Health Facility Assessment Report (2007 EIP KPC)

The Expanded Impact Child Survival Program
USAID/CHSHP COOPERATIVE AGREEMENT # GHS-A-00-05-0018-00

Implemented by:
Concern Worldwide with the International Rescue Committee
and World Relief

KABEHO MWANA
"The Living Child"

Rapid Child Health Service Provision Assessment for Quality and Access at the Health Center Level

Baseline Report, March 2007

Gisagara, Kirehe, Ngoma, Nyamagabe,
Nyamasheke, and Nyaraguru Districts, Rwanda

Table of Contents

Acronym List

ANC	Antenatal Care
BASICS	Basic Support for Institutionalizing Child Survival
CCM	Community Case Management
CHW	Community Health Worker
COSA	Community Health Management Committees at HCs
CSHGP	Child Survival and Health Grants Program
CSTS	Child Survival Technical Support
DHMT	District Health Management Team
DHO	District Health Officer
DIP	Detailed Implementation Plan
Distributors	Community Actors providing CCM for Malaria
DPT	Diptheria, Pertussis, and Tetanus
EPI	Expanded Program on Immunization
GMP	Growth Monitoring and Promotion
HBM	Home Based Malaria Management Initiative
HC	Health Center
HFA	Health Facilities Assessment
HW	Health Worker
ITG	Integrated Technical Guidelines
IPT	Intermittent Presumptive Treatment
ITN	Insecticide-Treated Nets
KPC	Knowledge, Practice, and Coverage
MNC	Maternal and Newborn Care
MoH	Ministry of Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
OPV	Oral Polio Vaccine
PNC	Postnatal Care
QA	Quality Assurance
SP	Sulfadoxine-Pyrimethamine
SPA	Service Provision Assessment
TT	Tetanus Toxoid
USAID	United States Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

Purpose of the Assessment

The purpose of this Rapid Health Service Provision Assessment tool is to assess the functioning of the health system at its first level and its articulation with the community within the program area of the Expanded Impact Child Survival Program in Rwanda. This tool is meant to fill a specific niche – it is a basic tool for mainly community-based PVO programming, So it is not comprehensive, but rather is meant to generate a *minimum* set indicators of quality and access, especially insofar as these support community-based child health programming. Application of this tool may well uncover areas for improvement that may require further delineation and investigation in order to formulate an adequate strategy.

The objectives of the health facility assessment are:

1. To determine the current knowledge and practices of health workers at outpatient clinics and community health workers regarding the assessment and management of sick children.
2. To use the information to prioritize and plan improvements in the quality of care at outpatient health facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices, training and supervision of outpatient health workers and community health workers.
3. To improve the capacity for assessment and supervision of local health workers and their supervisors. Specifically, these personnel should learn survey techniques, collection and analysis of survey data, and use of data to improve the quality of case management in first level health facilities and in the community.

Information collected by this assessment will help managers of primary health care programs and health workers plan and prioritize a number of elements that are essential for provision of quality and accessible child health services, including:

- Health worker and CHW training
- Health worker and CHW supervision
- Availability of essential equipment and drugs
- Health facility management practices like recordkeeping, supervision, and training

Description of Expanded Impact Child Survival Program

On September 30, 2006, Concern Worldwide (Concern), the International Rescue Committee (IRC), and World Relief (WR) initiated the Expanded Impact Child Survival Program in partnership with the Rwandan Ministry of Health and the National Malaria Programme (NMCP). This five-year project was awarded through the USAID Child Survival and Health Grants Program's (CSHGP) expanded impact category promoting the replication of previously successful district child survival interventions by the three NGO partners in Rwanda.

The project benefits 279,000 children under-five in the Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke, and Nyaraguru districts of Rwanda, which are all underserved, rural areas with extreme poverty (See Annex A: Program area map.) The program uses innovative community-based strategies to address the factors contributing to the high maternal and under-five mortality. Interventions include malaria (34% effort), diarrhea (33% effort), and pneumonia (33% effort).

Interventions will address the three leading direct causes of child mortality - malaria, diarrhoea, and pneumonia - through a community integrated management of childhood illness (C-IMCI) strategy. The purpose of this program is to mobilize communities as part of local health systems in order to protect and treat children so as to avoid unnecessary deaths and reduce costs of illness and treatment.

Rwandan Health System

Starting in the mid-1990s, the Rwandan health system was decentralized to improve access and quality of basic health care services. The current health care system provides services at the following levels: community health worker, health center; first-level district hospital; second-level hospital; and third– level referral hospital. All HFs (public and private) are required to provide a minimum package of activities to cover basic health problems in an equitable, effective and efficient manner and a complementary package at the hospitals of activities to provide curative care in an equitable, effective and efficient way using techniques unavailable at the primary level. As hospitals are designed to care for referrals from the health centers, they were excluded from this assessment.

Most districts in the program area have 12 primary care Health Centers with standard staffing structure including a head nurse, lab technician, pharmacy aide as well as several auxillary workers. Nyaraguru District is the only area that does not yet have a District Hospital. Plans exist to upgrade the Nyaraguru HC to a hospital in the coming years. Cost recovery is a reality in the Rwandan health system with about 1/3 of the population subscribing to social insurance schemes that entitle them to low co-payments for services at the health centers and hospitals.

Table 1: List of Health Services in Program Area

District	2007 Estimated Population	District Hospitals	Health Centers	Villages
Gisagara	261,262	2	12	515
Kirehe	230,833	1	12[1]	582
Ngoma	257,669	1	12	475
Nyamagabe	290,565	2	13	442
Nyamasheke	311,734	2	16 [2]	553
Nyaruguru	236,416	0	13	322
TOTAL	1,588,479	8	78	2,889

Facility-based health services in the Program area include 8 first-line District Hospitals, 77 Health Centers (HCs) and 1 health post. Three institutions manage individual facilities: the

[1] Includes one health post which offers smaller package of services than the Health Centers
[2] New HC to open in May '07 in Nyamasheke but not included in this HFA sample.

MOH, CARITAS, and one private clinic. All supervision and policy oversight is the authority of the Ministry of Health who manage clinical and community services through a District Health Management Team.

At the community level, the Community Health Worker (CHW) plays an important role in the national strategy for primary health care, coordinating with and complementing the work at the RHC. CHWs are trained to treat basic illnesses and to do health education and other preventive activities in their communities. The CHW is a volunteer and does not receive payment from the government, but is authorized small percentages of sales of commodities (such as bed nets and certain drugs). Many communities pay their CHWs with in-kind contributions and some are employed on commercial farms. Supervision of CHWs is generally the responsibility of the front-line HFs, although logistical challenges make such supervision difficult. CHWs report to and receive their drug/supply kits from health centers, ideally on a monthly basis. Most supervision takes place during these visits, rather than in the community setting. NGOs providing rural health services work alongside the government to support training and supervision of CHWs.

Distributors were introduced under the national home based malaria pilot in 2004-05 in Kirehe, Ngoma and parts of Gisagara and Nyamasheke districts to identify and treat simple malaria and refer complicated cases to the Health Centers. These were prioritized in the selection of CHW respondents in those districts.

II. METHODS

A HFA was implemented from January 22 to March 2, 2007 to measure access and quality of child health services in the 30 health centers in the program area, which are located in Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke, and Nyaraguru districts of Rwanda (See Annex A). The HFA was one of several baseline data tools applied for the Expanded Impact Program to provide a quantitative assessment of child health services as well as identify opportunities and constraints to the program that the district health systems present. Other baseline data tools included the population-based Knowledge, Practice, and Coverage (KPC) survey and the COSA/CDC capacity assessments were conducted in the same time period as the HFA. Results were used to inform the program strategies outlined in the Expanded Impact Program's Detailed Implementation Plan (DIP) for 2006-011.

Preparation and Partnership Building

From its design phase, the Rwandan MoH has been involved in identifying the need to assess status of health services. At the national level, the Health Care Desk and the Health Information System Desks of the Ministry of Health were consulted regarding the assessment and briefed before going to the project site.

Three health staff from the Program team and Technical Advising Units of Concern and WR were trained on the Assessment tool by CSTS+ in December 2006. The tool was reviewed in a two-day meeting from January 4-5 by the Assistant M&E Coordinator of Twubakane, the Acting in-Charge of MOH Community Health Desk/UPRC-'Unity Politique Planification et

Reinforcement de Capacites' the EIP Managers and a Dr Sani Aliou who was acting on behalf of the EIP Team Leader, with minor adaptations for the program context and two of the instruments were translated into Kinyarwanda. The team took into consideration the Service Provision Assessment (SPA) of 2001, the 2005 Twubukane Health Facility Assessment, and other Child Survival local assessments taking these into consideration in the survey adaptation as well as comparative findings.

The Quality Assurance and Mobilization Manager facilitated the training, survey implementation, and data analysis in the field. District Health Directors participated in the review of the tools and were represented on the HFA survey teams in their respective districts. The HFA survey team included all the EIP officers and Mobilization and QA Managers, and two health centre staff in each district.

Instruments Used and Their Adaptation

The survey instrument was based on the Rapid Service Provision Assessment tool that CSTS+ has developed for use in CSHGP projects. The full instrument can be found in Annex C. The tool has five individual modules which collectively contain 92 questions/observations:

- Observation of Clinical Care for Five Sick Children
- Exit Interview with Caretakers of Five Sick Children
- HF Checklist
- HF Interview
- CHW Assessment

The instruments were sent to project staff for review and comment two weeks before the national review meeting. Bilingual project staff translated the CHW Interview and Exit Interview from English into Kinyarwandais. The translations were each checked by a second bilingual staff member in conjunction with one of the consultants for accuracy of translation, and then adjusted as the instruments were adapted. These instruments are included in Annex C.

During the training, several adaptations were made to fit the context. These were done in consultation with MOH district staff involved in the assessment as supervisors.

Training

The Program Mobilization Manager and QA Manager conducted the training. Participants from each district included 5 Program Officers and two district health centre staff. The MOH staff attended as supervisors because of their clinical experience and authority in the HFs. The other interviewers were district based program staff with the necessary skills and who would be instrumental in adjusting strategies based on the survey results. The list of participants is found in Annex D. The HFA training took place in each district.

Originally planned to be a three-day process. The training schedule is included in Annex E. The training was composed of an introductory section, followed by review of the modules to prepare participants to implement the forms. Half a day was devoted to classroom review and role

playing. The training was concluded with a half-day module on logistics and the role of supervisors. (See results of the evaluation in Annex E).

Information Collected

This assessment collects information on the case management of the most important causes of infant and child morbidity and mortality in developing countries and on health worker communication with caretakers at the time of the visit with a sick child. It also gathers information on the facility supports (essential medications, equipment, and materials) required for the management of these conditions. Information is collected on the management of the following clinical presentations:

- Fever (malaria, measles, ear infection)
- Acute lower respiratory tract infection (pneumonia)
- Diarrhea (simple watery diarrhea, persistent diarrhea, or dysentery)

Any infant or child presenting to a health facility with fever, cough or difficulty breathing, or diarrhea is included in this assessment. Examples of the type of information collected on the quality of case management are:

- The assessment, diagnosis, and treatment of children with diarrhea, fever and malaria, and acute lower respiratory tract infections
- Whether the vaccination status of children is checked during the sick child visit and whether these children are vaccinated appropriately
- How well health workers counsel caretakers about preventive and curative care
- The quality of training and supervision received by health workers

Examples of the type of information collected on facility elements required to support quality child health service provision are:

- Availability of essential equipment (e.g., weighing scales, sterilizer, refrigerator)
- Availability of essential materials (e.g., measuring cups for oral rehydration salts, patient registers, stock cards, maternal and child health cards, growth monitoring charts)
- Availability of essential drugs (and vaccines) for the prevention and management of the most important causes of childhood morbidity and mortality
- Adequate number of staff and sufficient time for them to spend with each caretaker and child

Sampling Methodology

The assessment involved sampling of three universes: first-level HCs, sick child consultations/exit interviews, and CHWs. Sampling was slightly different for each universe.

Table 2: Summary of Units Assessed

Unit	Universe	Sample	Successful Assessments (Response Rate)
First-Level HFs	79 HCs 32 missionary/private 47 government run	30 HCs 6 missionary 24 government run	30 (100% RR)

Clinical Cases (Observations and Exit Interviews)	13,418 annual sick child visits	150 less 5 HCs in N yaruguru and 5 HCs in Gisagara =140	140 (93% RR)
CHWs	5,778 MOH-recognized CHWs	150	150 (100% RR)

Sampling of 30 Health Centers: There are 79 HCs in the six district program area. A random sample of five health centers were selected using the KK security guard at EIP Kigali office guard (a neutral person to draw the required HC sample from a box. This included 6 facilities managed by faith-based and 24 government run institutions. Formal private providers are not a significant source of care in most of the project area, and thus were not included in the survey. Hospitals were excluded as program intervention only includes the health center and community levels.

One checklist for facility inputs was applied in every facility. To complete the HW questionnaire, the surveyors interviewed the HW most experienced in caring for sick children, resulting in a purposively biased sample.

Observed Cases / Exit Interviews: Five cases of sick child care were observed in each sampled health center. These were the cases attended either by the only provider of sick child care in the facility or by the provider with the most experience present on the day of the survey. This constitutes a cluster sample with a design effect of 1.3. The sample was designed to include 5 x 30 = 150 observations or 25 per district.

CHW / Health Posts: A line listing of all MOH-recognized CHWs was obtained from each sampled Health Center for the program area. A convenience sampling of five CHWs were selected per sampled Health Center based as they had to be called for a meeting the following day. A 100% response rate was obtained, for a final sample of 150 CHWs. (See Annex F for the CHW sampling frame).

Data Collection

Data was collected by HFA teams of three people each. Each team consisted of a supervisor (who implemented the HF checklist and supervised other data collectors) and three other team members who specialized in the collection of the data from the other five forms (See Annex G for the survey teams and data collection schedule and Annex H for the detailed supervisory instructions). Each team collected data from one facility per day. The teams generally arrived at 8 AM, as facilities opened. They completed the observations and exit interviews first, and then filled out all remaining forms. Collection was generally finished by mid-day. CHW data collection was conducted the same afternoon.

Cases Observed and Caretakers Interviewed: In each facility visited, surveyors observed clusters of five consecutive eligible cases of consultation for care of sick children and interviewed their caretakers. Criteria for eligible cases included age (child 0-59 months), illness (malaria/fever, respiratory problem, or diarrhea) and caretaker consent. Since 30 facilities were assessed, the expected number of cases was 30 x 5 = 90 in the Observation and Exit Interview databases.

Sufficient numbers of sick children were available at the day of the survey to fulfill the sample size expectation.

CHWs Assessed: Before the day of the survey, the HC In-Charge selected 5 CHWs recognized by the MOH. Convenience sampling was required due to time constraints so CHWs residing closest to the HC were requested to come to the HC with their kits and registers they used for their work. In areas with malaria distributors, these cadre were prioritized over ordinary CHWs given the nature of the assessment on community case management of sick children.

Data Entry and Analysis

All data was entered into PHC Creations PDA data form at the end of each survey day and checked by the QA Manager for obvious error for correction. PDA data was exported into Excel for analysis. All frequencies and indicators were constructed as per the HFA manual.

Summary tables based on frequencies from the HFA database were prepared by the Concern Worldwide US office due to time constraints for the field teams who were involved in the DIP preparations. Detailed findings were documented by indicator. The survey team reviewed each indicator, identified issues regarding quality/limitations of the data, made general assessment of validity of the findings and identified key action points for the EIP based on the findings.

Feeding on Findings and Action Planning

Preliminary results of were presented at the Partnership DIP Workshop in Kibuye from 13-16 March 2007. Participants included Mayor of Nyamagabe, representatives of other mayors, District Health directors or their representatives, medical directors or supervisors of district hospitals, BASICS, NMCP, Twubakane, MOH/Community Health Desk, EIP Managers and Lead EIP officers, IRC, WR and CWR technical advisers.

III. RESULTS

Core Indicators

The table on the next page shows a summary of the 12 core and 10 optional indicators included in the assessment. (See Annex I for this table with additional explanations about indicators). These 22 indicators are meant to rapidly and feasibly give a "balanced score card" for preparedness of a first-level health centers to deliver the three essential child health services: growth monitoring and promotion (GMP); expanded program on immunization (EPI); and sick child care. This is a balanced score card in the sense that it examines indicators across a variety of domains all necessary for basic HF functioning: access; inputs; processes; and outputs:

- **Access**: CHW Coverage, Service Availability, Community Coordination
- **Inputs**: Staffing, Infrastructure, Equipment, Drugs
- **Processes**: HMIS, Training, Supervision, Quality Assurance (QA)
- **Outputs**: Utilization, Correct Assessment, Correct Treatment, Counseling, and Client Satisfaction

This same reasoning was used to construct a simpler balanced score card for CHWs. Seven of the core and one of the optional indicators used for HFs were selected and adapted to measure the preparedness to deliver quality care among CHWs:

- **Inputs**: Equipment, Drugs
- **Processes**: HMIS, Training, Supervision
- **Outputs**: Utilization, Correct Treatment (from register review)

Findings on Access

Access to health services is generally good in the program area, although there are variations in access. Each HC has a catchment area that includes an average of 41 villages (locally known as Umudugudus); however the range is wide from 12 to 56.

Table 5: Results for Access Indicators

Service Availability	% HF that offer three basic child health services (growth monitoring, immunization, sick child care)	87% (26/30)
	% HC with 24 hour staffing roster	83% (25/30)

Service Availability

Health centers run integrated maternal and child health days in which GMP and vaccination are performed. All health centers sampled provide sick child consultations every day, Monday through Friday and one-third do direct outreach services for sick children about once per week. All HCs provide some vaccination service, usually once per week at the facility and have

outreach one weekly. Nearly ¾ of the HCs provide growth monitoring at the facility, usually once per week; however collectively Gisagara, Kirehe, and Ngoma had no facility GM services. 83% of HCs organized GMP outreach services, mostly on a weekly basis but a few were doing it twice or more weekly. There seemed to be little integration of the outreach services based on these interviews. It was noted during sick child client observations that growth monitoring is not yet a routine child health service practice, even in areas recently trained in facility IMCI.

Table 6: Availability of three child health services at surveyed HCs, by District

Indicator 1: % HC that offer three basic child health services (growth monitoring, immunization, sick child care)	**Gisagara**	**Kirehe**	**Ngoma**	**Nyamagabe**	**Nyamasheke**	**Nyaraguru**	**Total**
	5	3	3	5	5	5	**26**
	100%	**60%**	**60%**	**100%**	**100%**	**100%**	**87%**

Outreach visit schedules vary greatly across health centers, even in the same district as indicated in the table below.

Table 7: Frequency of outreach services for three child health services, by District

	Gisagara	**Kirehe**	**Ngoma**	**Nyamagabe**	**Ny'sheke**	**Ny'guru**	**Total**	
	N=5	**N=5**	**N=5**	**N=5**	**N=5**	**N=5**	**N=30**	
Sick child outreach every day	0	0	0	0	2	1	3	10%
Sick child outreach 2 x week	0	0	0	1	0	1	2	7%
Sick Child Outreach 1 week	1	0	1	0	2	1	5	17%
No Sick child outreach	*4*	*5*	*4*	*4*	*1*	*2*	20	67%
Vaccination outreach every day	1	0	0	0	0	0	1	3%
Vaccination outreach 2 x week	0	0	0	2	0	0	2	7%
Vaccination outreach 1 x week	4	5	5	1	5	5	25	83%
Vaccination outreach 1 x month	0	0	0	2	0	0	2	7%
No Vaccination outreach	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
GMP outreach every day	2	0	0	0	0	0	2	7%
GMP outreach 2 x week	0	0	0	1	0	2	3	10%
GMP outreach 1 x week	2	3	3	1	4	2	15	50%
GMP outreach 1 x month	0	0	0	3	0	1	4	13%
No GMP outreach	*1*	*2*	*2*	*0*	*0*	*0*	*5*	*17%*

Table 8: Availability of 24 Hour Services at HCs, by District

	Gisagara	**Kirehe**	**Ngoma**	**Nyamagabe**	**Ny'sheke**	**Ny'guru**	Total
24 hour staff roster	5	4	5	5	2	4	**83%**
No 24 hr but staff live at site	0	0	0	0	3	1	**13%**
No 24 hours	0	1	0	0	0	0	**3%**

Findings on Facility Inputs

The survey assessed four indicators for facility inputs: staffing, infrastructure, supplies and drugs.

Table 9: Results for Input Indicators

Staffing	% staff who provide clinical services working in surveyed HC on the day of the survey	89% (160/179)
Infrastructure	% essential infrastructure available in surveyed HC on day of the survey (power, improved water source, functional latrine for clients, communication equipment, emergency transport, overnight beds, setting allowing auditory and visual privacy)	17% (5/30)
Supplies	% essential supplies to support child health in HCs on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	23% (7/30)
Drugs	% first line medications for child health in surveyed HC/CHW on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line anti-malarial, vitamin A)	HC: CHW:
Availability of Guidelines	% HC with all nationally-mandated guidelines for care of children available and accessible on day of survey	43% (13/30)
Infection Control	% HC with all infection control supplies and equipment on day of survey	40% (12/30)

Staffing

Staffing has improved at the Health Center levels following decentralization in recent years. However the availability of the highest grade (A1) nurses and doctors is very limited Some, are quite remote and have difficulty with recruitment and retention of qualified staff. All facilities surveyed had a qualified health workers to care for sick children present on the day of the survey.

As shown in the below table, while most clinical staff were present at the time of the survey, a higher level of absenteeism was noted among other staff, particularly the pharmacists and nutritionists. In mission-run facilities, the pharmacist does leave a small stock for the nurse in-charge. Since the 2003 termination of WFP food support to many health centers, many nutrition aides had been reappointed to other duties; however so there may have been misreporting regarding absenteeism of this cadre.

Table 10: Funded versus staffed posts at Health Centers by Type, by District

Staffing Type	**Gisagara**		**Kirehe**		**Ngoma**		**Nyamagabe**		**Ny'sheke**		**Ny'guru**		**Total**		
Clinical Staff	**Funded posts**	**Present**	**Funded posts**	**Present**	**Funded posts**	**Present**	**Funded posts**	**Present**	**Funded posts**	**Present**	**Funded posts**	**Present**	**Funded posts**	**Present**	**%**
Doctors	0	0	3	3	0	0	0	0	0	0	0	0	3	3	100%
A1 Nurses	2	2	3	2	1	0	1	0	1	1	1	1	9	6	67%
A2 Nurses	19	15	18	16	22	22	24	22	40	40	25	19	148	134	91%
A3 Nurses	0	0	3	3	4	4	4	4	2	1	148	134	5	3	60%
Midwives	0	0	1	1	0	0	0	0	0	0	0	0	1	1	100%
Other clinicians	0	0	3	3	0	0	10	10	0	0	0	0	13	13	100%
Total Clinical Staff	**21**	**17**	**29**	**26**	**23**	**22**	**36**	**33**	**41**	**41**	**29**	**21**	**179**	**160**	**89%**
		81%		***90%***		***96%***		***92%***		***100%***		***72%***			
Other staff															
Pharmacist	1	0	3	0	0	0	4	0	0	0	1	1	9	1	11%
Lab Technicians	0	0	1	1	0	0	0	0	0	0	2	2	1	1	100%
Social Workers	1	1	8	0	6	0	0	5	1	0	2	1	18	7	39%
Nutrition	3	0	4	1	2	0	5	1	12	0	1	0	27	2	7%
Other auxiliary staff	1	0	15	6	11	2	16	10	14	4	21	21	78	43	55%
Total other staff	**6**	**1**	**31**	**8**	**19**	**2**	**25**	**16**	**27**	**4**	**27**	**25**	**133**	**54**	**41%**
		17%		***26%***		***11%***		***64%***		***15%***		***93%***			

Infrastructure and Equipment

Nearly all HCs lacked one or more components required to meet criteria of basic infrastructure on the day of the survey. Only 5 of the facilities (17%) were equipped with all the necessary amenities (auditory and visual privacy, electricity, water from an improved source, and functioning client latrine). All but 2 facilities had overnight patient beds with an average of 28 beds per health center. Availability of communications, mostly radio calls and mobile phones, were largely accessible for the sampled health centers in most of the districts with the exception of Nyamagabe where only had one facility had access to communication within a five minute walk. Twenty percent of the HCs had no ambulatory service access – either a vehicle with fuel on site or on-call within the district. One-third of the facilities had no functioning electricity the day of the survey.

Table 11: Availability of Essential Infrastructure at Health Centers, by District

Infrastructure Item	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaraguru	% Total
	N=5	N=5	N=5	N=5	N=5	N=5	N=30
Overnight beds	5	4	4	5	5	5	**93%**
HC has communication within 5 minutes walk	4	4	3	1	5	5	**73%**
Ambulatory transport on site	2	2	2	0	0	2	**27%**
Ambulatory transport on call	3	2	3	0	5	3	**53%**
Electricity (current/generator/solar) on day of visit	4	3	2	4	3	3	**63%**
Useable client toilet/latrine on day of visit	3	3	5	4	4	5	**80%**
Water from improved source	3	4	2	3	5	2	**63%**
Client consultation area with auditory and visual privacy	2	5	5	0	5	3	**67%**
Indicator 3: % HCs essential infrastructure available	**1**	**2**	**1**	**0**	**0**	**1**	
	20%	**40%**	**20%**	**0%**	**0%**	**20%**	**17%**

Supplies

Less than a quarter (23%) of the facilities had all the basic equipment for child examination on the day of the survey; however, the majority had most supplies. Most problematic supplies included functional timers to count respirations and a container such as a jug or jar for mixing ORS. Results for individual amenities are shown in the table below.

Table 12: Health Centers by District with Essential Child Health Supplies

Item	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaraguru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**

Item	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaraguru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**
Functioning refrigerator for vaccine storage	5	5	4	4	5	3	**87%**
Functioning child scale (Salter/standing scale)	3	4	5	5	5	4	**87%**
Functioning adult scale	5	4	5	5	5	5	**97%**
Functioning Timer/watch with second hand	1	3	1	1	2	0	**27%**
ORS equipment (jar/jug)	1	1	0	2	4	0	**27%**
ORS equipment (cup/spoon)	2	4	5	2	4	0	**57%**
Indicator 4: HCs with all essential supplies to support child health on day of survey	**1**	**1**	**0**	**1**	**4**	**0**	**23%**
	20%	**20%**	**0%**	**20%**	**80%**	**0%**	

Almost half of the health centers sampled (48%) had all required items for infection control; however, two districts fared far worse than the others as indicated the table below. Most problematic items were the availability of a functioning autoclave or other sterilizer (63%) and the availability of a safe and protected system for sharps and infectious wastes.

Table 13: Infection Control Items Availability, by District

Items	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaraguru	TOTAL
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**
Autoclave/Sterilizer available & functioning	2	4	3	2	3	5	**63%**
Chlorine-based disinfectant	2	5	5	4	5	4	**83%**
Latex gloves (clean or sterile)	5	5	5	5	5	4	**97%**
Sharps container	5	5	5	4	5	5	**97%**
Handwashing soap (bar or liquid)	5	5	5	5	5	5	**100%**
Safe Disposal for Sharps	4	2	4	5	5	5	**83%**
Safe Disposal for Infect. Waste	4	5	4	4	4	4	**83%**
Protected site for sharps	5	1	4	3	5	5	**77%**
Protected site for waste	5	4	4	2	3	5	**77%**
Opt Indicator 6: HCs meeting all criteria for infection control	**2**	**1**	**3**	**1**	**2**	**3**	**12**
	40%	**20%**	**60%**	**20%**	**40%**	**60%**	**48%**

The nationally-mandated guidelines for care of children was available and accessible on day of survey at 52% (13 /25) of the HCs. Availability was highest in Nyaraguru and Nyamagabe (80% and 60%) and not at all available in Ngoma. 40% of HCs in Gisagara, Kirehe and Nyamasheke had guidelines that were observed by the interview team.

Drugs and Vaccines Availability

The drug supply at the surveyed HCs was pretty good with two-thirds of surveyed HCs (63%) having stock of essential child health drugs available at the time of the survey. Zinc has only recently been added to the national essential drug list and not widely available yet at the health centers. When zinc is factored in to the calculation, only 40% of HCs had all 7 drugs + zinc.

Most HFs had adequate supplies of drugs for malaria, with only six percent lacking SP and only 16% without Coartem. ITN supplies were very low, as expected, with only about one fourth of facilities having any ITNs at all.

Table 14: Drugs for Child Treatment Availability for Health Centers, by District

ITEM	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**
ORS Packets	5	5	5	5	5	5	**100%**
Amoxycillin (first line oral for child pneumonia)	4	5	5	5	5	5	**97%**
Ciproflaxin (first line oral for bloody diarrhea)	4	4	4	5	5	4	**87%**
Coartem (first line for malaria)	5	5	5	5	5	5	**100%**
Zinc	2	3	3	5	0	4	**57%**
Vitamin A supplements	5	3	4	5	5	5	**90%**
Iron sulfate	3	5	4	5	5	5	**90%**
Insecticide treated nets	5	2	3	5	4	4	**77%**
Indicator 6: HCs with all 7 Child Drug Items available	**3**	**1**	**2**	**5**	**5**	**3**	**63%**
	60%	**20%**	**40%**	**100%**	**100%**	**60%**	
Indicator 6*: HCs with 8 Child Drug Items available (with zinc)	**2**	**1**	**1**	**5**	**0**	**3**	**40%**
	40%	**40%**	**20%**	**0%**	**0%**	**20%**	

*Definition of "in-stock": item was available and at least one item was valid (not expired) by observation

Vaccine supply was particularly poor, as approximately one third of health centers were stocked out of basic childhood vaccines or Tetanus Toxoid (TT) on the day of the survey. Vaccines are supplied through the district and for monthly outreach visits, so that even those without the vaccines in the health centers themselves are still able to adequately do the job of vaccination according to MOH standards. Of course, this method of doing vaccinations makes for many missed opportunities for vaccination, as they are not usually given routinely in the health center itself.

Table 15: Vaccines Availability at Health Centers on Day of Survey, by District

Vaccine	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**
BCG Vaccine	5	5	4	4	5	4	**90%**
OPV Polio Vaccine	5	5	4	4	5	4	**90%**
DPT Vaccine	5	5	3	4	5	3	**83%**
Measles/MMR vaccine	5	5	4	4	5	4	**90%**
Opt Indicator 2: all	**5**	**5**	**3**	**4**	**5**	**3**	**83%**

Vaccine	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	**N=30**
vaccines available day of survey	**100%**	**100%**	**60%**	**80%**	**100%**	**60%**	
No stock out of all vaccines in past 6 months	**1**	**5**	**1**	**2**	**5**	**3**	**57%**
	20%	**100%**	**20%**	**40%**	**100%**	**60%**	

Stock outs at anytime within past six months were reported sporadically by Health Centers for the following vaccines: BCG, OPV and measles stock-outs reported in 3 districts; DPT stock-outs reported in 4 districts. This appeared to be localized, affecting specific facilities and not the whole district or country.

CHW drugs and supplies

Four of the six districts had CHWs trained to manage sick children, mostly malaria and diarrhea. The availability of the full package of drugs – ORS, antimalarial (AQ/SP), and zinc were largely available in Kirehe and Ngoma. Availability was fair in Nyamasheke as well with 90% have antimalarials and 50% ORS; however, zinc was not yet available to the CHWs. Availability of all drugs was very low in Gisagara.

Table 16: Drug Availability Among CHWs trained to Treat Sick Children, by District

	Gisagara	Kirehe	Ngoma	Nyamagabe	Nyamasheke	Nyaraguru	Total
Drug seen or reported	N=14	N=25	N=25	N=0	N=10	N=0	N=74
ORS	n/a	25	24	n/a	5	n/a	73%
AQ/SP	2	25	24	n/a	9	n/a	81%
Zinc	n/a	25	24	n/a	0	n/a	66%
Indicator 5 % CHWs with ORS, Anti-malarial and zinc	**0**	**25**	**24**	**N/A**	**0**	**N/A**	**66%**
	0%	**100%**	**96%**	**N/A**	**0%**	**N/A**	

None of the supplies stipulated in the assessment tool are currently part of the CHW package.

Findings on Facility Processes

The HFA used four indicators to evaluate quality of processes in the HFs: maintenance of the HMIS; supervision; training; and QA). Unfortunately, two of these indicators (supervision and QA) had some confusion in terms of their application. See the below table for results for these four indicators.

Table 17: Summary Results for Processes

HMIS	% HF/CHW that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HF: have report in last 3 months and evidence of data use	HF: 20 /29 (69%) CHW: 37/150 (25%)
Training	% HF/CHW that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HF: have report in last 3 months and evidence of data use	HF: 22/30 (73%) CHW: 82/150 (55%)
Supervision	% HF/CHW in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	HF: 28/30 (93%) CHW:41% (61/150)
QA	% HF that have documentation of routine quality assurance activities in last 3 months	87% (30)
Community Referral	% HF that received at least one referral from CHW in the last three months	13% (4 / 30)
Coordination Between HF and Community	% HF that have routine community participation in management meetings (with evidence through notes) OR have a system for eliciting client opinion and evidence that client feedback is reviewed	90% (27/30)

HMIS

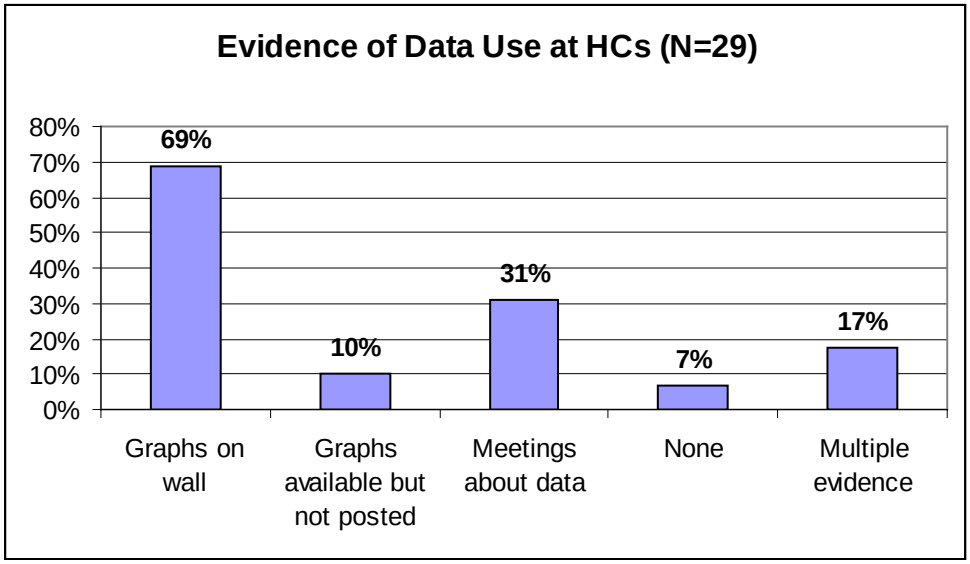
MOH-mandated registers were generally filled out properly. Those HCs that did not pass the benchmark generally only had one or a few entries missing for one or several of the items (age, sex, diagnosis, treatment). However, in Nyamagabe diagnosis and treatment were frequently missing from the child health registers. There is a need to have separate child and adult registers in Ngoma where 4 of the 5 HCs visited had combined registers.

Table 18: Strength of Child Health Data Collection, Reporting and Use, by Distirct

Items	**Gisagara**	**Kirehe**	**Ngoma**	**Ny'gabe**	**Ny'sheke**	**Ny'guru**	Total
	N=4	N=5	N=5	N=5	N=5	N=5	N=29
Age, diagnosis and treatment completely entered in registers	4	4	5	1	5	5	83%
Recent entry in register (past 7 days)	4	5	5	5	5	5	100%
Report written in past 3 months	3	5	5	5	5	5	97%
Evidence of data use	4	3	4	5	5	5	90%
Indicator 6: Functional HMIS child health	**3**	**2**	**4**	**1**	**5**	**5**	**69%**
	75%	**40%**	**80%**	**20%**	**100%**	**100%**	

As shown in figure 1 below, data use was well evidenced particularly through availability of summary graphics and data oriented staff meetings. Several clinics had both the graphics and meetings.

Figure 1: Evidence of Data Use among Surveyed HCs



CHWs trained to treat sick children were 73/150 interviewed. The majority only treated children with simple fever; however in Kirehe and Ngoma many also treated diarrhea. None treated pneumonia at the time of the survey. Of the 73 CHWs, only 53 had their register books available at the time of the survey (there were 13 CHWs with non-available register books). The table 17 derives from those 53 who were trained and had a book available.

Table 19: Completeness of CHW registers, by District

	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total %
ITEM	N=1	N=18	N=24	N=0	N=10	N=0	N=53
Register complete: age, diagnosis and tx written	0	18	22	0	10	0	94%
Last Entry less than 30 days ago	1	15	18	0	4	0	72%
More than 30 days ago	0	3	2	0	5	0	19%
Indicator 6b: CHWs maintain up-to-date records of sick children	**0**	**15**	**18**	**0**	**4**	**0**	**70%**
	O%	**83%**	**75%**	**N/A**	**40%**	**N/A**	

Training

While most interviewed providers who are responsible for provision of child care had been trained in past year (80%), only 10% had any IMCI training and those were limited to 3 HCs in two districts (Gisagara and Kirehe). While most providers received training, the depth of topics was limited, particularly in Ngoma, Nyamasheke and Nyaraguru. Training was particularly low in Nyamagabe where only one provider received any training and that was on vaccinations only.

Table 20: Training of Primary Child Care Giver in past 12 Months, by Topic, by District

Training Area	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	(n=5)	(n=5)	(n=5)	(n=5)	(n=5)	(n=5)	(n=30)

Training Area	Gisagara (n=5)	Kirehe (n=5)	Ngoma (n=5)	Ny'gabe (n=5)	Ny'sheke (n=5)	Ny'guru (n=5)	Total (n=30)
Any training past 12 months	4	5	4	1	5	5	80%
Vaccinations	*3*	*2*	*3*	*1*	*2*	*1*	*40%*
ARI/pneumonia treatment	*2*	*1*	*0*	*0*	*0*	*0*	*10%*
Diarrhea case management	*2*	*2*	*2*	*0*	*0*	*0*	*20%*
Child malaria case management	*3*	*4*	*4*	*0*	*5*	*3*	*63%*
Prevention of malaria	*0*	*2*	*2*	*0*	*5*	*2*	*37%*
Nutrition	*2*	*5*	*3*	*0*	*0*	*0*	*33%*
Breastfeeding	*2*	*1*	*0*	*0*	*0*	*0*	*10%*
IMCI	*2*	*1*	*0*	*0*	*0*	*0*	*10%*
Indicator 7: % of interviewed HW reported receiving training in child health in last 12 mos.	**4**	**4**	**4**	**1**	**5**	**4**	**73%**
	80%	**80%**	**80%**	**20%**	**100%**	**80%**	

Table 21: Training of CHWs in past 3 Years in Child Health, by District

Training	Gisagara N=25	Kirehe N=25	Ngoma N=25	Ny'gabe N=25	Ny'sheke N=25	Ny'guru N=25	Total % N=150
Diarrhea - past year	*0*	*23*	*24*	*0*	*0*	*0*	*31%*
Diarrhea - past 2-3 years	*0*	*1*	*0*	*2*	*1*	*0*	*3%*
Diarrhea - 3 years	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
Subtotal Diarrhea trained	**0**	**24**	**24**	**2**	**1**	**0**	**34%**
Malaria tx - past year	*3*	*24*	*24*	*3*	*4*	*0*	*39%*
Malaria tx - past 2-3 yrs	*9*	*1*	*0*	*4*	*5*	*0*	*13%*
Malaria tx - 3 years	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
Subtotal malaria tx trained	**12**	**25**	**24**	**7**	**9**	**0**	**51%**
Malaria prevention - past yr	*1*	*6*	*10*	*8*	*6*	*9*	*27%*
Malaria prevention - 2-3 yrs	*6*	*0*	*0*	*4*	*6*	*6*	*15%*
Malaria prevention - 3 years	*0*	*0*	*1*	*0*	*1*	*0*	*1%*
Subtotal malaria prevention trained	**7**	**6**	**11**	**12**	**13**	**15**	**43%**
Pneumonia tx - past year	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
Pneumonia tx - 2-3 years	*0*	*0*	*0*	*1*	*0*	*0*	*1%*
Pneumonia tx - 3 years	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
Subtotal pneumonia trained	***0***	***0***	***0***	***1***	***0***	***0***	***1%***
Indicator 7: Proportion of CHWs trained on one+ child health topic in past 12 months	**4**	**24**	**24**	**11**	**7**	**12**	**55%**
	16%	**96%**	**96%**	**44%**	**28%**	**48%**	

Supervision

Health Center

The quality of supervision was quite good with all centers receiving much more than supplies during the last visit (note the two HCs receiving supervision more than six months ago were not asked what happened during the visit. Of those receiving a visit in the past 6 months, they reported the following supervision components: Observed cases (23/28), reviewed reports/data (23/28), gave encouragement (22/28), provided updates (20/28), and discussed problems (24/28).

Table 22: HC Supervision by DHMT, by District

Date of last visit	Gisagara n=5	Kirehe n=5	Ngoma n=5	Ny'gabe n=5	Ny'sheke n=5	Ny'guru n=5	Total N=25
Within past 3 months	*3*	*3*	*5*	*3*	*5*	*5*	*80%*
Within past 4-6 months	*1*	*2*	*0*	*1*	*0*	*0*	*13%*
Within past 7-12 months	*1*	*0*	*0*	*1*	*0*	*0*	*7%*
More than 12 months ago	*0*	*0*	*0*	*0*	*0*	*0*	*0%*
Indicator 8: Supervision visit past 6 months more than supplies	**4**	**5**	**5**	**4**	**5**	**5**	**93%**
	80%	**100%**	**100%**	**80%**	**100%**	**100%**	

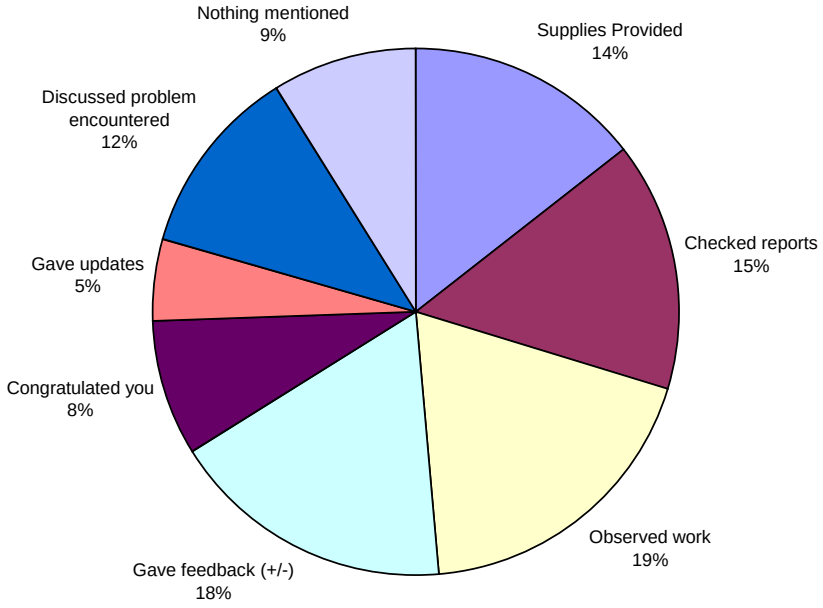
CHW Supervision

Only two HCs (7%) reported that they routinely supervise CHWs at the community level (1 in Nyamaseheke and 1 in Nyaraguru) while two HCs in Kirehe reported supervising community Distributers of anti-malarials ***(based on HW interview)***

Table 23: CHW Supervision by HC Personnel, by District

Timing of last supervision	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	TOTAL %
	N=25	N=25	N=25	N=25	N=25	N=25	N=150
Supervised past 3 months	**1**	3	**2**	**3**	**3**	2	**9%**
Supervised 4-6 months	9	11	12	1	10	5	**32%**
More than 6 months/never	15	11	11	21	8	18	**56%**
Indicator 8 CHW Supervision	**10**	**14**	**13**	**4**	**13**	**7**	**41%**
	40%	56%	52%	16%	52%	28%	

Figure 2: Service provided during CHW supervision in past 6 months



Quality Assurance Improvement

Most health centers (87%) reported QA activities but only 10 had documentation to evidence this such as a report or list of controls; hence one-third had documented evidence of quality improvement processes in place.

Table 24: Evidence of Quality Assurance Improvement at Health Centers, by District

	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	N=30
Report using QA processes	5	3	5	4	5	4	**87% (26/30)**
Opt Indicator 7: Evidence of quality Assurance activity in past 3 months seen by surveyors	2	1	4	1	1	1	**33% (10/30)**
	40%	**20%**	**80%**	**20%**	**20%**	**20%**	

Community Processes

With the exception of Nyamagabe and Nyamasheke, community participation in health center management committees (COSAs) existed in at least 80% of the health centers sampled. In Nyamasheke there were none and in Nyamagabe in only two of the health centers.

Table 25: Community Participation in HC Management, by Disrict

Type of Routine Engagement	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total
	N=5	N=5	N=5	N=5	N=5	N=5	N=30
Community Reps on COSA	5	4	4	2	0	5	67%

Meetings with CHWs / TBAs		3	1	1	5	5	50%
Indicator Opt 4 community participation in mgmt	**5**	**4**	**5**	**3**	**5**	**5**	**90%**
	100%	**80%**	**100%**	**60%**	**100%**	**100%**	

Health centers reporting holding regular monthly meetings with CHWs and/or TBAs was 100% in Nyamasheke and Nyaraguru but much lower in the other districts (80% overall). Only 7% of HCs reported conducting community-level supervision of either CHWs or Distributors. However, it is known that such routine meetings and supervision are taking place in Gisagara and Kirehe districts as well. Interviewers may not have recorded multiple responses to the questions, or the meetings may have ceased since the end of the last phase of intervention.

Reported referrals received by CHWs were very low with only four HCs (13%) reporting any referrals received. This may be due to challenges in accounting for referrals received. A total of 13 cases were reported as referrals and all were for malaria.

Table 26: Recorded Sick Child Referrals from CHWs at HCs, by District

	Gisagara	**Kirehe**	**Ngoma**	**Ny'gabe**	**Ny'sheke**	**Ny'guru**	**Total**
	N=5	**N=5**	**N=5**	**N=5**	**N=5**	**N=5**	**N=25**
# malaria referrals from CHWs	0	8	0	0	5	0	**13**
# ARI referrals from CHWs	0	0	0	0	0	0	**0**
# diarrhea referrals from CHWs	0	0	0	0	0	0	**0**
Opt Indicator 5: % HCs received at least one referral from CHW in past month	**0**	**3**	**0**	**0**	**1**	**0**	**13%**
	0%	**60%**	**0%**	**0%**	**20%**	**0%**	

CHW referrals captured in HC records was very limited due to problems with the proper functioning of the counter referral system at the district level Of the referrals captured, they were only coming from Kirehe and Nyamasheke and only for malaria cases, likely the result of the Home Based Malaria initiative.

Findings on Outputs

The final area of assessment is outputs of the Health Services at the facility and community levels. These outputs are client services and are expressed in terms of coverage in HFAs (vaccination coverage, ANC coverage, etc.). Given that the community-based KPC gives coverage estimates, the HFA characterizes outputs differently. This assessment estimates overall utilization of sick child services (service quantity) and derives some estimation of service quality. This data is derived from the observation of clinical cases and exit interviews. The sample size only allows for an aggregate score for all HCs, rather than individual ones for each HF. The table below illustrates results for outputs.

Table 24: Results for Outputs

HF/CHW Utilization	# clinical encounters (/HF / annualized) for sick children per U5 population	HF: 0.6 sick visits/yr. .
HW Performance (Assessment)	% key assessment tasks are made by HW (check presence of general danger signs, assess feeding practices, assess nutritional status, check vaccination status)	59% (83/141)
HW Performance (Correct Treat.)	% clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Obs. for HF)	HW: 58% (83/142)
HW Performance (Counseling)	% clinical encounters in which the HW counseled the caretaker to continue feeding sick child	19% (29/150)
	% clinical encounters in which the caretaker whose child was prescribed an antibiotic, anti-malarial, or ORS, can correctly describe how to administer all drugs	28% (42/149)
Client Satisfaction / Perceived Quality	% clinical encounters in which the caretaker was very satisfied (4 on a 4 point scale) for all three of the following: wait time, explanation of illness, and treatment received	10% (15/149)
HW Performance (Alternative for Counseling)	% clinical encounters in which the HW counseled the caretaker to continue feeding sick child	28% (42/149)

Utilization

The two indicators that allowed for individual scores for HFs were correct treatment (derived from registers) and utilization. Utilization rates vary widely from a high at Nyamasheke District of 1.2 sick child visits per child per year to a low of 0.2 at Gisagara.

Table 27: Utilization Rate of Sick Child Services by District

	Kirehe	**Ngoma**	**Nyamagabe**	**Nyamasheke**	**Total**
Number sick child consultations past 3 months	2162	2853	3504	4899	**13,418**
Estimated consultations for year	8648	11,412	14,016	19,596	**53,672**
Number children under 5	15,546	18,615	23,917	15,894	**73,972**
Ind 9: Utilization of Sick Child Services	**0.56**	**0.61**	**0.59**	**1.23**	**0.73**

Note: sick child consultations could not be extracted from registers in Gisagara and Nyaraguru so they were excluded from the analysis.

Table 28: Utilization Rate of Sick Child Services, by HC, by District

District	HC Code	Sick Child Consultations past 3 months	Estimated annual consultations	Population Under 5	Sick Child Utilization Rate
Nyamasheke	13	1,348	**5,392**	2,218	**2.4**
Kirehe	63	565	**2,260**	1,525	**1.5**
Nyamasheke	11	1,195	**4,780**	3,466	**1.4**
Nyamasheke	12	1,262	**5,048**	3,865	**1.3**
Nyamasheke	15	730	**2,920**	2,453	**1.2**
Nyamagabe	24	1,270	**5,080**	4,515	**1.1**
Ngoma	42	491	**1,964**	2,431	**0.8**
Kirehe	61	686	**2,744**	3,787	**0.7**
Nyamagabe	21	665	**2,660**	3,899	**0.7**
Kirehe	65	195	**780**	1,200	**0.6**
Ngoma	43	294	**1,176**	1,917	**0.6**
Ngoma	45	447	**1,788**	2,966	**0.6**
Ngoma	41	1,231	**4,924**	8,546	**0.6**
Nyamagabe	22	832	**3,328**	5,814	**0.6**
Ngoma	44	390	**1,560**	2,755	**0.6**
Gisagara	51	866	**3,464**	6,201	**0.6**
Kirehe	62	398	**1,592**	3,354	**0.5**
Nyamagabe	25	380	**1,520**	3,867	**0.4**
Nyamasheke	14	364	**1,456**	3,892	**0.4**
Nyamagabe	23	357	**1,428**	5,822	**0.2**
Kirehe	64	318	**1,272**	5,679	**0.2**

HW Performance

Quality of services was poor, as measured by the three HW performance indicators:

1. **% key assessment tasks are made by HW (check presence of general danger signs, assess feeding practices, assess nutritional status, check vaccination status)**

In only four clinical encounters were all the assessment tasks completed (3%). Given the low level of IMCI training roll-out, it was not surprising that there was very low checking of child's growth nor vaccination status. Inquiry about feeding difficulties (63%) and vomiting (53%) were pretty good, especially in the previous child survival districts; however, fewer providers in Gisagara inquired about convulsions.

Table 29: Sick Child Assessment Checks Made by Provider, by District

Assessment Step	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Overall %
	n=25	N=25	n=25	n=25	n=25	n=25	N=150
Inquired about child feeding	18	16	13	13	22	13	63%
Inquired about vomiting	18	15	9	9	19	9	53%
Inquired about convulsions	1	12	3	2	1	2	14%

Assessment Step	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Overall %
	n=25	N=25	n=25	n=25	n=25	n=25	N=150
Plotted weight for age	6	13	0	0	0	2	14%
Checked vaccination status	4	10	0	0	0	2	11%
Indicator 10: HW Performance Assessment	**0**	**4**	**0**	**0**	**0**	**0**	**3%**
	0%	**16%**	**0%**	**0%**	**0%**	**0%**	

2. % clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Observation at HF and register books for CHWs)

As shown in figure 2, the majority of cases observed were diagnosed as having fever and/or acute respiratory infections. There were far fewer cases of diarrhea or children with multiple symptoms including diarrhea presenting at the time of the clinical observations. Only 7% of assessed children did not have fever, diarrhea, or acute respiratory infections. No cases of bloody diarrhea were observed.

Table 30: Sick Child Treatment Provided by Observed Clinician, by Child Illness, by District

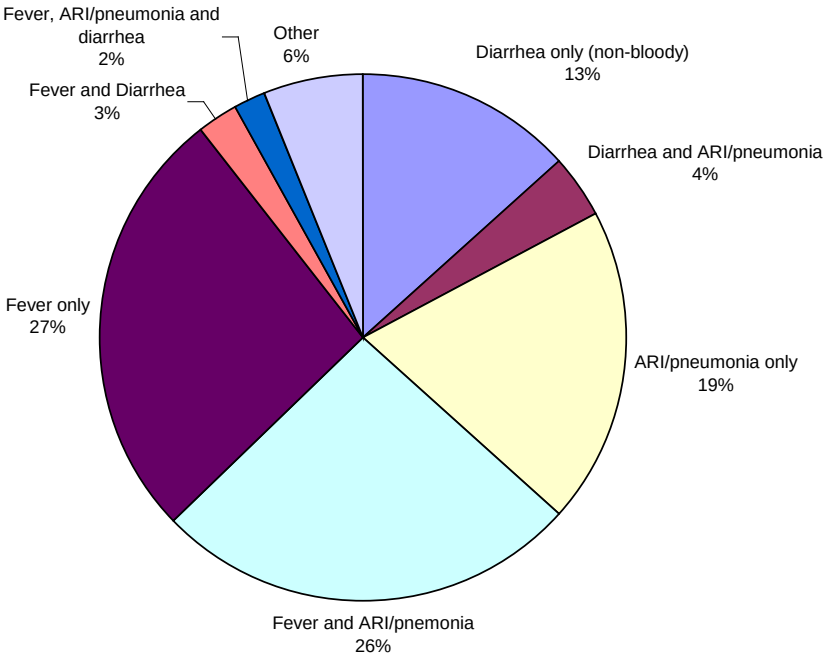
Treatment by Illness	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total (%)
	N=22	N=25	N=24	N=25	N=25	N=20	N=141
Number of child fever cases	**19**	**19**	**17**	**11**	**16**	**9**	**91 (58%)**
Number with fever received Coartem ®	18	18	15	9	16	8	84
Number not receive Coartem® and treatment deemed incorrect	1	1	2	1	0	0	5
Number not receive Coartem® but treatment deemed correct (e.g. not malaria)	0	0	0	1	0	1	2
Malaria treated correctly	**18**	**18**	**15**	**10**	**16**	**9**	**86 (95%)**
Received Counseling on use of Coartem ®	*17*	*17*	*14*	*7*	*16*	*0*	*71 (85%)*
Number of ARI/Pneumonia cases	**9**	**15**	**17**	**18**	**14**	**4**	**77 (55%)**
Number received first-line treatment, amoxicillin	5	10	10	9	4	2	38
Number received other antibiotic, deemed incorrect treatment	4	2	6	6	3	2	21
Number received no antibiotic but should have - deemed incorrect	0	0	0	2	2	0	4
ARI/pneumonia tx correctly	**9**	**12**	**16**	**15**	**9**	**4**	**59 (77%)**
Received counseling on use of antibiotic	*0*	*9*	*10*	*0*	*0*	*0*	*19 (32%)*
Number of non-bloody diarrhea cases	**4**	**6**	**8**	**4**	**3**	**8**	**33 (23%)**
Number received ORS	2	6	5	3	2	6	24
Number received nothing but should received ORS	2	0	2	0	1	0	5
Non-bloody diarrhea treated correctly	**2**	**6**	**5**	**3**	**2**	**6**	**24 (73%)**
Number shown how to prepare	*2*	*6*	*5*	*3*	*2*	*3*	*21*

Treatment by Illness	Gisagara	Kirehe	Ngoma	Ny'gabe	Ny'sheke	Ny'guru	Total (%)
	N=22	N=25	N=24	N=25	N=25	N=20	N=141
ORS (% among those who received it)							*(100%)*
Indicator 11: % clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea	**16**	**20**	**14**	**18**	**15**	**17**	**100 (71%)**
	73%	**80%**	**58%**	**72%**	**60%**	**85%**	

Note that 9 (6%) sick children not classified with fever, ARI nor diarrhea and excluded from this analysis.

To assess correct treatment, the survey examined whether first-line treatment was delivered for pneumonia/ARI, fever/malaria, and non-bloody diarrhea. Fever/malaria had the best compliance, with most receiving Coartem ®, the national first-line anti-malarial. Next in compliance was ARI treatment with the majority receiving amoxicillin antibiotics. ORS was almost universally prescribed to children with diarrhea. Over use of antibiotics for diarrhea and non-pneumonia respiratory infections was observed.

Figure 2: Classification of observed sick child diagnoses, N=150



3. % clinical encounters in which the HW counseled the caretaker to continue feeding sick child

Only 19% of observed clinical encounters with sick child including advising the caretaker on the need to maintain feeding and increase fluids. This is comparable to low practice found in the KPC survey results.

Table 31: Sick Child Counseling on Continued Feeding, by District

Option 10A: clinical encounters where HW counseled caretaker to continue feeding sick child	**Gisagara**	**Kirehe**	**Ngoma**	**Ny'gabe**	**Ny'sheke**	**Ny'guru**	**Overall %**
	n=25	n=25	n=25	n=25	n=25	n=25	n=150
	6	**13**	**5**	**3**	**1**	**1**	**19%**
	24%	**52%**	**20%**	**12%**	**4%**	**4%**	

3. % clinical encounters in which the caretaker whose child was prescribed an antibiotic, anti-malarial, or ORS, can correctly describe how to administer all drugs

Counseling on prescription administration was fairly good in observed cases as shown in table 30 with the exception of antibiotic use. However, only 28% of caretakers were able to explain how to correctly administer all medication given during the exit interviews. This communication gap is significant and considered to be partially due to rushed consultation time due to heavy work loads but also absence of counseling visual aids. The low level of counseling on continued feeding practices may also partially be explained by limited time for consultation.

Table 32: Familiarity of Caretakers Interviewed with Administration of Child Drugs Prescribed, by District

	Gisagara	**Kirehe**	**Ngoma**	**Ny'gabe**	**Ny'sheke**	**Ny'guru**	**Total**
Indicator 12: % clinical encounters in which the caretaker whose child was prescribed an antibiotic, anti-malarial, or ORS, can correctly describe how to administer all drugs	n=25	n=24	n=25	n=25	n=25	n=25	n=149
	10	**4**	**7**	**2**	**3**	**16**	**28%**
	40%	**17%**	**28%**	**8%**	**12%**	**64%**	

Client Satisfaction

All three satisfaction questions (satisfied with wait time, explanation of child's illness, treatment) gave similar information. Most respondents gave a response of "good" for all three components. However, only 8% responded with four on a one to four scale (very satisfied) to all three of these questions.

Figure 5: Overall Client Satisfaction Scores by District

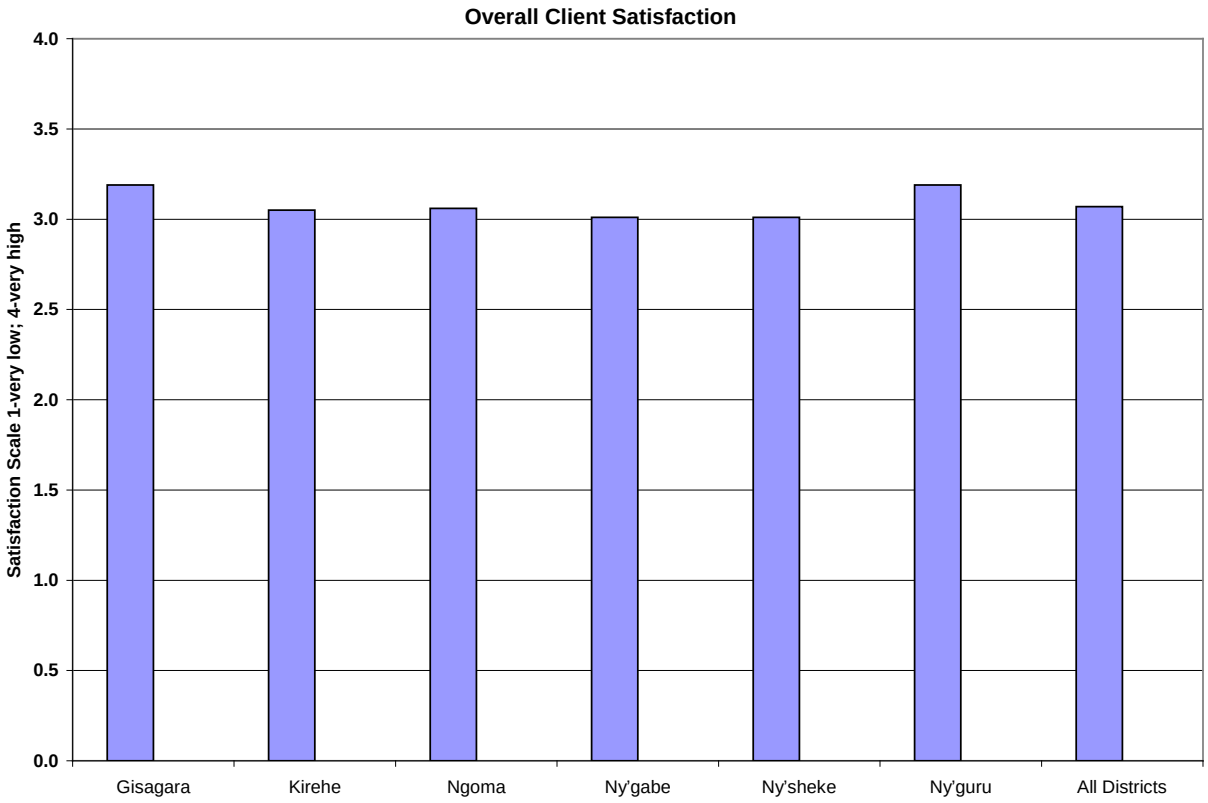


Table 33: Client Satisfaction for Child Consultation, by District

Client Satisfaction by Component (4=very good; 3=good; 2=fair; 1=poor)	**Gisagara** **n=23**	**Kirehe** **n=25**	**Ngoma** **N=25**	**Ny'gabe** **n=24**	**Ny'sheke** **n=25**	**Ny'guru** **n=23**	**Total** **N=145**
Average for the waiting time	2.92	3.04	2.88	3.13	3.04	3.13	3.02
Average for explanation received about child's illness	3.36	3.08	3.22	2.96	3.00	3.16	3.09
Average for treatment received	3.29	3.04	3.08	2.96	3.00	3.28	3.11
Overall Average Client Satisfaction Score	**3.19**	**3.05**	**3.06**	**3.01**	**3.01**	**3.19**	**3.07**
Opt 9: % clinical encounters in which the caretaker was very satisfied (4 on a 4 point scale) for all three of the following: wait time, explanation of illness, and treatment received	**8**	**0**	**1**	**1**	**0**	**5**	**15**
	35%	**0%**	**4%**	**4%**	**0%**	**22%**	**10%**

Table 34: Cost of Child Health Service, by Mutuelle Membership, by District (amounts in Rwandan Francs)

District	Mutuelle	Number	% Total	Avg Cost	Min	Max
Gisagara	No	5	21%	622	0	1,650
	Yes	19	79%	105	0	200
Kirehe	No	6	24%	687	0	1,700
	Yes	19	76%	158	0	230
Ngoma	No	11	44%	869	430	1,700
	Yes	14	56%	148	80	200
Nyamagabe	No	2	8%	775	720	830
	Yes	23	92%	97	0	150
Nyamasheke	No	7	28%	802	370	1,540
	Yes	18	72%	100	0	150
Nyaraguru	No	7	30%	681	0	1,890
	Yes	16	70%	138	100	515
OVERALL	**No**	**51**	**35%**	**563**	0	**1,890**
	Yes	**101**	**69%**	**132**	0	**515**
	Overall	**147**	**100%**	**286**	0	**1,890**

Summary of Findings

IV. DISCUSSION

1. HFA results and EIP Project Strategies

Health Worker

The summary findings identified several issues that the district health facilities and community health providers face in child health service delivery. One of the key identified problem at the health facility level, was a noted missed opportunities in growth monitoring, child vaccinations and advising on sick child feeding during sick child consultations, a similar findings noted in the 2006 Child Survival final evaluation HFA in the ex-Kibilizi district (now a part of Gisagara district) where it was noticed that plotting the weight and growth control were less performed (29%) in sick children consultations. This was particularly noted in nutrition counselling, especially the giving of more foods and fluids when a child is sick, with diarrhoea. Lack of integration amongst successful single or vertical program interventions (ORT, immunizations and growth monitoring) with the promotion of a whole range of key family and household practices critical for child health and nutrition can contribute to loss of effectiveness and lack of sustainability. This integrated strategy is a core element that the EIP project seeks to address with its IMCI partners at the health facility level, to ensure that in the facility based IMCI training of health workers, an orientation to the community component, local interventions and the role of health workers in supporting the community health providers are incorporated in the training modules.

Similarly with the HFA in Zambia, the quality of services provided by the health workers was poor, as evidenced by the health workers' performance, in prescribing antibiotics and anti-malarials for diarrhoea and in providing advice and instruction to caretakers, as evidenced by the clients' inability to retain prescription administration directions from health workers. The EIP will be a member of a review panel within the MOH PCIME task force to review the existing tools and guidelines to ensure that they are simple and standardized set of algorithms and guidelines for integrated management and adapted into local country context, including rational use of drugs. This will also limit the number of drugs dispensed brought about by unnecessary prescriptions. MSH/RPM+ are also involved at the district level pharmacies in drug management, an opportunity for potential synergy with the EIP project.

Health Facilities

Health facilities are ill-equipped with the basic inexpensive equipment such as jugs/jars, spoon and cups for diarrhoea case management, and for pneumonia, the newly introduced respiratory timers, obviously not yet included by the MOH as essential diagnostic equipment. The EIP program will be providing the respiratory timers in the project areas and will document the best practices from this experience. It will also advocate to other implementing partners at the health facility levels for the supply of these basic equipments and work with MOH to have these timers included into the essential diagnostic equipments at the first level health facilities, and approved for use at the community level by trained CHWs.

System for referral of sick children from the community health providers to health facilities and counter-referrals was barely non-functional. Referrals received from CHWs are very low. In Zambia, the HFA showed the same findings from CHWs. But this is contrary to the findings of the 2006 Child Survival HFA final evaluation in the ex-Kibilizi district (now a part of Gisagara district) which showed that community volunteers were referring more and more patients to the health facilities mainly childbirth and malaria cases. However, it confirmed the findings that counter referrals and feedback from health facilities is almost non-existent, which is also a nationwide practice. There is lack of communication about a child being referred, (referral slips, counter referral slips and poor accounting for CHW referrals). In the EIP project, collaboration with IMCI and MOH partners will introduce a system to improve the referral of cases and improve communication between households, community-based and facility based providers. A protocol will be develop integrated into the community-based health information system that comprised a community-to-facility patient referral and counter-referral protocol This will involve the use of referral slips for patients containing illustrations for easy use by the CHWs. This book bound referral slips consist of three duplicate copies- one to be retained in the booklet for monitoring by the CHW, the second copy for control by the health facility and the third one for counter referrals.

Some health centres do not have a separate register for sick children and adults. For IMCI to be an effective intervention strategy, an efficient organization of health services' delivery should be in place. Collaboration with the MOH/HMIS division to make efforts to ensure that separate registers for sick children is followed at health facilities.

Staffing is limited with the high grade A1 nurses at the health centres, same assessment findings noted in the 2006 Child Survival HFA final evaluation in the ex-Kibilizi district (now a part of Gisagara district). Continuous in-service training of lower grade nurses to improve their diagnostic and treatment skills is a strategy undertaken by the project's other IMCI partners responsible for health facility IMCI.

There is a limited health worker training on IMCI especially in the non-child survival intervention areas, notably in pneumonia, diarrhoea and breastfeeding/nutrition. With the roll out of the community IMCI into the HBM experience, this is expected to move forward, along with supply of drugs, tools and equipment.

Supervision by the district to health facilities was generally good, although down to the community level is inadequate. The EIP program will engage a CHW supervisor on a performance contract with the health facilities and the district to improve the level of supervision for the community health providers.

CHWs

Poor quality of CHW registers, except for the distributors of the HBM, is attributable to their lack of motivation and training. In most non-child survival intervention districts, CHWs are not trained or allowed to provide treatment for malaria (except the Distributors), pneumonia and diarrhoea. This explains the CHWs low on training on diarrhoea, pneumonia and malaria treatment, which the EIP project seeks to address. This was also the findings obtained in the

2006 Child Survival HFA final evaluation in the ex-Kibilizi district (now a part of Gisagara district), where trainings on diarrhoea and respiratory infections were not received mainly due to the specific child survival intervention activities. The EIP project will play a significant role in implementing and scaling up the management of simple fever/malaria, diarrhoea and acute respiratory infections at the community level. In the EIP project, activities to upgrade the skills of community based providers will incorporate the principles that underlie clinical IMCI, such as classifications and treatment of all the problems a sick child has, not jut presenting complaint

The MOH are providing incentives for and monitoring health worker performance. Other community incentives (particularly by the HBM component) use the existing association groups to motivate and improve community health worker performance.

HFA findings on CHW supervision by health facilities had been irregular since the end of the former child survival programs, with the exception of the HBM. Supervision activities that were mostly overlooked and cause for CHW demotivation were the lack of complements for the work done and failure to provide updates on current trends. EIP project will use incentives for monitoring of health worker performance, facilitate regular monthly meetings at various levels and use supervisory checklist (that will include acknowledgement of good performance and updating CHWs) to improve the quality of supervision.

Similarly, with the health workers at the health facilities, CHWs were ill-equipped with skills, training, tools/drugs needed to implement an integrated package of treating children with fever, diarrhoea and ARI, again due mainly to their limited mandate in child treatment at the community level- only trained malaria Distributors were allowed to give treatment. With the EIP project, using documented in-country experiences of community management (malaria) and the community-based health activities of community growth monitoring and PD-Hearth models, the community component of IMCI will scale up and the role of the CHW will move further from an information sharing strategy to a more aggressive strategy of stimulating rapid expansion of a package of life-saving interventions.

Clients were generally satisfied (good) with regards to waiting time, explanation received about children's illness by the health facility health worker and the treatment received. This was the opposite of the 2006 Child Survival HFA final evaluation findings in the ex-Kibilizi district (now a part of Gisagara district), which showed a dissatisfaction in waiting time (minimum 4 hours to a maximum of 8 hours).

2. Intervention Specific Approaches

1. Malaria

    i. HFA showed poorly equipped and trained CHWs and low utilization rates of sick child services to 0.2 sick child visits per child per year at some health facilities. With the EIP project of community IMCI, CHWs will be available and provided with the skills, tools, equipment and materials, supported by regular supervision/monitoring, to carry out the case management of malaria in children less than five years and increase the quality treatment rate within 24 hours.

ii. The assessment also revealed a stock out of ITNs at the health facilities, necessary for preventive measures against malaria. The project will work with the National Malaria Control Programme to plan for ITN coverage through vaccination sites, antenatal clinics, CHWs social marketing of ITNs and in national health days campaigns. Latest promotion strategy by the national malaria control programme is through the community insurance schemes 'mutuelles', which will be fully supported by the EIP project.

2. Diarrhoea

According to the HFA, health workers did not examine the sick children for nutrition status and did not provide any counselling on feeding the child when ill (19% of health workers observed). Furthermore, the irrational use of antibiotics and anti-diarrhoeal medications was also noted. The project will address the control of diarrhoeal diseases through culturally appropriate health education, including key home preventive practices, such as hand washing, latrine use and safe water use (social marketing strategy for Sur'eau) and specific messages for home case management such as the increased fluid and food intake during episodes, treatment with ORS and other home available fluids, zinc supplementation, and discourage use of unnecessary anti-diarrhoeal drugs and antibiotics.

3. Pneumonia

i. From the result of the HFA, zinc was not yet widely available to CHWs, except in few districts where diarrhoea control was one of the previous child survival interventions. As mentioned above, the project will make zinc readily available to the CHWs for diarrhoea but will also contribute to the pneumonia prevention. In addition, Vitamin A supplementation will also be made available to reduce the risk of future cases of pneumonia through national health campaigns and vaccination outreach services and maternal services.

ii. Of the health workers interviewed, only 10% of them received training on IMCI and 1% of the CHWs interviewed were trained on pneumonia, 34% on diarrhoea and 43 % on malaria. With the project objective of involving CHWs for training as C-IMCI providers of first-line treatment of pneumonia, there will be an increase in the number of children receiving appropriate treatment for pneumonia symptoms. Project will also procure Amoxicillin, the first line drug for treatment of pneumonia. CHWs will also be trained in referral protocol.

Dissemination of Findings and Next Step

The issues raised in the HFA findings that are of vital importance to the community IMCI implementation needs to be addressed, given the existing data, although the result should be interpreted with caution due to the relatively sample size. Comparison with other in country HFA data and within the region point to a similar trend and results that merits further examination in the course of the project implementation through monitoring and evaluation and to focus on

evidence based strategy for advocacy, including a change in key family practices that are likely to have the greatest impact.

Immediate next step is to organize and facilitate a district level consultation to share the findings of the assessment with partners at the community, sector and cellule levels, discuss its recommendations, and set joint action plan of activities, sharing technical expertise and resources with a potential for scaling up interventions for wider coverage.

ANNEX A. HFA Survey Instruments

CLINICAL OBSERVATION OF FIVE CONSECUTIVE SICK CHILDREN

Start Time:	_____	**Facility Code:**											**Interviewer Code:**													
	READ CONSENT FORM TO HEALTH WORKER. READ CONSENT FROM TO THE CHOSEN CARETAKERS *BEFORE* THEY ENTER THE CONSULTATION ROOM.																									
	OBSERVE FIVE CONSECUTIVE ELIGIBLE CLINICAL CASES. ELIGIBLE CASES ARE THOSE THAT ARE SICK CHILDREN, 1-59 MONTHS OF AGE.																									
	THEY SHOULD BE SEEN FOR ANY ONE (OR A COMBINATION) OF THE THREE FOLLOWING REASONS:																									
	MALARIA OR FEVER, ARI OR RAPID OR DIFFICULT BREATHING, DIARRHEA.																									
	THERE IS A SEPARATE COLUMN FOR EACH OF THE FIVE CASES OBSERVED. FOR EACH QUESTION, CIRCLE YES, **N**O, OR **N**OT **A**PPLICABLE.																									
												CODING CLASSIFICATION														
NO.	**QUESTIONS**			**CASE 1**				**CASE 2**				**CASE 3**				**CASE 4**				**CASE 5**						
101	AGE DE L'ENFANT(EN MOIS - DE 1 A 59 MOIS)																									
102	MOTIF DE LA CONSULTATION (ENCERCLE LA REPONSE) (Fièvre ou Malaria, Toux, Respiration Rapide ou Difficulté Respiratoire et ou Diarrhée)	cough / breathing problem		fever / malaria	diarrhea	cough / breathing problem		fever / malaria	diarrhea	cough / breathing problem		fever / malaria	diarrhea	cough / breathing problem		fever / malaria	diarrhea	cough / breathing problem		fever / malaria	diarrhea					
103	DIALOGUE DE L'AGENT DE SANTE																									
	A. Si l'enfant est capable de manger ou teter?	Y		N		Y		N		Y		N		Y		N		Y		N						
	B. Si l'enfant vomit tout ce qu'il mange?	Y		N		Y		N		Y		N		Y		N		Y		N						
	C. Si l'enfant a eu les convulsions?	Y		N		Y		N		Y		N		Y		N		Y		N						
104	ACTES DE L'AGENT DE SANTE																									
	A. Verifier l'etat nutritionnel de l'enfant sur la fiche de croissance?	Y		N		Y		N		Y		N		Y		N		Y		N						
	B. Verifier le statut vaccinal de l'enfant sur la fiche de croissance?	Y		N		Y		N		Y		N		Y		N		Y		N						
105	CLASSIFICATION DE L'ETAT SANTE DE L'ENFANT (DIAGNOSTIC)																									
	A. Fièvre ou MALARIA?	Y		N		Y		N		Y		N		Y		N		Y		N						
	B. PNEUMONIE OU RESPIRATION RAPIDE / DIFFICULTE RESPIRATOIRE?	Y		N		Y		N		Y		N		Y		N		Y		N						
	C. DIARRHEE **NON** SANGLANTE?	Y		N		Y		N		Y		N		Y		N		Y		N						
	D. DIARRHEA **SANGLANTE**?	Y		N		Y		N		Y		N		Y		N		Y		N						

106	TRAITEMENT PRESCRIT															
	A. ANTIMALARIAE DE PREMIERE LIGNE? COARTEM	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	B. ANTIBIOTIQUE DE PREMIERE INTENTION POUR LA PNEUMONIE? Amoxycillin	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	C. SRO?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	D. ANTIBIOTIQUE DE PREMIERE INTENTION POUR LA DIARRHE SANGLANTE?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	Ciproflaxcin															
	E. AUTRE ANTIBIOTIQUE?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
Opt	EXPLICATION DU TRAITEMENT PRESCRT PAR L'AGENT DE SANTE															
107	A. ANTIMALARIAE DE PREMIERE LIGNE?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	B. ANTIBIOTIQUE DE PREMIERE INTENTION POUR LA PNEUMONIE?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	C. SRO?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	D. ANTIBIOTIQUE DE PREMIERE INTENTION POUR LA DIARRHEE SANGLANTE?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
Opt	CONSEIL PRODIGUE PAR L' AGENT DE SANTE															
108	CONSEIL DE MANGER ET DE BOIRE D'AVANTAGE EN CAS DE MALADIE?	Y	N		Y	N		Y	N		Y	N		Y	N	

ENTRETIEN AVEC L'AGENT DE SANTE ET REVUE DES DOCUMENTS

Code de la formation sanitaire | **Code enqueteur** | **Heure de début** _____

IL EST RECOMMANDE DE S'ENTRETENIR AVEC L'AGENT DE SANTE LE PLUS IMPLIQUE DANS LA PRISE EN CHARGE AU NIVEAU DES SERVICES DE SOINS DE S/

IL EST CONSEILLE DE REMPLIR CETTE FICHE EN DERNIER LIEU.

PRESENTER-VOUS A L'AGENT DE SANTE ET OBTENEZ SON CONSENTEMENT

NO.	QUESTIONS	CLASSIFICATION DE LA CODIFICATION	GO TO
400	Pouvez-vous me dire la taille de la population		
	de la zone de rayonnement de votre formation sanitaire?	A. TAILLE DE LA POPULATION CIBLE	
	Ceci correspond à la population que couvre	DE LA FORMATION SANITAIRE	
	et que sert le centre de santé?		
		B. ENFANTS DE MOINS DE 5 ANS DANS LA ZONE	
		(ECRIVEZ "00" SI CETTE POPULATION)	
		DES MOINS DE 5 ANS EST INCONNUE	
		C. NOMBRE DES IMIDUGUDU DANS LA ZONE	
		NE CONNAIT PAS LA TAILLE DE LA POPULATION	
		DE LA ZONE DE RAYONNEMENT 9	
401	Je voudrais vous demander si les services cités plus bas sont offerts par votre formation sanitaire ; si oui		
	combien de jours par mois, que ce soit au niveau de la formation ou en stratégie avancée.		
	DANS LE CAS PRESENT, LE MOIS CORRESPOND A QUATRE SEMAINES DE TRAVAIL		
01	Consultation or services curatifs pour les enfants malades	A. # DE JOURS PAR MOIS AU NIVEAU	
		DE LA FORMATION SANITAIRE	
	SI AUCUNE FOIS, ECRIVEZ "00"		
	SI TOUS LES JOURS,ECRIVEZ "30"	B. # DE JOURS PAR MOIS AU NIVEAU	
	SI UNE FOIS PAR SEMAINE, ECRIVEZ "4"	EN STRATEGIE AVANCEE	

02	SERVICES DE VACCINATION INFANTILE	A. # DE JOURS PAR MOIS AU NIVEAU	
		DE LA FORMATION SANITAIRE	
	SI AUCUNE FOIS, ECRIVEZ "00"		
	SI TOUS LES JOURS,ECRIVEZ "30"	B. # DE JOURS PAR MOIS AU NIVEAU	
	SI UNE FOIS PAR SEMAINE, ECRIVEZ "4"	EN STRATEGIE AVANCEE	
03	Suivi de la croissance et promotion de la santé (courbe de	A. # DE JOURS PAR MOIS AU NIVEAU	
	de l'enfant et conseils nutritionnels aux mamans)	DE LA FORMATION SANITAIRE	
	SI AUCUNE FOIS, ECRIVEZ "00"	B. # DE JOURS PAR MOIS AU NIVEAU	
	SI TOUS LES JOURS,ECRIVEZ "30"	EN STRATEGIE AVANCEE	
	SI UNE FOIS PAR SEMAINE, ECRIVEZ "4"		

402	Maintenant je voudrais vous poser des questions sur la situation du personnel dans cette formation sanitaire. Pour chaque catégorie, je voudrais connaitre le nombre d'agents affe		
	par le ministère de la santé et le nombre d'agents qui sont présents aujourd'hui		
	Catégorie de l'agent de santé	A. # d'agents affectés	B. # d'agents qui sont **présents aujourd'hui**
01	MEDECIN		
02	ASSISTANT MEDICAL/INFIRMIER(ère)		
	Niveau A1		
	Niveau A2		
	Niveau A3		
03	SAGE-FEMME		
04	AUTRE PERSONNEL SOIGNANT		
05	PHARMACIEN		
06	LABORANTIN		
7	ASSISTANTE SOCIALE		
8	NUTRITIONNISTE		
9	AUXILIAIRE DE SANTE		
10	PERSONNEL D'APPUI(NON SOIGNANT) (Exemple:nettoyeur, secrétaire, etc.)		
403	Avez-vous reçu au cours des 3 dernières années une formation académique ou en cours d'emploi en rapport avec la santé de l'enfant?	OUI ..... 1 NON ..... 2 → 405	

404	Demandez s'il a reçu une formation dans l'une des disciplines suivantes SI OUI, DEMANDEZ: En quelle année la plus récente il a reçu cette formation	YES, IN PAST 12 MONTHS	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS			
01	Vaccinations	1	2	3			
02	Traitement de la pneumonie ou infections respiratoires aigues	1	2	3			
03	Traitement de la diarrhée	1	2	3			
04	Traitement du paludisme chez l'enfant	1	2	3			
05	Prévention du paludisme / Utilisation de la Mll	1	2	3			
06	Nutrition (exemple: supplémentation, micronutriments)	1	2	3			
07	Allaitement maternel	1	2	3			
08	Prise en charge intégrée des maladies de l'enfant(PCIME)	1	2	3			
T 404A	Demandez si lui ou quelqu'un d'autre a reçu une formation dans les disciplines suivantes						
01	Traitement préventif intermittent chez la femme enceinte	1	2	3			
02	Soins essentiels aux nouveaux-nés	1	2	3			
405	Maintenant je voudrais vous poser quelques questions sur la supervision que vous avez reçu en personne par un superviseur externe à cette formation sanitaire a. Avez-vous été supervisé ou reçu un appui technique au cours de votre travail ? b. SI OUI, à quand cela remonte-t-il ?	OUI, IL Y A 3 MOIS OUI, IL Y A 4-6 MOIS OUI, IL Y A 7-12 MOIS OUI, IL Y A PLUS DE 12 MOIS PAS DE SUPERVISION RECU			1 2 3 4 5	→ → →	 407 407 407

406	Qu'est-ce que votre superviseur a fait				NE	
	la dernière fois qu'il vous a rendu visite?		OUI	NON	SAIT PAS	
01	Fourni du matériel	MATERIEL FOURNI		2	9	
02	Verifié vos registres/rapports	REGISTRES VERIFIES		2	9	
03	Observé votre travail	OBSERVE		2	9	
04	Fourni une rétroinformation écrite sur votre performamce	RETROINFORMATION		2	9	
	on your performance					
05	Félicité pour le travail bien fait	ENCOURAGEMENT		2	9	
	doing your work well					
06	Fourni des actualisations sur des questions administratives	ACTUALISATIONS		2	9	
	ou techniques relatives à votre travail					
07	Discuté de problèmes que vous avez rencontrés	PROBLEMES DISCUTES		2	9	
Opt 406A	Avez vous des mecanismes de participation communautaire dans votre FOSA?	OUI			1	
		NON			2	→ 406D
		NE SAIT PAS			9	→ 406D
Opt 406A	Pouvez-vous me dire les mecanismes utilises pour susciter la participation communautaire?	PARTICIPATION COMMUNAUTAIRE DANS LES COMITES DE GESTIO			A	
		REUNIONS AVEC LES ASC/AT			B	
		ENQUETE DE SATISFACTION DES CLIEN			C	
	Encercler toutes les reponses possibles.	AUTRE (PRECISEZ) _____			D	
Opt 406C	Pouvez-vous me dire si votre FOSA utilise l'information emanent de la participation communautaire?	DISCUTE AU COURS DES REUNIONS DES COMITES DE GESTION			A	
		L'AGENT DE SANTE SIGNALE UN CHANGEMENT DANS LES PRATIC			B	
		AUTRE UTILISATION DE L'INFORMATION			C	
		L'INFORMATION N'EST PAS UTILISEE/L'AGENT NE SAIT PAS			D	

02	Votre FOSA collabore-t-elle avec une ou des associations d'ASC/Distributeurs?	Reunions mensuelles avec l'association des AS	A		
		Reunions mensuelles avec l'association des Distributeurs	B		
		Supervision au niveau de la communaute des ASCi	C		
		Supervision au niveau de la communaute des Distributeurs	D		
Opt 406E	Y a-t-il des activities d'assurance qualite au niveau de l'un ou l'autre service de votre FOSA?	OUI	1		
		NON	2	→	406F
Opt 406F	DEMMANDER A VOIR UNE DOCUMENTATION AD HOC	RAPPORT / LIST DE CONTROLE / ≤ 3 MOIS ...	1		
		RAPPORT / LIST DE CONTROLE / > 3 MOIS ...	2		
		DOCUMENTS SIGNALES MAIS NON OBSERVES ...	3		
		PAS DE DOCUMENTATION	4		
	DEMANDEZ A L'AGENT DE SANTE DE VOIR LES REGISTRES DES PATIENTS EXTERNES			→	
407	Y a-t-il un registre pour les enfants malades?	REGISTRE VU	1		
	SI OUI, DEMANDEZ DE VOIR LE REGISTRE	REGISTRE SIGNALE MAIS NON VU	2	→	End
		PAS DE REGISTRE	3	→	End
408	L' INFORMATION DANS LE REGISTRE EST-ELLE COMPLETE				
	AGE, DIAGNOSTIC, TRAITEMENT POUR LES CAS	L' INFORMATION SUR L'AGE EST COMPLETE	A		
	DES 3 DERNIERS MOIS ?	L'INFORMATION SUR LE DIAGNOSTIC ET LES SYMPTON	B		
	ENCERCLE TOUTES LES REPONSES OBSERVEES	L'INFOMRATION SUR LE TRAITEMENT EST COMPLE	C		
	TO BE COUNTED AS COMPLETE, THERE CAN BE NO	AUCUNE DES INFORMATIONS CI DESSUS N'EST COMPLE	D		
	BLANKS FOR THAT COLUMN				
409	A QUAND REMONTE LE DERNIER ENREGISTREMENT ?	INFERIEUR OU EGALE A SEPT	1		
		PLUS DE SEPT(7) JOURS	2		
410	NOTEZ LE NOMBRE D'ENFANTS MALADES,	NOMBRE		→	End
	EN DESSOUS DE 5 ANS QUI ONT ETE RECU				
	EN CONSULTATION	SI AUCUN, ECRIVEZ "00" DANS LA CASE			
	AU COURS DES 3 DERNIERS MOIS (CALENDRIER)				

	PASSEZ EN REVUE LES ENREGISTREMENTS POUR LES ENFANTS MALADES (SEULEMENT POUR LES MOINS DE 5 ANS)				
	NOTEZ TOUS LES CAS DE PALUDISME/FIEVRE, PNEUMONIE/DIFFICULTES RESPIRATOIRES, ET DIARRHEE				
	NOTEZ AUSSI LES CAS OU L'UN DES 3 MALADIES EST COMBINE A UNE AUTRE				
	PASSEZ EN REVUE TOUS LES CAS ENREGISTRES DE LA 1ère A LA DERNIERE DATE **POUR UN MOIS CALENDRIER COMPLET**				
411	REVUE DU REGISTRE DE L'ENFANT MALADE.....	Nombre de cas enfants<5ans	Nb. Cas traités correctement (antipaludique de 1ere ligne, ATB	Nb. Cas referrés à l' Hop.	Nb cas reçus des ASC/Distributeurs
01	FIEVRE/PALUDISME				
02	PNEUMONIE/DIFFICULTES RESPIRATOIRES (avec un médic 1ere ligne de la pneumonie)				
03	DIARRHEE NON SANGLANTE (Cas traités avec SRO mais sans ATB)				
412	Demandez à voir le dernier rapport mensuel envoyé au District? EXAMINEZ LE RAPPORT	DERNIER RAPPORT VU ET IL DATE DE MOINS DE 3 MO.....			1
		DERNIER RAPPORT VU ET IL DATE DE PLUS DE 3 MOI.....			2
		LE RAPPORT N'A PAS ETE VU MAIS IL EST MENTIONNE Q.....			3
		LE RAPPORT N'A PAS ETE VU MAIS IL EST MENTIONNE Q.....			4
		PAS DE RAPPORT			5
413	CHERCHEZ A VERIFIEZ L'UTILISATION DES DONNEES				
	Avez-vous des graphiques affichés ou avez-vous au cours des 3 derniers mois tenu des réunions où vous avez discuté des données avec le personnel de votre formation sanitaire ?	GRAPHIQUES AFFICHES SUR LE MUR		.....	A
		GRAPHIQUES DISPONIBLES MAIS NON AFFICHES		.....	B
		REUNIONS OU LES DONNEES ONT ETE DISCUTEES		.....	C
		AUTRES : SPECIFIEZ		.....	D
	CIRCLE ALL THAT APPLY	AUCUNE OPTION MENTIONNEE CI-DESSUS		.....	E
	NOTEZ ICI TOUTE INFORMATION D'INTERET QUALITATIF:			**Heure de fin**	

HEALTH FACILITY CHECKLIST (INFRASTRUCTURE, EQUIPMENT, SUPPLIES, DRUGS)

Facility Code: | Interviewer Code: | Start Time:

OBTAIN INFORMED CONSENT

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
	OBSERVER LA PRESENCE DE CES STRUCTURE DANS LA FOSA, SI C'EST DISPONIBLE DEMANDE DE VOUS LES MONTRER			
301	y- a- t il des lits d'hospitalisation des patients?	YES	1	
		IF YES, PLEASE INDICATE NUMBER OF BEDS		
		NO	2	
302	Le service est- il operatonnel 24h/24h?	YES, 24-HOUR DUTY ROSTER	1	
	Si Oui, Observer l'horaire des gardes	YES, STAFF LIVE ONSITE	2	
		NO DUTY ROSTER NOR STAFF LIVE ONSITE	3	
303	La FOSA dispose le moyen de communication fonctionnelle et accessible	YES, OBSERVED ONSITE OR WITHIN 5 MINUTES WALK	1	
	(Telephone ou la Radiophonie)available at all times client services are offered?	YES, REPORTED ONSITE OR WITHIN 5 MINUTES WALK	2	
	si oui, essayer de communiquer avec d'au moins 3 FOSA	PAY PHONE OR HW CELL PHONE	3	
		NO	4	
304	Y- a-t - il un ambulance fonctionnel ou un autre vehicule pour le transport	YES, OBSERVED FUNCTIONING AND WITH FUEL	1	
	des cas d'urgence?	YES, REPORTED FUNCTIONING AND WITH FUEL	2	
	Si Oui, verifier si le vehicule est en bon etat et contient du carburant	VEHICLE BUT NO FUEL	3	
		VEHICLE AVAILABLE ON CALL FROM DISTRICT WITHIN ONE HOUR	4	
		NO VEHICLE	5	
305	La FOSA dispose du courant éléctrique actuellement?	YES, OBSERVED	1	
	Si oui, verifier la présence du courant éléctrique	NO	2	
306	La FOSA dispose d'un générateur ou panneau solaire pour éléctricité ?	YES OBSERVED FUNCTIONING AND WITH FUEL	1	
	Si oui, verifier la présence d'un générateur fonctonnel et rempli du carburant	YES OBSERVED FUNCTIONING AND BUT **NO** FUEL	2	
		YES, REPORTED FUNCTIONING AND WITH FUEL	3	
		YES, REPORTED FUNCTIONING BUT **NO** FUEL	4	
		NO	5	
307	Y-a -t-il des latrines pour les malades?	YES	1	
	Les latrines pour les malades doivent etre differents à celles du personnel	NO	2	→ 310
308	Observer si les latrines remplissant les normes	FLUSH / POUR FLUSH	1	
		VENTILATED IMPROVED PIT LATRINE (VIP)	2	
	Si presence plusieurs types de toilettes , encerclez la reponse qui	SIMPLE PIT LATRINE	3	
	correspond aux types de latrine.	COMPOSTING TOILET	4	
		OPEN PIT	5	
		OTHER _____	7	
309	LA latrine est il utilisable?	YES	1	
	Latrine inutilisable, Latrine non remplissant les normes d'utilisation	NO	2	
		UNABLE TO OBSERVE	3	

310	La FOSA dispose de l'eau courante?	YES	1		
		NO	2	→	312
311	La distance entre la FOSA et le robinet(l'eau pour laver les mains)	PIPED INTO FACILITY	1		
	La distance doit etre dans 500m	PIPED ONTO FACILITY GROUNDS	2		
		PUBLIC STANDPIPE	3		
		TUBE WELL / BOREHOLE ON GROUNDS	4		
	Si les ressources d'eau sont multiples, encerclez la reponse correspondant ,	PROTECTED DUG WELL ON GROUNDS	5		
	à la source disponible	BOTTLED WATER	6		
		RAINWATER, SURFACE WATER, OR TANKER TRUCK	7		
		OTHER _____	8		
312	S'il vous plait, puvez vous nous montrer le lieu de traitement des enfants	THERE **BOTH** IS VISUAL AND AUDITORY PRIVACY	1		
	Endroit pr	THERE IS **VISUAL BUT NOT AUDITORY** PRIVACY	2		
	Marqué "BOTH" si la presence de la porte qu'on peut fermer	THERE IS **NEITHER** VISUAL NOR AUDITORY PRIVACY	3		
	Marqué "VISUAL"si la presence du paravant ou rideau				

Verifier si les points ci desoous mentinné se trouve dans le
Lieu de Consultation des Enfants ou dans d'autres services.

		(a) AVAILABILITY				(b) FUNCTIONING		
313	Les Points en rapports avec la Maladies CONSULTATION DES ENFANTS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Optional (for Infection Control): Autoclave electrique or Sterilisateur dry heat sterilizer	1 → b	2 → b	3	9	1	2	9
02	Refrigerateur des vaccins	1 → b	2 → b	3	9	1	2	9
03	Balance pese -enfant accessible	1 → b	2 → b	3	9	1	2	9
04	Balance pese Adult accessible	1 → b	2 → b	3	9	1	2	9
05	Montre	1 → b	2 → b	3	9	1	2	9
06	Jug pour la preparation de SRO	1	2	3	9			
07	Goberet et cuillère pour SRO	1	2	3	9			

Question en rapport avec l'administration des médicaments, si l'un des medicaments sont à differents locaux, veillez observer. . Si vous ne trouvez pas lesdits médicaments, demandez s'ils sont disponible (encerclez la reponse correspondant)

		(a) AVAILABLE TODAY						(b) (OPTIONAL) IN LAST 6 MONTHS		
		OBSERVED AND AVAILABLE			NOT OBSERVED					
314	Médicaments et Traitements de l'Enfants	AVAILABLE ALL VALID	AVAILABLE AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY / DON'T KNOW	NEVER AVAIL-ABLE	YES	NO	DON'T KNOW
01	ORS packets	1	2	3	4	5	6	1	2	99
02	Zinc									
03	First line oral drug for child pneumonia									
	Amoxycillin tablets or capsules	1	2	3	4	5	6	1	2	99
	Amoxycillin syrup	1	2	3	4	5	6	1	2	99
04	First line oral drug for child dysentery (bloody diarrhea) ciprofaxcin	1	2	3	4	5	6	1	2	99
05	First line oral antimalarial COARTEM	1	2	3	4	5	6	1	2	99
06	Vitamin A	1	2	3	4	5	6	1	2	99
07	Optional: Sulfate de Fer	1	2	3	4	5	6	1	2	99
08	Optional:Moustiquaire Impregné d'insecticide (ITN)	1	2	3	4	5	6	1	2	99
09	BCG vaccine	1	2	3	4	5	6	1	2	99
10	OPV (Polio) vaccine	1	2	3	4	5	6	1	2	99
12	DPT or Pentavalent vaccine	1	2	3	4	5	6	1	2	99
13	Measles or MMR vaccine (VAR)	1	2	3	4	5	6	1	2	99
314A	OTHER EIP INTERVENTION DRUGS & TREATMENTS									
01	Fansidar for IPT	1	2	3	4	5	6	1	2	99

Opt	Presence des Guides ( )	OBSERVED AND	REPORTED,	NOT	DON'T
314B	Ordinograme	IN PATIENT AREA	NOT SEEN	AVAILABLE	KNOW
01	Prise en Charge des enfants malades	1	2	3	9
02	Vaccination	1	2	3	9

Opt	CONTRLE DE L' INFECTION	(a) AVAILABILITY			
314C		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Disinfectant à base de Chlorine	1	2	3	9
02	Gant (propre ou sterile)	1	2	3	9
03	Poubelle	1	2	3	9
04	Seringue de 5 ml sterile emballé	1	2	3	9
05	Aiguille de 19 ou 21sterile emballé (peut etre avec les seringue)	1	2	3	9
06	Savon pour laver les mains (ordinaire or liquide)	1	2	3	9

Opt	Entretien du système d'evacuation des dechets (serinques ou bistouri usés,		i. SHARPS	ii. INF. WASTE
314D	poubele, tempons utilisé, trousse de perfusion usé)	INCINERATOR - HIGH TEMPERATURE (2 CHAMBER)	 1	 1
		INCINERATOR - ONE CHAMBER, DRUM OR BRICK	 2	 2
	Pouvez vous m'expliquer la dernière methode d'evacuation des déchets	BURN AND BURY	 3	 3
	ci-haut mentionnés	BURY BUT NOT BURN	 4	 4
		PUT IN COVERED PIT (MAY BE LATRINE)	 5	 5
		BURN (IN GROUND OR PIT), BUT NOT BURY	 6	 6
		OPEN TO AIR (NO BURN OR BURY)	 7	 7
		STORE AND REMOVE OFFSITE (MAY BE BURNED PRIOR)	 8	 8
		NEVER HAVE ITEMS	 9	 9

Opt	Demander leur endroit d'evacuation des dechets infectés tranchants.		i. SHARPS	ii. INF. WASTE
314E	Indiquer si l'endroit est protegé ou les déchets sont eparpué ou pas	YES, PROTECTED AND WASTE IS VISIBLE	 1	 1
		YES, PROTECTED AND NO WASTE VISIBLE	 2	 2
	Protegé: Les déchets sont à l'interieur, puits couvert et personne	NO, NOT PREOTECTED AND WASTE VISIBLE	 3	 3
	ne peut pas y entrer facilements	NO, NOT PROTECTED AND NO WASTE VISIBLE	 4	 4
		SITE NOT OBSERVED	 5	 5

End Time: _____

Noter les observations qualitatives:

COMMUNITY HEALTH WORKER INTERVIEW (in Kinyarwanda)

Nom de C.S. _____

Code ya CS: | CHW Code: | Interviewer Code: | Start Time:

OBTAIN INFOMRMED CONSENT

NO.	IBIBAZO	CODING CLASSIFICATION			GO TO
501	Ni iyihe mirimo mukora ku birebana n'ubuzima bw'abana ?	INYIGISHO KU BUZIMA		A	
	SOMA IBIKURIKIRA	GUKURIKIRANA IMIKURIRE Y'ABANA		B	
	SHYIRA AKAZIGA KU BYO AKWEMEREYE	GUKINGIRA NO GUKANGURIRA IKINGIRA		C	
		KOHEREZA ABANA BARWAYE KWA MUGANGA		D	
		KUVURA INDWARA Z'IMPISWI		E	
		KUVURA INDWARA ZO MU MYANYA Y'UBUHUMEKERO		F	
		KUVURA MALARIYA		G	
		GUSHAKA NO KUGURISHA INZITIRAMIBU		H	
		GUSHAKA NO KUGURISHA SUR'EAU			
		IBINDI (BIVUGE) _____		I	
502	Mu myaka itatu ishize , hari amahugurwa mwigeze muhabwa mbere yo gutangira akazi cyangwa mu kazi ku birebana n'ubuzima cyangwa uburwayi bw'abana?	YEGO		1	
		OYA		2	→ 504
503	Ndagira ngo mbasomere zimwe mu nyigisho ku birebana n'ubuzima bw'abana	YEGO, MU	YEGO, MU	NTA MAHUGURWA	
	Ndifuza ko mumbwira niba izo nyigisho mwarazihawe	MWAKA 1	MYAKA 2-3	TWAHAWE	
	NIBA BARAZIBONYE , BAZA UTI: Ihugurwa riheruka mwarihawe ryari ?	USHIZE	ISHIZE	MU MYAKA 3 ISHIZE	
01	Amahugurwa ku Ikingira	1	2	3	
02	Kuvura indwara zifata mu myanya y'ubuhumekero	1	2	3	
03	Kuvura indwara z'impiswi	1	2	3	
04	Inyigisho ku isuku				
05	Kuvura Malariya	1	2	3	
06	Kwirinda Malariya / Goresha Inzitiramibu iteye umuti	1	2	3	
07	Konsa	1	2	3	
08	Imirire myiza	1	2	3	
09	Kwita ku ndwara z'abana'mu giturage (C-IMCI)	1	2	3	
504	Ndagira ngo nkubaze ku masurwa wakorewe mu bijyanye n'akazi kawe	YEGO,MU MEZI ATATU ASHIZE		1	
		YEGO,HAGATI Y'AMEZI 4-6 ASHIZE		2	
	Wigeze usurwa n'umuyobozi wawe mu rwego rwo	YEGO,HAGATI Y'AMEZI 7-12 ASHIZE		3	→ 507
	kugufasha mu mirimo ushinzwe	YEGO,MUMEZI 12 ARENGA		4	→ 507
	NIBA YARASUWE ,MUBAZE UTI:Iryamaze igihe kinini kurusha ayandi uriheruka ryari?	OYA,SINIGEZE NSURWA		5	→ 507
505	Ubwo uheruka gusurwa , ni ibihe umuyobozi wawe yagenzuye muri ibi bikurikira ?		YEGO / OYA / SIMBIZI		
01	Ibikoresho wahawe	IBIKORESHO WAHAWE	1 / 2	9	
02	Kugenzura raporo zawe	YAGENZUYE RAPORO ZANJYE	1 / 2	9	
03	Kureba uko uri gukora	YAREBYE IMIKORERE YANJYE	1 / 2	9	
04	Gutanga isubiza butumwa (ryiza cg ribi) ku bushobozi bwawe	Isubiza butumwa	1 / 2	9	
05	Kugira ibyo akubwira kugirango urusheho gukora neza imirimo yawe	Gushima	1 / 2	9	
06	Kuguha amabwiriza agezweho ajyanye n'ibyo ushinzwe	Kuguha amabwiriza agezweho	1 / 2	9	
07	Kuganira ku bibazo uhura nabyo	TWAGANIRIYE KU BIBAZO MPURA NABYO	1 / 2	9	

	BWIRA UMUJYANAMA AKWEREKE IGITABO CYANGWA IKAYI AVURIRAMO ABARWAYI.WIFASHISHIJE IBIGARAGARA MURI ICYO GITABO CYANGWA IKAYI , SUBIZA IBIBAZO BIKURIKIRA						
506	Uvura abana barwaye , bari munsi y'imyaka itanu ?	AVURA ABANA BARWAYE				1	
		NTAVURA ABANA BARWAYE				2	→ 513
507	Ufite igitabo cyangwa ikaye wandikamo abana bari munsi y'imyaka 5 barwaye ?	IGITABO CYANGWA IKAYE ARAGIFITE,NAKIBONYE				1	
		YEGO,YAVUZE KO AGIFITE ARIKO NTACYO NABONYE				2	→ 513
	NIBA AGIFITE, MUBWIRE AKIKWEREKE	NTA GITABO CYANGWA IKAYI AFITE				3	→ 513
508	ICYO GITABO CYANGWA IKAYI GIFITE UMWANYA WANDIKWAMO	IMYAKA IRAGARAGARA				A	
	IMYAKA Y'UMWANA,UBURWAYI BW'UMWANA,N'IMITI UMWANA UVUWE	UBURWAYI BURAGARAGARA				B	
	YAHAWE ?	IMITI IRAGARAGARA				C	
	SHYIRA AKAZIGA KU BYO WABONYE BYOSE	NTA NA KIMWE MURI IBYO				D	
509	ICYO GITABO GIFITE AMAKURU AHAGIJE YAGUFASHA KUMENYA	IMYAKA IRUZUYE				A	
	IMYAKA Y'UMWANA,UBURWAYI BWE N'IMITI YAHAWE ?	IBIMENYETSO BIKURU BY'UBURWAYI BIRAHAGIJE				B	
	KUBA BYUZUYE, NTIHAGOMBA KUBAMO UMWANYA UTUZUYE MUMEZI 3 ASHIZE	IBIREBANA N'IMITI BIRAHAGIJE				C	
		NTA NA KIMWE MURI IBYO KIGARAGARA				D	
	SYIRA URUZIGA KU BISUBIZO BYOSE						
510	NI IYIHE TALIKI IGITABO GIHERUKIRA KUZUZWA?	MU MINSI 30 ISHIZE				1	
		BIRENZE IMINSI 30				2	
511	REBA UMUBARE W'ABANA BARI MUNSI Y'IMYAKA ITANU,	UMUBARE W'ABANA					
	BASUZUMWE **MU MEZI ATATU ASHIZE**						
		NIBA ARI NTABO ANDIKA "00" HANYUMA UJYE KU KIBAZO CYA 514					→ 513
	REBA IBYANDITSE MU GITABO CYANDIKWAMO ABARWAYI(IBIREBANA GUSA N'ABANA BARI MUNSI Y'IMYAKA 5) ANDIKA UMABARE W'ABIVUJE MALARIYA/UMURIRO,IMPISWI UMUSONGA/GUHUMEKA BIMUGOYE,CYANGWA URUHURIRANE RW' INDWARA ESHATU HARIMO IMWE MURI IZO						
	REBA UMUBARE W'ABIVUJE BOSE **MU MEZI ATATU ASHIZE**						
512	REBA UMUBARE W'ABANA BIVUJE (MU GITABO CYANDIKWAMO ABARWAYI)						
01	A. MALARIA CYANGWA UMURIRO	A1 UMUBARE W'ABARWAYE MALARIYA BIREBEWE MU GITABO		A2	NO. CASES TREATED WITH FIRST LINE MALARIAL		
02	B. UMUSONGA/GUHUMEKA BIMUGOYE	B1 UMUBARE W'ABIVUJE UMUSONGA BIREBEWE MU GITABO		B2	NO. CASES TREATED WITH FIRST LINE ANTIBIOTIC		
03	C. IMPISWI	C1 UMUBARE W'ABIVUJE IMPISWI BIREBEWE MU GITABO		C2	NO. CASES TREATED WITH ORS BUT NO ANTIBIOTIC		

UMUBARE	.....	
NTABYO AFITE	.....	999
UMUBARE	.....	
NTABYO AFITE	.....	999

EREKE

	(a)BIRAHARI			(b) FUNCTIONING		
REBA	IBYATANGIWE NTA BIBONETSE	ROPORO NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
heje 1 → b	2 → b	3	9	1	2	9
1	2	3	9			

NZE

(a) IMITI IHARI

KUREBA IHARI						
YOSE IRACYAFITE IGIHE	BYIBURA IMWE IRA CYAFITE IGIHE	IRAHARI ARIKO YARENGEJE IGIHE	REPORTED AVAILABLE, NOT SEEN	NTIBONEKA UYU MUNSI NTABIZI	NTIBAHO NTIBAHO	
1	2	3	4	5	6	
1	2	3	4	5	6	
1	2	3	4	5	6	
1	2	3	4	5	6	
1	2	3	4	5	6	
1	2	3	4	5	6	
1	2	3	4	5	6	

YEGO	OYA
1	2
1	2
1	2
1	2
1	2

516	Wakwita gute ku mwana urwaye impiswi mu rugo ?	YEGO	OYA
01	Kumuha ibinyobwa byinshi biruta ibyo yari asanzwe ahabwa	1	2
02	Kumuha uruvange rw'imyunyu (SRO)	1	2
03	Kumwonsa kenshi	1	2
04	Kumuha ibiribwa bingana cyangwa biruta ibyo yari asanzwe ahabwa	1	2
517	Ni ibihe bimenyetso by'impuruza bituma umubyeyi yihutira kujyana umwana urwaye impiswi ku Kigo Nderabuzima ?	YEGO	OYA
01	Kwituma umusarani urimo n'amaraso	1	2
02	Umuriro	1	2
03	Impiswi imaze cyangwa irengeje icyumweru	1	2
04	Umwana yanga kurya no kunywa	1	2
05	Kuruka ibyo ariye byose	1	2
518	Ni ikihe kimenyetso gikuru cya malariya kandi uburyo bwiza bwo kuyirinda ni ubuhe ?	YEGO	OYA
01	Ikimenyetso gikuru cya malariya: Umuriro	1	2
02	Uburyo bwiza bwo kwirinda malariya: Kurara mu nzitiramibu iteye umuti	1	2
519	Ni bande malariya izahaza kurusha abandi ?	YEGO	OYA
01	Abana bari munsi y'imyaka itanu	1	2
02	Abagore batwite	1	2
520	Mu gihe umwana agize umuriro , ni ryari wamujyana kumuvuza ?	YEGO	OYA
01	Uwo mwanya mu masaha 24 agifatwa	1	2
	IBIBAZO BIREBA IBIKORWA BY'ABAJYANAMA B'UBUZIMA MU MASHYIRAHAMWE		
	Uri umunyamuryango mu ishyirahamwe ry'abashinzwe ubuzima mu giturage ?	YEGO 1	OYA 2
521	Ni uwuhe musaruro ishyirahamwe ryanyu ryagezeho ?		
522	Uwo musaruro muwukoresha gute kandi muwubika gute ?		
523	Ni iyihe mirimo mukora mu ishyirahamwe ryanyu ?		

	GUHINDURA IMYIFATIRE															
524a	Hari ibyo wahinduye mu rugo rwawe bitewe n'ibyo wigiye mu ishyirahamwe ryanyu ?		YEGO								OYA					
			1								2					
524 b	Kuki wabihinduye/															
	Kuki ntabyo wahinduye ?															
525	Ufite ingo zingahe ushinzwe?															
526a	Ugira gahunda ihoraho yo gusura ingo naho nta bana barwaye baba bazirimo?		YES								NO					
			1								2					
526b	Ugereranije waba usura buri rugo inshuro zingahe mu kwezi mu gace ushinzwe?															
527a	utekereza ko ababyeyi benshi baba baratangiye guhindura imyifatire hakurikijwe		yego								oya					
	ibyo bigishijwe?		1								2					
527b	Kubera iki?															
528a	Wagira icyo utubwira kubyo uzi ku babyeyi bari mu gace ushinzwe		yego								oya					
	Waba hari inzitizi wahuye nazo mu guhugura ababyeyi?		1								2					
528b	Niba ari yego,waba warabyifashemo ute?															
	NOTE ANY QUALITATIVE OBSERVATIONS HERE:															

EXIT INTERVIEW (FIVE CARETAKERS OF SICK CHILDREN)

Facility Code: | Interviewer Code: | Start Time:

OBTAIN INFORMED CONSENT FROM EACH CARETAKER IF THE SUPERVISOR HAS NOT ALREADY DONE SO.

CODING CLASSIFICATION (PUT CASE CODE AT TOP OF EACH COLU

NO.	QUESTIONS		UMWANA 1				UMWANA 2				UMWANA 3				UMWANA 4				UMWANA 5			
pt200	Kuri buri kibazo mu bikurikira , ndifuza ko umbwira niba ibyo wakorewe byari BYIZA CYANE,BYIZA,BIBI CYANE		Bibi cyna	Bibi	Byiza	Byiza cyane	Bibi cyna	Bibi	Byiza	Byiza cyane	Bibi cyna	Bibi	Byiza	Byiza cyane	Bibi cyna	Bibi	Byiza	Byiza cyane	Bibi cyna	Bibi	Byiza	Byiza cyane
01	Igihe wamaze hano utegereje wabyakiriye ute		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Was this very good, good, fair, or poor?																					
02	Wakiriye ute ibisobanuro wahawe ku burwayi bw'umwana wawe		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Was this very good, good, fair, or poor?																					
03	Wakiriye ute imiti umwana wawe yahawe ?		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Was this very good, good, fair, or poor?																					
201	Uwakuvuriye umwana , hari imiti yakwandikiye		Yego			1	Yego			1	Yego			1	Yego			1	0			1
	y'uyu munsi ?		Oya (hagarik			2	Oya (hagarik			2	Oya (hagarik			2	Oya (hagarik			2	Oya (hagar			2
202	Ushobora kunyereka imiti wahawe cyangwa urupapuro wandikiweho imiti wahawe na muganga ?																					
	BAZA UMUBYEYI AKWEREKE BURI MUTI CYANGWA URUPAPURO YANDIKWEHO IMITI .HANYUMA WANDIKE IZINA RYA BURI MUTI																					
	MUBAZE UMUBARE W'IMITI AZAJYA AMUHA BURI GIHE , ISHURO AZAJYA ABIMUHAMO KU MUNSI , UMUBARE W'IMINSI AZAYIMUHAMO																					
01	ANDIKA IZINA RY'UMUTI WA MBERE	UMUTI WA 1	Umuti wa 1				Umuti wa 1				Umuti wa 1				Umuti wa 1				Umuti wa 1			
	a. Uko ubimuhaye uzajya umuha bingahe ?		Ingano yawo				Ingano yawo				Ingano yawo				Ingano yawo				Ingano yawo			
	b. Uzajya umuha inshuro zingahe ku munsi ?		Inshuro/munsi				Inshuro/munsi				Inshuro/munsi				Inshuro/munsi				Inshuro/munsi			
	c. Uzabimuha mu minsi ingahe ?		iminsi				iminsi				iminsi				iminsi				iminsi			
02	ANDIKA IZINA RY'UMUTI WA KABIRI	UMUTI WA 2	Umuti wa 1				Umuti wa 1				Umuti wa 1				Umuti wa 1				Umuti wa 1			
	a. Uko ubimuhaye uzajya umuha bingahe ?		Ingano yawo				Ingano yawo				Ingano yawo				Ingano yawo				Ingano yawo			
	b. Uzajya umuha inshuro zingahe ku munsi ?		Inshuro/munsi				Inshuro/munsi				Inshuro/munsi				Inshuro/munsi				Inshuro/munsi			
	c. Uzabimuha mu minsi ingahe ?		iminsi				iminsi				iminsi				iminsi				iminsi			

03	ANDIKA IZINA RY'UMUTI WA GATATU	UMUTI WA 3	Umuti wa 1		Umuti wa 1		Umuti wa 1		Umuti wa 1	
	a. Uko ubimuhaye uzajya umuha bingahe ?		Ingano yawo		Ingano yawo		Ingano yawo		Ingano yawo	
	b. Uzajya umuha inshuro zingahe ku munsi ?		Inshuro/munsi		Inshuro/munsi		Inshuro/munsi		Inshuro/munsi	
	c. Uzabimuha mu minsi ingahe ?		iminsi		iminsi		iminsi		iminsi	
ot 204	WATANZE AMAFARANGA ANGAHE ? (gusuzumwa, imiti , ...) (Andika umubare w'amafaranga Rfw)									
ot 205	UYU MWANA ASANZWE ARI UMUNYAMURYANGO WA MUTUWELLE DE SANTE ?		Yego	Oya	Yego	Oya	Yego	Oya	Yego	Oya

Murakoze mu ruhare mugize .Ibyo tuganiriye bizadufasha mu guteza imbere ibikorwa by'ubuzima muri aka karere . **End Time:** _____

		UMWANA 1		UMWANA 2		UMWANA 3		UMWANA 4		UMWANA 5	
Uwita ku mwana azi imiti umwana yandikiwe,	UMUTI WA 1	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza
inshuro agomba kuyifata n'igihe igomba	UMUTI WA 2	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza
kumara ?	UMUTI WA 3	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza	Neza	si neza
Erekana umubare 12 (umubare =byose nibyo)		Byose nibyo	Ntabwo byose ari byo	Byose nibyo	Ntabwo byose ari byo	Byose nibyo	Ntabwo byose ari byo	Byose nibyo	Ntabwo byose ari byo	Byose nibyo	Ntabwo byose ari byo

Ababajije: _____ _____

Annex B. List of Supervisors and Interviewers

Health Facility Survey Team

	Dr John Bosco Ahoranayezu	M&E Manager	Technical Coordinator
TEAM A	Leonard Bagilishya	QA Manager	Team A Coordinator
	Samuel Ndangamiyumukiza	QA Officer	Supervisor
	Beata Numupfasoni	M&E Officer	Supervisor
	Camarade Ruganza Rutambwe	M&E Officer	Supervisor
	Fidele Ntawukuriryayo	Mobilization Officer	Supervisor
	Felicien Ndayisenga	Mobilization Officer	Supervisor
	Ephraim Mudenge	Pediatrie Nurse, Kibilizi Hosp	Interviewer
	Florence Mukakalisa	Titulaire Musha HC	Interviewer
	Bosco Nzabahimana	Titulaire Munini HC	Interviewer
	Nyirakanyana Marie Claire	Titulaire Nyabimata	Interviewer
	Josue Munyengango	Titulaire CS Rukira	Interviewer
Team B	Melene Kabadege	Mobilization Manager	Team B Coordinator
	Consolee Uwibambe	M&E Officer	Supervisor
	Marcel Nzabimana	Mobilization Officer	Supervisor
	Beatrice Muteteli	QA Officer	Supervisor
	Beatrice Nyiranzeyimana	M&E Officer	Supervisor
	Chantal Uwamahoro	Mobilization Officer	Supervisor
	Thamar Nyiransabiyaremye	Superviseur Hopital Kibogora	Interviewer
	Pierre Sezirahiga	Infirmrier Hopital Bushenge	Interviewer
	Dative Madamu	Infirmriere Hopital Kigeme	Interviewer
	Emmanuel Uwimana	Infirmier Hopital Kigeme	Interviewer
	Alice Uwera	Infirmiere Rwamagana	Interviewer

Participants to the HFA tool review/adaptation meetings/consultations

January 4-5, 2007

1	Dr Sani Aliou	Acting Team Leader, EIP
2	Dr John Bosco Ahoranayezu	M&E Manager
3	Leonard Bagilishya	QA Manager
4	Melene Kabadege	Mobilization Manager
5	Samuel Ndangamiyumukiza	QA Officer
6	Beata Numupfasoni	M&E Officer
7	Camarade Ruganza	M&E Officer

	Rutambwe	
8	Fidele Ntawukuriryayo	Mobilization Officer
9	Felicien Ndayisenga	Mobilization Officer
10	Consolee Uwibambe	M&E Officer
11	Marcel Nzabimana	Mobilization Officer
12	Beatrice Muteteli	QA Officer
13	Beatrice Nyiranzeyimana	M&E Officer
14	Shantal Uwamohoro	Mobilization Officer
15	Georges Gahenda	MoH Community Health Acting-in-Charge
16	Philibert Ndaruhutse	Asst M&E Coordinator, Twubakane
17	Dr Bonaventure Nzeyimana, consulted January 8, 2007	In-Charge of Health Care, Policy & Planning Unit, MoH
18	Dr Emilien Nkusi, consulted March 21, 2007	In-Charge of HIS, MoH
19	Olivier Byicaza, consulted March 9, 2007	Monitoring & Evaluation Coordinator, Twubakane

Annex C. Survey Teams and Data Collection Schedule

Team	Districts	January - February 2007	February - March 2007
A	**Kirehe**		Feb 26th to March 1st
B	**Ngoma**		February 19th to February 23rd
A	**Gisagara**		February 19th to February 23rd
A	**Nyaraguru**		February 12th to February 17th
B	**Nyamagabe**	January 22nd to January 26th	
B	**Nyamsheke**	January 15th to January 19th	

ANNEX D: Sampling Framework

Summary of Sampled Health Centers and Cases by District

District	Health Centers Assessed	Number of Sick Child Cases Observed	Number of Exit Interviews	Number of CHWs Interviewed
Gisagara District				
	Kirarambogo	5	5	5
	Kibilizi	5	5	5
	Gikore	5	5	5
	Musha	5	5	5
	Gakoma	5	5	5
Kirehe District				
	Kirehe	5	5	5
	Gashongora	5	5	5
	Nasho	5	5	5
	Musaza	5	5	5
	Kabuye	5	5	5
Ngoma District				
	Kibungo	5	5	5
	Gituku	5	5	5
	Sangaza	5	5	5
	Rukumberi	5	5	5
	Remera	5	5	5
Nyamagabe District				
	Kitabi	5	5	5
	Musebeya	5	5	5
	Nyarusiza	5	5	5
	Nyamagabe	5	5	5
	Jenda	5	5	5
Nyamasheke District				
	Muyange	5	5	5
	Mwezi	5	5	5
	Rangiro	5	5	5
	Kibingo	5	5	5
	Hanika	5	5	5
Nyaruguru District				
	Kabirizi	5	5	5
	Munini	5	5	5
	Muganza	5	5	5
	Nyantanga	5	5	5
	Ruhero	5	5	5
TOTAL	**30 HCs**	**150**	**150**	**150**

ANNEX E: Core Indicators Results by District

Area of Analysis	Indica-tor	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL
ACCESS	**1**	Service Availability	% HC that offer three basic child health services (growth monitoring, immunization, sick child care)	HW Interview	100% (5/5)	100% (5/5)	100% (5/5)	60% (3/5)	100% (5/5)	60% (3/5)	**87% (26/30)**
INPUTS	**2**	Staffing	% staff who provide clinical services working in surveyed HC on the day of the survey	HW Interview	100% (41/41)	92% (33/36)	76% (21/29)	96% (22/23)	81% (17/21)	90% (26/29)	**89%** (160/179)
	3	Infrastructure	% essential infrastructure available in surveyed HC on day of the survey (power, improved water source, functional latrine for clients, communication equipment, emergency transport, overnight beds, setting allowing auditory and visual privacy)	HF Checklist	0% (0/5)	0% (0/5)	20% (1/5)	20% (1/5)	40% (2/5)	40% (2/5)	**17% (5/30)**
	4	Supplies	% essential supplies to support child health in HC on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	HF Checklist	80% (4/5)	20% (1/5)	0% (0/5)	0% (0/5)	20% (1/5)	20% (1/5)	**23% (7/30)**
		Supplies	% essential supplies to support child health in CHW on day of the survey (accessible and working scale for child, accessible and working scale	CHW Interview	0%	0%	0%	0%	0%	0%	**0%**

Area of Analysis	Indica-tor	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL
			for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)								
	5	Drugs	% first line medications for child health in surveyed HC on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line anti-malarial, vitamin A)	HF Checklist	100% (5/5)	100% (5/5)	60% (3/5)	40% (2/5)	60% (3/5)	20% (1/5)	**63% (19/30)**
		Drugs	% first line medications for child health in surveyed CHW on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line anti-malarial, vitamin A)	CHW Interview	40% (4/10)	N/A	N/A	96% (24/25)	0%	100% (25/25)	**66% (49/74)**
PROCESSES	**6**	Information System	% HC that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HC: have report in last 3 months and evidence of data use	HW Interview (record review)	100% (5/5)	20% (1/5)	100% (5/5)	80% (4/5)	75% (3/4)	40% (2/5)	**69% (20/29)**
		Information System	% CHWs that maintain up-to-date records of sick U5 children (age, diagnosis, treatment)	CHW Interview	40% (4/10)	N/A	N/A	75% (18/24)	0% (0/1)	83% (15/24)	**70% (37/53)**
	7	Training	% HC/CHW in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	HW interview	100% (5/5)	20% (1/5)	80% (4/5)	80% (4/5)	80% (4/5)	80% (4/5)	**73% (22/30)**

Area of Analysis	Indica-tor	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL
		Training	% HC/CHW in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	CHW Interview	28% (7/25)	44% (11/25)	48% (12/25)	96% (24/25)	16% (4/25)	96% (24/25)	**55% (82/150)**
	8	Supervision	% HC that received **external** supervision at least once in the last 6 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	HW interview	100% (5/5)	80% (4/5)	100% (5/5)	100% (5/5)	80% (4/5)	100% (5/5)	**93% (28/30)**
	8	Supervision	% CHW that received **external** supervision at least once in the last 6 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	CHW Interview	52% (23/25)	16% (4/25)	28% (7/25)	52% (13/25)	40% (10/25)	56% (14/25)	**40% (61/150)**
OUTPUTS	**9**	Utilization of Curative Services	# clinical encounters (CHW/HC / annualized) for sick children per U5 population	HW interview (record review)	1.2	0.6	n/a	0.6	n/a	0.6	**0.6**
		Utilization of Curative Services	# clinical encounters (CHW/HC / annualized) for sick children per U5 population	CHW Interview	**Unable to calcualate with ratios of under-fives to CHWs**						

Area of Analysis	Indica-tor	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL
	10	HW Performance (Assessment)	% key assessment tasks are made by HW (check presence of general danger signs, assess feeding practices, assess nutritional status, check vaccination status)	Clinical Observation	0% (0/25)	0% (0/25)	0% (0/25)	0% (0/25)	0% (0/25)	16% (4/150)	**16% (4/150)**
	11	HW Performance (Treatment)	% clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from Clinical Obs. for HC)	Clinical Observation	60% (15/25)	72% (18/25)	85% (17/20)	58% (14/24)	73% (16/22)	80% (20/25)	**71% (100/141)**
		HW Performance (Treatment)	% clinical encounters in which treatment is appropriate to diagnosis for child with malaria, pneumonia, or diarrhea (from record review for CHW)	CHW Interview	**Unable to find data in CHW data sheet – information jumps from supplies to handwashing knowledge**						
	12	HW Performance (Counseling)	% clinical encounters in which the caretaker whose child was prescribed an antibiotic, antimalarial, or ORS, can correctly describe how to administer **all** drugs	Exit interview	12% (3/25)	12% (3/25)	64% (16/25)	28% (7/25)	40% (10/25)	17% (4/24)	**28% (42/149)**

TABULATION PLAN - OPTIONAL INDICATORS

Area of Analysis	Indic. #	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL

Area of Analysis	Indic. #	Domain	Indicator	Instrument	Nyamasheke	Nyamagabe	Nyaruguru	Ngoma	Gisagara	Kirehe	TOTAL
ACCESS	**Opt1**	Geographic Access	% population with geographic access to an authorized provider of curative child health services	Access document (separate Word file)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
INPUTS	**Opt2**	Availability of Immunizations	% HC with all nationally-mandated vaccines in stock on day of survey	Check list	100% (5/5)	80% (4/4)	60% (3/5)	60% (3/5)	100% (5/5)	100% (5/5)	**83% (25/30)**
	Opt3	Availability of Guidelines	% HC with all nationally-mandated guidelines for care of children available and accessible on day of survey	Check list	40% (2/5)	60% (3/5)	80% (4/5)	0% (0/5)	40% (2/5)	40% (2/5)	**43% (13/30)**
	Opt6	Infection Control	% HC with all infection control supplies and equipment on day of survey	Check list	40% (2/5)	20% (1/5)	60% (3/5)	60% (3/5)	40% (2/5)	20% (1/5)	**40% (12/30)**
PROCESSES	**Opt4**	HF-Community Coordination	% HC with routine community participation in management meetings (with evidence through notes) OR have a system for eliciting client opinion, and evidence that client feedback is reviewed	HW Interview	100% (5/5)	60% (3/5)	100% (5/5)	100% (5/5)	100% (5/5)	80% (4/5)	**90% (27/30)**
	Opt5	Community Referral	% HC that received at least one referral from CHW in the last month	HW Interview	20% (1/5)	0% (0/5)	0% (0/5)	0% (0/5)	0% (0/5)	60% (3/5)	**13% (4/30)**

Area of Analysis	Indic. #	Domain	Indicator	Instru-ment	Nyama-sheke	Nyama-gabe	Nyaru-guru	Ngo ma	Gisa-gara	Ki-rehe	TOTAL
	Opt7	Quality Improvement Process	% HC that have documentation of routine quality assurance activities in last 3 months	HW Interview	20% (1/5)	20% (1/5)	20% (1/5)	80% (4/5)	40% (2/5)	20% (1/5)	**33% (10/30)**
OUTPUTS	**Opt8**	Utilization of Preventive Services	Rate of encounter (CHW/HC / annualized) for children for immunization / growth monitoring per U5 population in project area	CHW Interview	**Unable to calcualate with ratios of under-fives to CHWs (can we use the estimated 17.3% under 5 population in each HC zone area)**						
	Opt9	Client Satisfaction / Perceived Quality	% clinical encounters in which the caretaker was very satisfied (4 on a 4 point scale) for all three of the following: wait time, explanation of illness, and treatment received	Exit interview	0% (0/25)	4% (1/24)	22% (5/23)	4% (1/25)	35% (8/23)	0% (0/25)	**10% (15/145)**
	Opt10	HW Performance (Alternative for Counseling)	% clinical encounters in which the HW counseled the caretaker to continue feeding sick child	Clinical Observation	4% (1/25)	12% (3/25)	4% (1/25)	20% (5/25)	24% (6/25)	52% (13/25)	**19% (29/150)**