaluation meeting for CSP activities.

Umucyo supported KHD in the setting up and follow up of Malaria Home Based Management

In the KHD managerial staff meeting, CSP shared the results of the Assessment on the Quality of Healthcare jointly conducted with the School of Public Health of National University of Rwanda.

The project regularly participated in the monthly coordination meetings of KHD Health Centers.

Together with KHD, Umucyo has continued the referral/ counter-referral system of children with severe malnutrition.

CSP has collaborated with KHD in the national VIT A supplementation campaign and mebendazole distribution for children under five and post-partum women.

CSP has nurtured a close relationship with KHD on the community-based nutrition program.

On the invitation of KHD, Umucyo participated in the ceremonies to receive the Certificate of Merit in Family Planning awarded to KHD by the MOH.

KHD has continued to participate in the welcoming of distinguished guests visiting the project.

CSP supported the Kibogora Hospital in getting internet installment.

Together with the Bushenge Health District, CSP continually participated in the planning/ execution meetings of CSP activities in the new Gisakura region.

b. Cyangugu Province, Gatare and Nyamasheke Districts

Umucyo participated in a three-day workshop prepared by the Provincial Commission in Charge of the Fight against HIV/AIDS (CPLS) on the evaluation of activities in the fight against HIV/AIDS for 2004 and planning for 2005.

Nyamasheke District collaborated with Umucyo in the extension of CSP activities within the operating zone of Gisakura HC.

Umucyo supported Nyamasheke District in the training of its Commission in Charge of HIV/AIDS (CDLS).

CSP participated in the commemorative ceremonies of the World Day of the Rural Woman at the Gatare and Nyamasheke Districts' sectors.

The administrative districts participated in the presentation ceremonies of the support of goats and sheep that the project provided to volunteer associations.

Umucyo trained sector CDCs on community-based nutrition program and the strategies have been taken for more involvement in that domain.

The project was invited by the districts to participate in the inauguration ceremonies of new offices of the administrative sectors.

c. The MOH and other NGOs

MOH

This year, the malaria HBM was one of the most important areas of collaboration with the MOH. The CSP was designated as a member of the national steering committee for malaria HBM, and KHD was one of the six pilot districts that started that strategy in the whole country. The MOH requested the project to support the KHD in the new initiative, and at the end of this year the strategy has become fully operational in all KHD Health Centers.

Umucyo has also continued to collaborate with MOH in the follow up of the distribution of mosquito nets "Mamans Nets" that the MOH prepared specifically for pregnant women who attend antenatal checkups in HCs.

CSP participated in the international "Roll Back Malaria" conference held in Kigali and shared the KHD results on malaria intervention.

CSP also participated in the national workshop on C-IMCI planning.

CSP participated in two workshops prepared by the National Integrated Program for Fighting Malaria (PNILP). The first involved preparing the curriculum for Information Education Communication on malaria, and the other focused on the adaptation of the training module on the prevention and control of malaria during pregnancy.

Other NGOs

CSP participated in the assessment on qualitative evaluation on child health in Rwanda prepared by USAID in collaboration with the MOH and other partners such as UNICEF, World Health Organization and World Bank.

Umucyo participated in the presentation workshop on the contractual approach prepared by Cordaid.

Umucyo has continued to collaborate with MEMISA, Cordaid and PSI Rwanda on ITN distribution in the community.

As NGOs operating in KHD, Memisa Cordaid and CARE International were invited to the presentation meeting of the results from the Assessment of the Quality of Healthcare in the KHD HCs.

CSP/ IRC Rwanda, FHI, ADRA, World Vision, CSP/IRC Congo and Intra Health visited the CGs and Positive Deviance/ Hearth of Umucyo.

Local Churches

Umucyo trained the local church leaders on Community-Based Nutrition program and Reproductive Health in order to prepare them to disseminate key messages in their respective churches.

With the support of CSP Umucyo, the churches have initiated PLWHA and Hearth groups.

I. COLLABORATION WITH THE USAID MISSION TO RWANDA

Umucyo participated in the CSP meetings supported by USAID in order to share field experiences.
CSP participated in several meetings organized by the USAID Mission who visited the project area twice.
The Director of USAID accompanied by WR Director in the Great Lakes Region, visited the Positive Deviance/Hearth groups, the Malaria Home Based Management distributors, and CG volunteers in the community.
A USAID agent, and two consultants, of MINISANTE in Family Planning visited the volunteers

and the pastoral CG in order to collect information to help in developing a national strategic plan for the country.
The project participated in a two day workshop organized by USAID on the process of developing community indicators for Family Planning interventions.

J. TIMELINE OF ACTIVITIES FOR FISCAL YEAR 2006

Refer Annex 4 for detailed timeline.

K. KEY SUCCESSES OF THE PROJECT

Volunteer Care Groups

Before the project, it was not possible for HCs or Health Animators to reach every household to disseminate health messages or to collect data on vital events. Volunteers selected by the community for this task received training in community education. Each household receives training during scheduled home visits. During this year, volunteers were motivated to form/join income generating associations. Currently, there are 202 associations recognized at the administrative district level and they are committed to continuing their work in the community even after the end of the project. To date, 96% of volunteers remain in care groups.

Malaria Control

The mosquito nets use: Since the project began distributing ITNs to households with children under five and pregnant women in July 2004, , ITN utilization rates have increased from 3% to 82.5% for under-fives, and 3.5% to 83.3% for pregnant women (comparing baseline figures to Sept 2005 figures). Volunteer associations receive US$ 0.3 for every ITN sold. The HIS of KHD reports no malaria deaths in under fives in KHD this year. At the beginning of the project only 3.7% of mothers sought care in the first 24 hours for fever in under-fives, but now 72% of mothers do (project LRA Sept 2005). In collaboration with MOH, the project supported the KHD in implementing the new malaria HBM strategy, with 496 distributors of anti-malarials selected by the community and trained by KHD in collaboration with Umucyo.

Fighting Malnutrition

At the end of September 2004 malnutrition rates among under-fives in the project area was 39%, using growth monitoring data. One of the strategies adopted to fight malnutrition this year was to strengthen the Positive Deviance/Hearth approach. By September 2005, reports from Hearth showed that 40% of malnourished children attending hearth sessions had recuperated and the monthly GM data revealed a 6% decrease in malnutrition rates among under-fives.

ANNEX 1: Chart of Main Accomplishments

Umucyo Objectives	Progress estimation	Comments
Hygiene and Diarrhea 1. Increase from 31% to 50% the children with diarrhea who will be treated with more fluids than usual. (ORT use.)	Yes	
2. 75% of mothers will know at least 3 danger signs of diarrhea requiring medical treatment. ** Note: Baseline KPC for *two* danger signs was 83%.	Yes	
Immunization 1. Increase from 47.1% to 75% the children who will be completely immunized by 1 year of age for BCG, polio, DPT,TT, and measles	Yes	
2. Increase from 43.8% to 50% of pregnant women in project area who will receive at least 2 doses of TT before the birth of a child	No	
Malaria 1. Increase from 3.7% to 50% the children with fever (suspected malaria) whose caretakers will seek treatment for them within 24 hours at health facility	Yes	
2a. Increase from 3% to 40% the children < age 2 who sleep under an ITN. 2b. Increase from 3.5% to 40% of pregnant women who sleep under an ITN	Yes	
Nutrition 1. Increase from 19.5% to 50% the mothers who will introduce appropriate weaning foods (enriched porridge) at least once/day	Yes	
2. Increase from 11.2% to 60% the mothers who will give same or more food to child during illness (3.7% of mothers gave more food to sick child; 7.5% gave same amount at baseline.) *Midterm: 30%*	Yes	
3. 80% of children who completed the *Hearth* program achieve and sustain adequate (200 grams) or catch-up growth (400 grams) per month during at least 2 months after period of supervised feeding.	No	Only 40 % of children attending Hearth achieved catch up growth. Low socioeconomic level of most households is a major challenge to food availability.
4. Increase from 33.8% to 80% the children 6-59 mo. who receive Vitamin A capsules at least once per year and increase from 0.4 to 40% twice a year	Yes	
Exclusive Breastfeeding Increase from 50% to 75% mothers who exclusively breastfeed for 6 months. *Midterm:*	Yes	

Umucyo Objectives	Progress estimation	Comments
60%.		
Maternal Care 1. Increase from 24.6% to 70% the pregnant women who have emergency plan in place before delivery. *Midterm: 25%*	No	We hope to reach the EOP objective in the coming year because people are motivated to join Hammock associations.
2. Increase from 23% to 50% the women who will give birth at a health facility	Yes	
HIV/AIDS/STIs 1. Decrease stigma by increasing willingness of women to care for a relative with AIDS in their own household to 80%. *Midterm: 50%*	Yes	
2. Increase from 47% to 80% the women who know at least two common symptoms of STIs (other than HIV/AIDS.) *Midterm: 65%*	Yes	
Sustainability Objectives		
1. 75% of Health Centers in the project area will perform well enough to receive 100% of the performance based subsidy of Cordaid in the last year of the project.	Yes	
2. The proportion of scheduled community visits for immunization services missed by MOH personnel will increase by no more than 10%.	Yes	

Annex 2: Umucyo Forms for MIS and HIS Monthly Data Collection

1. FORMS FOR COMPILATION OF MONTHLY MIS AND HIS

UMUCYO CSP
Area: _____ Month:_____

COMPILATION OF MONTHLY MIS AND c-HIS

INDICATOR	EXPECTED	PERFORMANCES	%	REMARK
A. HIS				
General				
# Diarrhea cases				
# Fever cases				
# Births				
# Deaths among children under 5 years				
0-11 months				
12-59 months				
# Deaths among women in child bearing age				
Home Based Management				
# Children treated				
# Children treated before 24 hours				
# Children treated after 24 hours				
# Children referred to HC				
# Children healed				
# Children died after treatment				
Animators of Maternal Health				
# Deliveries at home				
# Pregnant women				
# Women followed up in post natal period				
#Deaths among women in post partum period				
# Deaths among children in perinatal period				

B. MIS by intervention				
Diarrhea fighting by Hygiene promotion				
# Sûr'Eau bottles sold by volunteers associations				
# ORS packets sold by volunteers associations				
Immunization				
# Defaulters referred by volunteers to HCs				
#Defaulters recuperated by immunization services				
# Immunization outreach sessions supported by CSP				
HIV/AIDS				
# Community Anti AIDS clubs trained				
# CSP volunteers Anti AIDS clubs trained				
# CSP volunteers				
# Church Anti AIDS clubs trained				
# Primary schools Anti AIDS clubs trained				
# High school Anti AIDS clubs trained				
# CSP volunteers care givers associations trained				
Malaria				
# ITN sold by volunteers associations				
# Packets of "Kalishya" (insecticide for mosquito nets re-treatment) sold by volunteers associations				
# Distributors in activity				
# Distributors supervised by CSP				
# Distributors supervised by HCs				
# Amount of money received from anti-malaria drugs sold				
Community Based Nutrition Program				
# Growth Monitoring sessions				
Children weighed				
# Old cases				
# New cases				
# Total cases				
Malnourished children				

# Old cases: Moderate malnutrition				
Severe malnutrition				
# New cases: Moderate malnutrition				
Severe malnutrition				
# Total malnutrition cases (moderate+ severe)				
# Malnourished children referred				
# Children counter- referred by Hospital for follow up in CBNP				
# Children counter referred by hospital followed up by volunteers				
# Children who received deworming drugs (Mebendazole)				
Positive Deviance/Hearths				
# Hearths started this month				
# Children registered				
# Children in good nutritional status				
Hearth started in Jun 2004				
Hearth started in October 2004				
Hearth started in November 2004				
Hearth started August 2005				
# Children counter- referred by Hospital attending the PD/Hearths				
# Mothers trained in PD/Hearths				
Maternal and New born care				
# Animators of Maternal Health *(former TBAs)*				
# Associations of Animators of Maternal Health *(former TBAs)*				
# Pregnant women referred by Animators of Maternal Health to HCs				
# Hammock Associations				
# Pregnant women who received iron pill on HCs				
C. VARIOUS MANAGEMENT INFORMATION				
#Home visits carried out by volunteers				
#Home visits carried out by CSP promoters				
#Home visits carried out by coordinators				
# Chiefs of CGs who facilitated CG trainings				

# CGs supervised by promoter s				
# CGs supervised by coordinator				
# CGs supervised by HC staff				
# CGs supervised by CDC members				
# CGs supervised by church leaders				
# Pastoral CGs trained				
# Growth Monitoring sites visited by promoters				
# Growth Monitoring sites visited by coordinator				
# Growth Monitoring sites visited by HC staff				
# Growth Monitoring sites visited by CDC members				
# Hearths sites visited by promoters				
#Hearths sites visited by coordinators				
# Hearths sites visited by HC staff				
#Hearths sites visited by CDC members				
# Meetings with CDC/Promoters				
# Meetings with anti malaria drugs distributors/Promoters				
# Meetings with anti malaria drugs distributors/ Coordinator				
#Community meetings on sector level sensitized by promoters				
#Community meetings on sector level sensitized by coordinators				
# Community meetings on cell level sensitized by coordinators				
# Community meetings on cell level sensitized by promoters				
# Community meetings on cell level sensitized by volunteers				
# Meetings with Health Committees.				
# Specific groups trained in churches				
# Local Churches that delivered messages on health				
# Volunteers				
# Volunteers associations				
# Volunteers associated				
# Church leaders in pastoral CGs				
% of attendance in volunteers CGs				
% of attendance in pastoral CGs				

2. FORM FOR MONTHLY REPORT TO CDCs

CSP UMUCYO
SECTOR: _____ MONTH/YEAR:_____/_____

REPORT ON CHILDREN HEALTH AND VOLUNTEERS ACTIVITIES IN COMMUNITY

Indicator	**Cells names**						**Total**	**Remark**
Vital events								
# Births								
# Deaths among children under 5 years								
Growth monitoring								
# children weighed								
# children in good nutrition status								
#children in moderate malnutrition								
# children in severe malnutrition								
#children received deworming drugs								
Positive Deviance /Hearths								
# Hearths in activity								
# Children attending hearths								
# Children in good nutrition status								
Products sold by volunteers associations								
# Bottles of Sûr'Eau sold								
# ORS packets sold								
#ITN sold								
# Kalishya sold								
Total amount of francs perceived								

Names and signature of the reporter:_____
Date_____/_____/_____

3. FORM FOR MONTHLY REPORT TO HCs ON COMMUNITY BASED GROWTH MONITORING

CSP UMUCYO
HEALTH CENTER:_____
MONTH_____

MONTHLY REPORT TO HEALTH CENTER ON GROWTH MONITORING

	Children age in months				
Children followed up	**0-11**	**12-23**	**24-35**	**36-59**	**Total**
Old cases					
New cases					
Total children weighed					
Children in good nutritional status					
Old cases					
New cases					
Total children in good nutritional status					
Children in moderate malnutrition					
Old cases					
New cases					
Total children in moderate malnutrition					
Children in severe malnutrition					
Old cases					
New cases					
Total children in severe malnutrition					

Names and signature of the reporter:_____

Date of the report: _____

Annex 3: Results of LRAs

N⁰	Objectives	KPC_b *Nov. 01*	*MTE* *Sept. 04*	LRA_9 *Sept. 05*	EOP Objectives
	Diarrhea & Hygiene				
1.	Percentage of women who now at least 3 dangers signs of diarrhea	83 (2 signs)	77	96	75%
2.	2. Percentage of mothers who give more liquids when their child has diarrhea	31	67	95	60%
3.	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	0	39	81	50%
4.	Percentage of mothers of children age 0-23 months who make available Soap for washing hands(seen by interviewer)	_____	_____	93	NA
5.	Percentage of women who have a latrine in good condition	_____	_____	72	NA
	Immunization				
6.	Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	41	85	88	80%
7.	Percentage of children age 9–23 months who received a measles vaccine	77	87	84	NA
8.	Percentage of women who received at least 2 doses of TT during the previous pregnancy	44	54	47	55%
	HIV/AIDS & STIs				
9.	Percentage of mothers of children age 0–23 months who cite at least three known ways of reducing the risk of HIV infection	80	91	97	70%
10.	Percentage of women who know at least 2 symptoms of STIs or AIDS	47	92	93	80%
	Malaria				
11.	Percentage of children age 0–23 months who slept under an insecticide-treated bed net the previous night	3	66	83	40%
12.	Percentage of pregnant women who sleep under ITN	3	65	83	40%
	Nutrition and Breastfeeding				
13.	Percentage of children age 0–23 months who are underweight (-2 SD)	16	28	18	NA

14.	Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	60	83	93	75%
15.	Percentage of infants age 6–23 months receiving breast milk and complementary foods	19	50	68	50%
	Maternal and Newborn Care				
16.	Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	73	77	88	NA
17.	Percentage of pregnant women who have emergency plan for transport in place before delivery	25	47	58	70%
18.	Percentage of children age 0–23 months whose births were attended by skilled health personnel	23	35	55	50%
	IMCI				
19.	Percentage of mothers who know at least three signs of childhood illness that indicate the need for treatment	92	98	98	NA
20.	Percentage of sick children age 0–23 months who received increased feeding during an illness in the past two weeks	11	67	89	60%

Annex 4: Year 5 WORK PLAN

Responsibility coding: PM=Program Manager, MOH=Ministry of Health, AM= Asst. Manager, AC = Area Coordinators, P = Promoters, V= Volunteers, KHD = Kibogora Health District, WRHQ = WR Headquarters Backstop, WRR = World Relief Rwanda, PSI=Population Services International

Planned Activities	FY 2006				
	Responsibility	Q1	Q2	Q3	Q4
Interventions					
a. Review Maternal Care (RH) Intervention					
Maternal Health Animators Training	P (supervised by AC)	X	X	X	X
Strength existing MHA Associations and initiate new MHA Associations	P (supervised by AC)	X	X	X	X
Strength Hammock Associations	P (supervised by AC)	X	X	X	X
MHA Association Follow-up	P (supervised by AC)	X	X	X	X
Follow up screening pregnant women for syphilis at first ANC visit at HC	PM, AM, KHD	X	X	X	X
Increase emphasis on Child Spacing	AC, P, V	X	X	X	X
b.Review Nutrition					
Strength and follow up Hearth Program	PM, AM, HC,AC, P, V	X	X	X	X
Strength and involve committee of community Development (CDC) and Churches on Nutrition Community based Program	PM, AM, HC,AC, P	X	X	X	X
Monthly Growth Monitoring	V	X	X	X	X
Improve records on Vita A and continue to involve volunteers in vita A distribution	P, V	X	X	X	X
Integrate agriculture activities with Nutrition Program	PM, AM, AC, P		X	X	X
c. Review Diarrhea and Hygiene					
Continue to train families on Hygiene and Diarrhea cases management	P, V	X	X	X	X
e. Review EPI					

Improve records during EPI Outreach sessions	P, V	X	X	X	X
Continue to support EPI Outreach sessions	P, V	X	X	X	X
f. Review HIV/AIDS					
Support PLWA and Care Givers Associations within the churches	PM, AM, AC, P	X	X	X	X
Support Anti AIDS Clubs	AM, AC, P	X	X	X	X
Train Primary schools on HIV/AIDS	AM, AC, P			X	X
Provide more training and more audio-visual materials for HIV/AIDS	PM, AM, AC, P		X	X	X
Promote PMTCT and VCT	AC, P, V				
g. Review Malaria				X	
Support and supervise HBM Program	PM, AM, AC, P	X	X	X	X
Continue to make bed nets available	PM, MOH,AM, AC, P	X	X	X	X
Maintain BN re-treatment system in the community	PM, MOH,AM, AC, P	X	X	X	X
Monitoring and Evaluation					
Improve HIS @ MIS	PM, AM, AC, P	X	X	X	X
Bimonthly meeting to give feedback from field		X	X	X	X
Monthly monitoring visits to field	AC, P	X	X	X	X
Monthly program narrative and financial report to WRHQ	PM, Accountant	X	X	X	X
Strength and use in routine monitoring and evaluation vital events registration system	PM, AM, AC, P	X	X	X	X
Repeat Prevalence assessments of malnutrition, diarrhea and malaria in September and December 2005, 2006	PM, AM, AC, P, V	X	X	X	X
Continue to give feedback on evaluation resultants to volunteers, local authorities and HC staff and have discussions	PM, AM, AC, P	X	X	X	X
LRA covering phased-in interventions	PM, AM, AC, P, V	X	X	X	X
Final KPC	PM, AM, AC, P, V				X

Final Evaluation	HQ,PM, AM, AC, P, V				X
Phase- Out activities					
Involve HC, CDC, Churches in Community Health Activities	PM, AM, AC, P	X	X	X	X
Provide more training and support to volunteers associations	PM, AM, AC, P	X	X	X	X
Provide more assistance with volunteers income generating activities	PM, AM, AC, P	X	X	X	X
Care Groups Graduation & Incentives	PM, AM, AC, P			X	
Involve the HC staff, local authorities, churches in volunteers health activities	PM, AM, AC, P	X	X	X	X
Continue to involve volunteers in HC activities	PM, AM, AC, P	X	X	X	X