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FINAL EVALUATION REPORT FOR THE TUBARAMURE PM2A PROGRAM

Cooperative Agreement No. AID-FFP-A-09-00004-00



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**Final Evaluation Report
for the
Tubaramure PM2A Program
Cooperative Agreement No. AID-FFP-A-09-00004-00**

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List of Acronyms

ADS	Automotive Directive System
ASC	<i>Agent de Santé Communautaire</i> (Community Health Worker or CHW in English)
BCC	Behavior change communication
BDS	<i>Bureau de District Sanitaire</i> (District Health Department)
BIF	Burundi Francs
BPS	<i>Bureau Provincial de Santé</i> (Provincial Health Department)
CDC	Commune Development Committee
CDS	<i>Centre de santé</i> (health center)
CG	Care Group
CHW	Community Health Worker (<i>Agent de Santé Communautaire</i> or ASC in French)
C-IMCI	Community-Based Integrated Management of Childhood Illness
CMAM	Community-Based Management of Acute Malnutrition (<i>Prise en Charge Communautaire de la Malnutrition Aigüe</i> or PCMA in French)
CPN	Prenatal consultation (<i>consultation prénatale</i>)
CPoN	Postnatal consultation (<i>consultation postnatale</i>)
<i>Colline</i>	Literally "hill;" an administrative unit
Cordaid	Catholic Organization for Relief and Development Aid
CoSA	<i>Comité de Santé</i> (Health Committee)
CRS	Catholic Relief Services
CSB	Corn-soy blend
DHA	District Health Authority
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DPAE	<i>Direction Provinciale de l'Agriculture et de l'Elevage</i> (Provincial Directorate for Agriculture and Livestock)
EBF	Exclusive breastfeeding
EDSB	<i>Enquête Démographique et de Santé de Burundi</i> (National Demographic and Health Survey of Burundi)
EHA	Essential Hygiene Actions
ENA	Essential Nutrition Actions
EPI	Expanded Program on Immunization
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
FARN	<i>Foyer d'Apprentissage et de Réhabilitation Nutritionnelle</i> (or PD [Positive Deviance]/Hearth)
FFP	Food for Peace
FH	Food for the Hungry
FLM	<i>Federation Luthérienne Mondiale</i> (Lutheran World Federation)
FY	Fiscal Year

GoB	Government of Burundi
<i>Groupements</i>	Economic associations
GM	Growth monitoring (<i>Suivi Promotion de la Croissance</i> or SPC in French)
HDDS	Household Dietary Diversity Score
HF	Health facility
HH	Household
HIV/AIDS	Human immunodeficiency virus infection /acquired immunodeficiency syndrome
HPT	Health Promoter Technician
HW	Hand washing
IBF	Immediate breastfeeding
IEC	Information, Education, Communication
IFPRI	International Food Policy Research Institute
IGA	Income-generating activity
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illness (<i>Prise en Charge Intégrée des Maladies de l'Enfance</i> or PCIME in French)
IPTT	Indicator Performance Tracking Table
IR	Intermediate result
IRA	<i>Infection respiratoire aiguë</i>
IRC	International Red Cross
ISTEEBU	<i>Institut de Statistiques et d'Etudes Economiques du Burundi</i> (Burundian Institute for Statistics and Economic Studies)
ITN	Insecticide-treated net
ITSH	International transport, storage, and handling
IYCF	Infant and Young Child Feeding
Kg	Kilogram
Km	Kilometer
LOA	Life of Activity
LF	Leader Father
LM	Leader Mother
M&E	Monitoring and evaluation
MAE	<i>Ministère d'Agriculture et d'Elevage</i> (Ministry of Agriculture and Livestock)
MD	Doctor of Medicine
MEAL	Monitoring, evaluation, accountability, and learning
MoH	Ministry of Health (<i>Ministère de Santé Publique et la Lutte Contre le Sida</i> or MSPLS in French)
MS	Master of Science
MSPLS	<i>Ministère de Santé Publique et la Lutte Contre le Sida</i> (Ministry of Health or MoH in English)
MT	Metric Ton

MTE	Mid-Term Evaluation
MUAC	Mid-upper arm circumference
MYAP	Multi-Year Assistance Program
N/A	Not available or not applicable
NGO	Non-governmental organization
ORS	Oral Rehydration Salts
PAIOSA	<i>Programme d'Appui Institutionnel et Operational au Secteur Agricole</i>
PBF	Performance-based financing
PCMA	<i>Prise en Charge Communautaire de la Malnutrition Aigüe</i> (Community-Based Management of Acute Malnutrition or CMAM in English)
PCDC	<i>Plans Communaux de Développement Communautaire</i> (Commune Community Development Plans)
PCIME	<i>Prise en Charge Intégrée des Maladies de l'Enfance</i> (Integrated Management of Childhood Illness or IMCI in English)
PD/Hearth	Positive Deviance/Hearth Model (or FARN in French)
PHA	Provincial Health Authority
PM2A	Preventing Malnutrition in Children Under 2 Approach
PNDS	<i>Plan National de Développement Sanitaire</i> (National Development Plan for Health)
PRONIANUT	<i>Programme National Intégré d'Alimentation et de Nutrition</i> (National Integrated Program of Food and Nutrition in English)
PSN	<i>Promoteurs de Santé et Nutrition</i> (Tubaramure Health Promoters of THP in English)
PSP	Private Service Provider
SAM	Severe acute malnutrition
SD	Standard deviation
SILC	Savings and Internal Lending Community
SMART	Standardized Monitoring and Assessment Relief and Transitions
SOW	Scope of work
SPC	<i>Suivi Promotion de la Croissance</i> (growth monitoring or GM in English)
TBD	To be determined
THP	Tubaramure Health Promoter (<i>Promoteurs de Santé et Nutrition</i> or PSN in French)
TOPS	Technical and Operational Performance Support
TOR	Terms of reference
TPS	Public Health Technician
Tubaramure	Kirundi for, "Let's Help Them Grow"
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAZ	Weight-for-age Z score

WFP World Food Program (*Programme Alimentaire Mondial* or PAM in French)
WHO World Health Organization

Executive Summary

1.0. Program Overview

Catholic Relief Services (CRS)/Burundi led a consortium of international and national non-governmental organizations (NGOs)—International Medical Corps (IMC), Food for the Hungry (FH), and Caritas-Burundi—in the implementation of a five-year (2009-2014) United States Agency for International Development (USAID)-financed development program entitled Tubaramure, “Let’s help them grow.” The program used a Preventing Malnutrition in Children Under 2 Approach (PM2A), which recent research in Haiti had identified as possibly being more effective in reducing malnutrition than historically favored remedial methods.¹

USAID’s decision to fund a second multi-year assistance program (MYAP) in Burundi was conditional on that program conducting a comparative assessment of the PM2A model for preventing malnutrition that was being co-executed by the International Food Policy Research Institute (IFPRI) and the Food Aid and Nutrition Technical Assistance (FANTA) Project in two countries, Guatemala and Burundi. This unique context accounts for several features of this program, which are critical for understanding the global context of this evaluation:

- First and foremost, it explains why the Tubaramure Program focuses exclusively on improving food utilization—i.e. only one of the four dimensions of the traditional Title II food security model for building household food security. Most traditional MYAPs include four strategic objectives: increasing food availability, increasing food access, increasing food utilization, and improving the local communities’ ability to identify and manage risk;²
- Second, it explains why the program is built around the PM2A approach; and
- Third, it explains why 60 of the 269 program villages are linked to a special research program conducted by IFPRI with funding from USAID through the FANTA II Project. IFPRI is conducting study of a series of 60 *collines* (communities)³ to assess the impact and cost effectiveness of the Tubaramure PM2A model on child nutritional status, as well as to evaluate the differential and absolute impact of varying the duration of receiving food rations in two countries, Burundi and Guatemala.

The principal objective of the Tubaramure Program was to prevent malnutrition in children under 2 years of age in 268 *collines* in two highly food-insecure provinces of Burundi, Cankuzo

¹ In 2008, International Food Policy and Research Institute (IFPRI)—in collaboration with World Vision-Haiti, Cornell University, and the Food and Nutrition Technical Assistance (FANTA) Project—provided the first programmatic evidence that the preventative approach of blanket-targeting of a food-assisted maternal-and-child health and nutrition program to all children 6-to-24-months old was more effective in reducing the prevalence of stunting, wasting, and being underweight than the traditional recuperative approach based on solely targeting underweight children (weight-for-age Z-score [WAZ] < -2) under 5 years of age.

² Although the priorities of the Title II Food for Peace (FFP) Program have shifted, the basic structure has remained focused on the classic three-pronged program with the addition of an early warning and response component since 1995. See van Haften, R.; Anderson, M.A.; Caudill, H.; and Kilmartin, E. 2013. Second Food Aid and Food Security Assessment (FAFSA-2) Summary. Washington, DC: FHI 360/FANTA. [http://www.usaid.gov/sites/default/files/documents/1866/FAFSA-2Summary_Web.pdf].

³ The term *colline* (hill) is used to refer to the local communities and settlements in Burundi.

and Ruyigi. To achieve this goal, the program's activities were organized around the achievement of three intermediate results (IRs):

- **IR1:** Women and children under 5 access quality nutrition and health services;
- **IR2:** Households practice appropriate health and nutrition behaviors; and
- **IR3:** Eligible women and children have increased intake of nutrient-rich diverse foods.

2.0. Evaluation Methodology

This final evaluation of the program was conducted by a team of two development professionals in Burundi from July 6-August 7, 2014, in close collaboration with the nutrition focal point for the Burundi Ministry of Health or MoH (*Ministère de Santé Publique et la Lutte Contre le Sida* or MSPLS in French). The principal objective of the evaluation was to determine:

- The relevance, effectiveness, efficiency, and acceptability of processes and outputs;
- The factors affecting the implementation and the degree of adherence to the terms of the agreement;
- What and why results (outcomes/impacts) have/have not been achieved; and
- The sustainability of results.

This evaluation was also expected to describe the outcomes and impact (intended and unintended) of the program's activities; how contextual or program-related factors contributed to greater or less positive outcomes; and factors that promote/threaten the sustainability of positive impacts after the program ends. The team was also asked to address a number of more specific sub-objectives and key questions for each of the IRs.

The evaluators reviewed existing secondary sources of information and available quantitative information from baseline to endline household surveys, and used qualitative survey methods in order to better understand the program's impact. These qualitative methods included the organization of focus group discussions in a representative sample of 20 local *collines*, as well as key informant interviews with staff, local partners, and local authorities at the provincial, commune, and local levels.

3.0. Evidence of Results

The recently completed (May 2014) *Institute de Statistiques et d'Etudes Economiques du Burundi* (ISTEEBU) study of a stratified random sample of 1,200 households in 40 *collines* in both provinces found statistically significant reductions ($p < 0.05$) in the rate of acute malnutrition (from 8.4% in 2010 to 4.8% in 2014) and the percentage of children classified as underweight (from 46.7% in 2010 to 22% in 2014). The same study showed a decrease in the number of children classified as stunted from 52.3% in 2010 to 50.5% in 2014, giving a difference of 1.8 points non-statistically significant ($p = 0.236$). A disaggregated analysis by province shows the Tubaramure Program had a higher impact on stunting in Cankuzo (38.9%) province than Ruyigi (57.2%). The Tubaramure final household survey showed a remarkable 13-point decrease in the prevalence of stunting—from 52.3% in 2010 to 38.9% in 2014—that was statistically significant ($p = 0.000$).

This significant reduction in the rate of malnutrition (acute malnutrition and underweight) was confirmed using other information gathered during the final evaluation focus group discussions and key informant interviews. Most of the beneficiary focus group discussions stated that the program had a significant impact on children's health and well being; and the majority of beneficiary women continue to follow the program's recommendations for child nutrition and improved hygiene even after graduation.

In addition to the Tubaramure Program's direct impact on malnutrition, it has had a huge impact on local capacity at a variety of levels:

- *The MoH National Nutrition Policies:* The MoH staff at all levels are aware of the recently revised (under the Tubaramure Program) protocols to support malnutrition,⁴ and how these newly revised protocols and the MoH's training modules for these protocols can be used to build the capacity of the local health districts and Community Health Workers to both treat and prevent malnutrition;
- *Commune and Provincial-Level Administration:* There is an increased awareness of the critical importance of the nutrition activities at the commune and local level that is reflected in the new Commune Community Development Plans (PCDC), even though there is very little formal-level understanding of the actual commune-level data on the activities that were executed in specific villages or how these affected the principal nutrition and sanitation behaviors; and
- *Gender:* Local authorities at all levels of the administration underscored the critical impact of the program on women's empowerment, which was reflected in:
 - The much more prominent discussion of sanitation and health issues in the most recent generation of the PCDC; and
 - The small but important percentage of the 4,930 Leader Mothers (LMs) trained by the program who were elected to district-level community development plans (196), elected to commune-level women's forums (537), and selected to be MoH Community Health Workers (205).

These gender impacts were attributed to the high-quality training the women received during the program, and the program's emphasis on empowering them as teachers and leaders.

4.0. Key Factors That Affected Program Effectiveness and Efficiency

Some of the key factors that effected program implementation, effectiveness, and efficiency were:

- The Tubaramure Program's commitment to a regular model of quarterly meetings with local authorities and Government of Burundi (GoB) staff, and field visits to facilitate joint planning and program integration;
- The use of front-line innovators (such as the Tubaramure Health Promoters, who were program employees recruited from and placed in the commune centers) to facilitate all of the community-level program activities in collaboration with representatives of the main

⁴ These protocols include the MoH-endorsed modules for the Integrated Management of Childhood Illnesses (IMCI); Community Management of Acute Malnutrition (CMAM); Severe and Acute Malnutrition (SAM); Growth Monitoring (GM); and Prenatal and Postnatal Consultation (CPN/CPoN).

ministries that support these activities (such as the volunteer MoH Community Health Workers and the community-based agricultural monitors and veterinary workers);

- The program's emphasis on training female and—after the mid-term—male village leaders (LMs and Leader Fathers [LFs]) to lead and execute the health and nutrition activities;
- The early introduction of the Savings and Internal Lending Communities (SILCs) in the second year; and
- The program's development of a new, sophisticated model of commodity tracking at the end of the second year (November 2011) liberated the Tubaramure Health Promoters from the labor-intensive manual reporting on the program's PM2A activities.

The efficacy of the Tubaramure Program was reduced by:

- The MoH staff's insufficient understanding of the Care Group Model, which was not recognized by any standard MoH protocol;
- The program's staffing structure that inhibited the full range of activities, such as the Tubaramure Health Promoters working more closely with the MoH/health centers;
- The insufficient involvement of men in the program start up in the villages (as outlined in the original MYAP proposal) until just prior to the program's mid-term evaluation; and
- The fact that the original MYAP proposal did not anticipate a wing of activities that would:
 - Facilitate the LMs developing the types of income-generating activities (IGAs) that would motivate them to continue this volunteer work;
 - Help the beneficiary households develop the types of agricultural and livestock activities they would need to maintain a more diversified diet after they were no longer eligible for the PM2A rations; or
 - Provide livelihood benefits whose income would impact the consumption of nutrient-rich food.

To address these issues, which were a major focus of discussion during the mid-term evaluation, the Tubaramure Program facilitated:

- The creation of 874 *groupements*, 713 (82%) which are registered, which is a pre-requisite to working with the Ministry of Agriculture and Livestock (*Ministère d'Agriculture et d'Élevage* or MAE);⁵
- Helping organize, train, and equip (with seed, start-up livestock, food processing equipment, and technical assistance) at least two of the new *groupements* per *colline* where the program was active;
- Training and certifying 48 SILC Private Service Providers (PSPs) in 2013 to help develop and/or sustain a total of 869 program-related SILCs in the area; and
- Encouraging the development of 28,117 keyhole gardens in both provinces.

Many of these new agro-economic activities (i.e. activities added after mid-term evaluation that were not envisioned in the original program design) have had a huge impact on households' willingness and capacity to sustain some of the new health behavior and nutrition practices.

⁵ Approximately 54% of the Tubaramure-facilitated *groupements* in Cankuzo Province have SILCs and 35% of the Tubaramure-facilitated *groupements* in Ruyigi.

5.0. Critical Challenges to Sustaining the Tubaramure Program's Results

The training needed to sustain the Tubaramure Program IR1 clinic-based activities is likely to be continued because it is built on existing MoH protocols, modules, and trainers. The most critical challenge to maintaining the community-level achievements under IR1 and the new health behaviors that were developed under IR2 will be for the MoH to find better ways to connect the 4,920 Tubaramure-trained LMs with its existing community-based programs.

The most critical challenges to sustaining the program's IR3-level impacts will be for the MAE and the new agriculture and food security programs to continue to train and provide technical assistance to the Tubaramure facilitated-SILCs and *groupements*; and strengthen the local communities' access to the improved seed that they need to maintain the keyhole gardens (which are recognized by GoB's agricultural policy) as a major source of dietary diversity and food intake.

6.0. Examples of Best Practice

The evaluators identified a number of examples of programmatic best practices that merit replication and distilled them into a series of best practice and lessons learned checklists for future programs. These best practices include the program's:

- Strong commitment to building MoH capacity through the use of existing training modules, protocols, and staff under IR1, and providing technical and logistical support to the GoB for the revision and/or formulation of key national policies;
- Innovative use of the Care Group Model to develop local experts who continue to lobby on behalf of the mainstream MoH programs under IR2;
- Use of the PM2A food distribution to attract program participants to the training programs they need to develop new health and sanitation behaviors being promoted under IR1 and IR2;
- Innovative Care Group training model, which helped build women's confidence in their own ability to lead and lobby on behalf of women's issues like health and hiring women for key community-level positions;
- Introduction of a number of two new low-cost innovations— keyhole gardens and Tubaramure facilitated economic *groupements*—after the mid-term evaluation—that helped build the LMs and beneficiaries to strengthen their livelihoods; and
- Early introduction of the low-cost SILC model, which helped provide agricultural loans for livelihood investments as well as build women's capacity for other types of investments that they needed to ensure a more diversified and nutrient-rich diet.

7.0. Lessons Learned

7.1. For Activities to Build Clinical and Community Capacity to Prevent Malnutrition

The final evaluation highlights the critical importance of building new Food for Peace (FFP) programs that conform to the pre-existing national policies and protocols, goals, and priorities of the MoH. One useful contribution of the Tubaramure Program was to highlight the way that a Title II program can provide technical, material, and logistical support to assist with updating

national policies and protocols (Table A). This type of policy support is much easier when there is a pre-existing MoH protocol that just needs updating, as was the case of the five policy areas that were heavily influenced by Tubaramure under IR1. It is harder when the GoB does not yet have a draft policy or protocol, as was the case of the Care Groups (CGs) in IR2 and PM2A under IR3.

7.2. For Activities to Help Households Practice Appropriate Health and Nutrition Behaviors That Prevent Malnutrition

The evaluation provides clear evidence that the Care Group Model can be efficient for galvanizing the types of broad-based behavior change that are needed to sustain the short-term nutritional impacts of a PM2A program. For the Care Group Model to be successful, two top priorities need to be considering how the program's CG structure will be integrated into the existing health systems from the start of the program; and anticipating the costs and institutional relationships needed to ensure appropriate training of the LMs and MoH staff working with them both during and after the program (Table A).

7.3. For Activities to Help Households Increase Food Intake and Diversity

The Tubaramure evaluation shows how the integration of PM2A into a Title II program can accelerate the speed with which the program's beneficiaries will be willing to develop the new health and nutrition behaviors needed to prevent malnutrition. It also confirms the Tubaramure Mid-Term Evaluation Report's conclusion that for these PM2A new health and nutrition behaviors to be sustainable, the PM2A activities must be linked to a communication strategy that facilitates high levels of local government buy-in, as well as buy in from the wider population; and more broad-based initiatives to increase food availability and access (Table A). The Tubaramure Program's commitment to helping the MoH develop a system of regular quarterly coordination meetings helped create high levels of government and interagency buy-in in a format that is likely to be sustained once program funding ends. The program's behavior change communication (BCC) activities and culinary demonstrations are examples of best practice that helped build the demand for a more diversified diet. Although the program's support for SILCs and keyhole gardens helped increase the households' access to a more diversified diet, it is unlikely to be sufficient to build the types of higher-yielding crop and livestock production systems that both areas will need to sustain the program's positive population-based nutritional impacts.

7.4. For Monitoring, Evaluation, Accountability, and Learning

The inclusion of PM2A activities in a Title II program creates a host of monitoring, evaluation accountability, and learning (MEAL) challenges not found in the classic USAID-funded FFP programs. Especially important is managing beneficiary statuses that change regularly based on where they are in the cycle (pregnancy, lactating, child receiving ration, etc.) that has an impact on ration distribution. To address this issue, these programs must develop parallel systems for accountability and reporting for the PM2A distributions, as well as for tracking the routine program outputs, outcomes, and impacts that are reported on in the Indicator Performance Tracking Table (IPTT) required by all USAID FFP programs (Table A).

8.0. Summary Comments

Was the Tubaramure Program a good investment? That is a question that is being asked by a more in-depth analysis of the cost-benefits by the IFPRI/FANTA program in December 2014. What the evaluation team is able to conclude is the use of PM2A commodities helped jumpstart some of the key capacities that will be needed to reduce both provinces' chronic malnutrition rates. For these achievements to be sustained, however, will require a host of complementary innovations to reduce the area's chronic food insecurity. Future programs that combine PM2A programs with other types of food security programming may help identify the magic formula that determines how these can be better linked.

Based on the evaluation team's initial analysis of the most recent update of the program's quantitative tracking data and the results of their initial focus group discussions and key informant interviews, the current program has met and exceeded the US Government's expectations for its implementation and impact. The program's direct link to the IFPRI/FANTA research programs should provide USAID and the GoB with more in-depth analyses of the cost benefits of the PM2A rations versus more conventional recuperative models for treating malnutrition.

Table A. Tubaramure Program Lessons Learned and Best Practice Checklist

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
IR1: Women and children under 5 access quality nutrition and health services.			
Lesson 1. Training programs that contribute to the preparation and revision of existing protocols for the MoH and/or other partners are more likely to be effective, efficient, and sustainable.			
1. Build training programs to prevent malnutrition on existing MoH protocols and training modules.	X	X	X
2. Train all MoH staff in the key nutrition treatment and preventions protocols (at the provincial, commune, and community levels) from the start of the program in order to build the roots for sustainability.		X	X
3. Include a flexible budget for technical and logistical support to update and revise critical MoH protocols and training manuals.		X	X
4. Build the capacity of the existing MoH trainers in the provincial and district-level health centers to execute training programs for the key protocols being supported.		X	X
5. Anticipate the need to train and equip Community Health Workers from the start.		X	X
6. Anticipate the need for a flexible budget line to support formative supervision missions to follow up on basic training of staff in all health centers.		X	X
7. Anticipate the need for baseline, mid-program, and end-of-year training programs on all of the key modules in order to accommodate staff turnover.		X	X
8. Offer certificates to individuals who complete the training to validate their new knowledge to themselves and their managers.		X	X
9. Strengthen systems for supervising program and staff performance on critical protocols that are underperforming.	X		
Lesson 2. Providing material support to health centers can help motivate the staff and strengthen their capacity to offer higher-quality health and nutrition services.			
10. Anticipate the need for a flexible line item of equipment for all local health centers that provide technical support to community-based nutrition and health programs.		X	X
11. Anticipate the need to update and renew this equipment in the last year of the program.		X	X
12. Give assistance that is 'demand driven' by a health center list of priority needs and MoH norms.		X	X
Lesson 3. The implication and good collaboration with local authorities and NGO partners is essential for the efficient execution and mainstreaming of nutrition interventions into local development plans.			
13. Strengthen the existing system and/or create MoH-managed quarterly meetings that bring together the different health and nutrition actors in the program intervention areas.	Maintain	Maintain	X
14. Strengthen the existing systems for collaborative planning between the MoH Public Health Technicians and Community	Yes	Yes	X

⁶ This column refers to MoH activities that are critical to maintaining or sustaining the Tubaramure-supported activities once program funding ends. If there is no X in the column, it should be assumed that the MoH is already supporting this activity.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
Health Workers.			
15. Offer training courses to the nurses who manage the local health centers to help them better manage the centers' nutrition activities and better connect these activities to the other actors (like the MAE), as well as the provincial and commune-level development planning processes that affect their centers.	X	X	X
16. Provide technical and logistical support for local development plans that local governments can use for strategic planning processes as soon as possible in order to ensure that the malnutrition prevention programs are mainstreamed.	X ⁷	X	X
Lesson 4. <i>Program systems that build on and strengthen the MoH's existing supervision, monitoring, and evaluation systems help supervisors provide on-the-job training in technical issues that improve service quality and ownership of results.</i>			
17. Facilitate joint supervision missions that permit national, provincial, and district-level supervisors to monitor the execution of the activities being supported by the program.	Maintain	Yes	X
18. Harmonize future program's M&E systems with those of the health centers for the key protocols being supported in order to avoid duplication.		X	X
19. Strengthen the MoH's district-level systems for the collection and analysis of nutrition data.	X	X	X
20. Build MoH capacity for more decentralized nutrition data entry and analysis.	X ⁸	X	X
21. Support MoH efforts under way in 2014 to add nutrition and community-level sanitation indicators to the list of performance-based financing indicators being tracked by the government to give greater visibility to MoH efforts to promising clinical and community-based new initiatives to prevent malnutrition.		X	
22. When conducting pilot studies/tests of new initiatives, develop careful tracking systems that allow comparisons of the new initiatives with existing initiatives.		X	X
IR2: Households practice appropriate health and nutrition behaviors.			
Lesson 1. <i>Care Groups can be a powerful model for promoting the types of broad-based behavior change that are needed to sustain the short-term nutritional impacts of a PM2A program.</i>			
1. Consider how the program's CG structure will be integrated into the existing health systems from the start to ensure its sustainability once program funding ends.		X	X
2. If the national health system does not recognize the Care		X	X

⁷ In the case of Burundi, the timing for this should be no later than the mid-term of the new 2013-2014 Commune Community Development Plans (PCDC)—which should be in 2017—to ensure that the NGOs facilitating these processes and the local administrators are well-versed in the ongoing community-based nutrition and health programs. Early and consistent implication of local administrators in the program's activities should increase but not guarantee (due to turnover) a more sophisticated and useful analysis of the most critical constraints and planning issues.

⁸ Train and retrain the provincial and district-level staff in data entry, analysis database creation, and management to avoid labor-intensive hand entry of the MoH and donor forms, which can create costly duplications of effort for M&E and technical staff.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
Group Model, consider developing the model as a complement to other activities (like the Hearth Model and community-based growth monitoring [GM]) that are recognized by existing or draft protocols; and continuing to work with the MoH to determine if and how the concept could be better recognized by the existing protocols both during and after the program.			
3. Participate in national forums that review various ways that the Care Group Model can strengthen the existing models for community-level BCC.	X	X	X
4. Avoid any sort of direct linkage between the Care Group Model and eligibility for PM2A rations in order to keep the Care Group voluntary and to ensure more broad-based participation.			X
5. Complement the Care Groups with mechanisms to reach the wider society with consistent BCC messages that build the wider community's support and understanding of the messages.		X	X
Lesson 2. <i>Care Groups require careful training and retraining of the implementing staff and beneficiary LMs to be effective BCC agents both during and after the program.</i>			
6. Consider adding other staff to deal with non-BCC issues (like IGAs and food distribution) and/or reducing the area of intervention to ensure appropriate backup support.		X	X
Lesson 3. <i>Encourage Care Groups to develop IGAs in order to sustain their BCC activities over time.</i>			
7. Anticipate the costs of developing IGAs and/or SILCs to support the LMs developing IGAs from the start of the program.		X	X
8. Identify the partnerships to develop and sustain the LMs' IGAs in the initial design, and monitor them so they can be adjusted as the most viable IGAs are identified.		X	X
9. Budget adequate staff/partner time needed to support these activities so that the IGA activities do not detract from Care Group and BCC trainings.		X	X
Lesson 4. <i>Anticipate the need for a gender-sensitive communication strategy that develops a wide base of community support and understanding for the BCC messages, both during and after a PM2A program.</i>			
10. Include a well-thought-out draft gender strategy in all PM2A proposals that anticipates some of the special challenges associated with PM2A that are not found in more conventional food security programs.			X
11. Ensure that this strategy complies with the gender strategy of the funding agency (like USAID), as well as donor expectations for gender monitoring and reporting (only recently adopted). ⁹			X
12. Ensure that the program gender strategies are compatible			X

⁹ The USAID gender strategy was formally adopted in March 2012 and updated in 2013 in the USAID Automative Directive System (ADS), Chapter 205 (aka ADS 205) (Integrating Gender Equality and Female Empowerment in USAID's Program Cycle, New Edition Date: 07/17/2013, Responsible Office: PPL File Name: 205_07171307/17/2013 New Edition), which outlines the expectations for staff integration of the policy into existing and future USAID-funded programs.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
with the national gender strategy, and provincial and commune-level coordination structures.			
13. Conduct an annual review of each PM2A program's gender strategy as part of the routine annual review and planning processes.			X
14. Include internal indicators for the gender strategy that are tracked as part of the routine internal and donor tracking of the program, even if these are not in the IPTT.			X
15. Have a field-based gender specialist in each program intervention zone that can also function as the local capacity building and M&E officer.			X
16. Budget basic gender training and retraining of staff and all local government and NGO partner staff the program works with.			X
IR3: Eligible women and children have increased intake of nutrient-rich diverse foods.			
Lesson 1. <i>Given the complexity of selecting and distributing rations to the target beneficiaries, programs need strong two-way communication with the local governments.</i>			
1. PM2A programs need to anticipate strong public awareness campaign at the beginning of the program to explain the activities and target audiences to local authorities before discussing the activities at the community level to help avoid misunderstandings about why the food is only given to some people and to help control illegal sales.			X
2. Strengthen existing coordination groups as a mechanism for staying in touch with local authorities in order to elicit their support in resolving conflicts, avoiding commodity theft, and promoting the program's community-level activities.		X	X
3. Produce attractive posters that promote key Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) themes, and distribute them through local authorities to health facilities, food distribution points, and households to help sustain community awareness of critical themes and behaviors.			X
Lesson 2. <i>Food distribution sites can offer a useful locale for building local government and wider community understanding of the new ENA and EHA themes being promoted by a program.</i>			
4. Consider innovative methodologies (e.g. posters, culinary demonstrations, skits) for promoting new ENA and EHA messages at the food distribution sites.			X
5. Anticipate the need for water, basic hygiene, and sun and rain protection at PM2A distribution sites.			X
Lesson 3. <i>Culinary distributions that promote local foods in conjunction with food rations proved a useful tool for on-the-ground nutrition training at the start of a program, which can then be scaled up to promote nutritious local foods.</i>			
6. Integrate information on local foods that can complement food rations from the start into all PM2A culinary demonstrations.			X
7. Consider ways that cookbooks can help build local authorities, MoH, MAE, and program staff's understanding of the culinary demonstrations and foods being promoted.			X
8. Encourage government agencies (like the district and			X

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
provincial MoH and the commune and provincial offices of the MAE) to consider ways that cookbooks could be incorporated into and/or support their programs.			
9. Consider linking any culinary demonstrations and/or cookbooks developed under the program staff to any new or existing programs to promote community-based GM and <i>Foyer d'Apprentissage et de Réhabilitation Nutritionnelle</i> (FARNs or Positive Deviance [PD]/Hearth).			X
10. Network to identify promising high-nutrient foods like soy, soy processing, and amaranth that the local people may not be aware of for pilot testing.			X
11. Identify options for high-nutrient weaning foods made with local foods and nutrient-dense foods like soy, and promote them from the start both for children's health and as potential IGAs for program beneficiaries.			X
Lesson 4. <i>Keyhole gardens and SILCs are a useful, low-cost model for increasing household diversity, which can be quickly scaled up and sustained with minimum outside support for both PM2A beneficiaries and the wider community.</i>			
12. Before introducing keyhole gardens, identify examples of regional or national best practices and options for improved seed in order to make sure that the package is appropriate to the target area.		X	X
13. Once an appropriate keyhole garden model and package of seeds has been identified, encourage staff to work through the local MAE staff to adapt the program to the local microenvironments in each area.		X	X
14. Consider ways that the pre-existing technical resources in the area (like the MAE or existing agricultural development programs) can help support the pilot testing and scale up of keyhole gardens to avoid overburdening the program extension agents and strengthening the program's links to the MAE.		X	X
15. Identify an experienced SILC expert to train staff on basic principles and models.		X	X
15. Identify different models for creating new or building the capacity of SILC Private Service Providers (PSPs) in the program area as a way of reducing the burden that SILC activities might place on the program extension agents and/or local MoH staff.		X	X
16. Anticipate the need to help the most successful SILCs to identify IGAs and access IGA loans from the existing microfinance institutions in the program intervention zone.		X	X
Cross-Cutting MEAL			
Lesson 1: Programs need to anticipate the need for a well-designed database that tracks PM2A beneficiaries both prior to, during, and after the distributions end in order to ensure appropriate distribution and follow-up support.			X
Lesson 2: MEAL programs that build on and strengthening the government's existing systems for tracking health and development (as the Tubaramure system did for the Burundi			X

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ⁶	Future Donor-Funded Activities	Future PM2A and Food Security Programs
MoH) can reduce duplication and strengthen government buy-in both during and after the program (see IR 1, recommendations 18-20).			
Lesson 3: Anticipate the need for PM2A programs to have an experienced M&E staff to develop the types of sophisticated MEAL systems that these programs will require from the start of their field operations rollout.			X

Source: Tubaramure Final Evaluation; July-August, 2014. Revised based on feedback to the first draft, September 25-October 5, 2014.

Chapter 1 Context and Methodology

1.0. Overview of the Tubaramure PM2A Program

The principal objective of the Tubaramure Multi-Year Assistance Program (MYAP) is “malnutrition in children under 2 years of age is prevented” (Table 1.1). The title of the program, *Tubaramure*, means, “*Let’s help them grow*” in Kirundi, a Bantu language spoken in parts of Burundi, and was chosen to reflect the central role of the local community in preventing malnutrition.

The program’s emphasis on preventing malnutrition was very different from more conventional approaches to nutrition in Sub-Saharan Africa, which focus on treating malnutrition once it has already occurred. The program was designed to support three intermediate results (IRs) deemed critical to preventing malnutrition (Table 1.1). It was also designed to provide a background to a more broad-based, in-depth analysis of the impact and cost effectiveness of Preventing Malnutrition in Children Under 2 Approach (PM2A), an approach that was first identified in 2008 as more effective in reducing malnutrition than the historically favored remedial methods.¹⁰

Table 1.1. Framework for the Tubaramure Program

Strategic Objective: Malnutrition in children under 2 years of age is prevented.	
Intermediate Result (IR)	Output
IR1. Women and children under 5 access quality nutrition and health services (Technical lead: International Medical Corps [IMC])	1.1. Pregnant and lactating women access pre and postnatal care services. 1.2. Implementation of national Integrated Management of Childhood Illness (IMCI) plan is supported. 1.3. Health facilities supported in providing growth monitoring (GM). 1.4. Severe acute malnutrition (SAM) is detected and referred for treatment.
IR2. Households practice appropriate health and nutrition behaviors (Technical Lead: Food for the Hungry [FH])	2.1. Households (HHs) adopt Essential Nutrition Actions (ENA). 2.2. HHs adopt Essential Hygiene Actions (EHA). 2.3. HHs adopt prevention and management behaviors for maternal and childhood illnesses.
IR3. Eligible women and children have increased intake of nutrient-rich diverse foods (Technical Lead: Catholic Relief Services [CRS] in partnership with Caritas)	3.1. Food for Peace (FFP) rations distributed to eligible women and children at community level. 3.2. Mothers and children use FFP rations appropriately. 3.3. HHs use appropriate local foods in addition to FFP ration.

Source: CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. (Revised submission, June 29, 2009). Pg. 7.

¹⁰ IFPRI, in collaboration with World Vision-Haiti, Cornell University, and the Food and Nutrition Technical Assistance (FANTA) Project, provided the first programmatic evidence that the preventative approach of blanket-targeting of a food-assisted maternal-and-child health and nutrition program to all children 6-to-24-months old was more effective in reducing the prevalence of stunting, wasting, and being underweight than the traditional recuperative approach based on solely targeting underweight children (weight-for-age Z-score [WAZ] < -2) under 5 years of age.

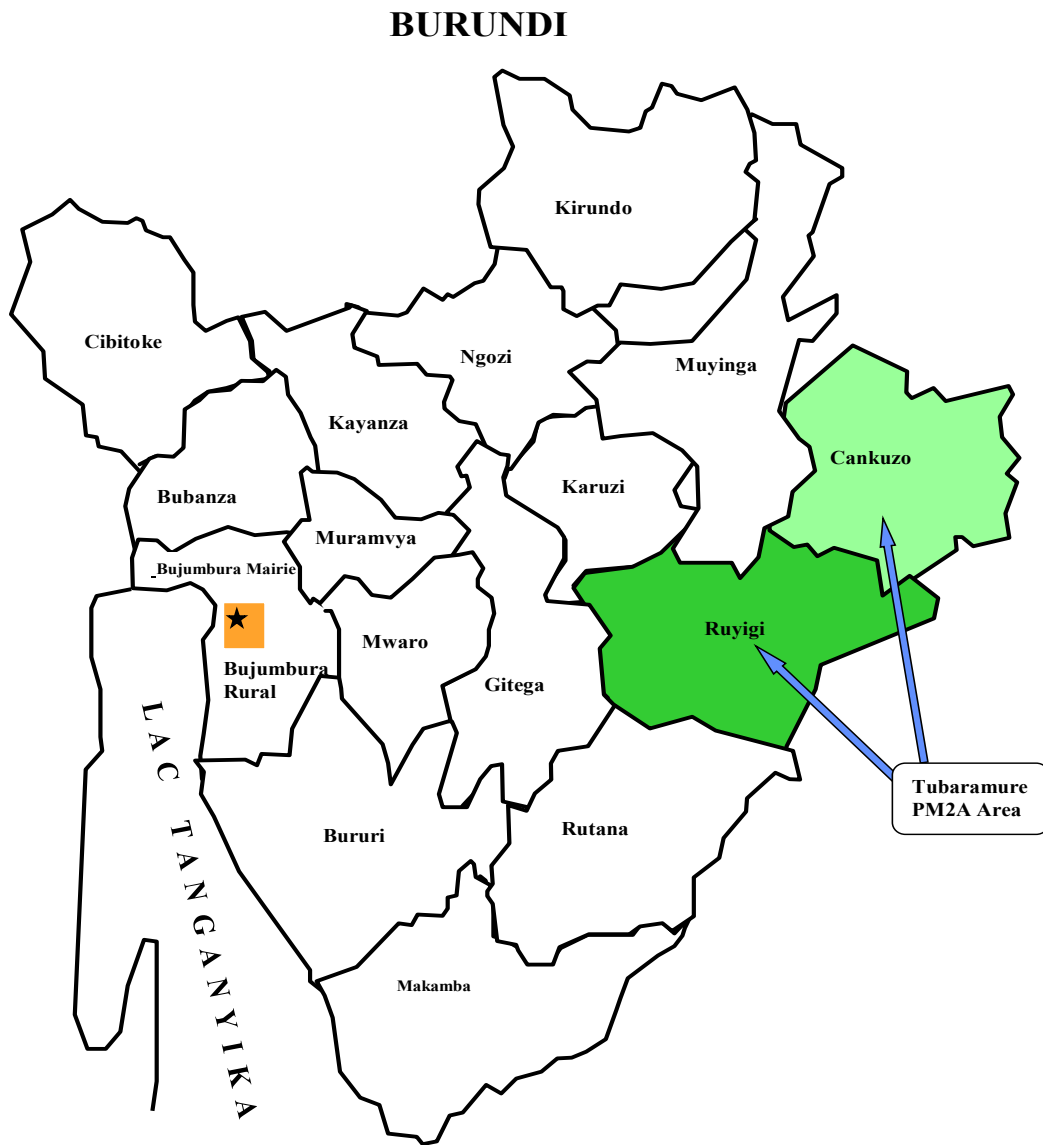
The Tubaramure Program was designed to achieve three IRs.

- The first program IR (**IR1**) was to ensure “*women and children (0-59) access quality nutrition and health services*” designed to prevent malnutrition, not just treat it. To achieve this, the Tubaramure Program provided technical and logistical support to help the Ministry of Public Health and the Fight Against AIDS (MSPLS or *Ministère de Santé Publique et la Lutte Contre le Sida*, hereafter referred to as the MoH) revise its existing training modules and protocols dealing with malnutrition and preventing childhood diseases; train staff and health volunteers using the revised modules and protocols; provide certain types of basic equipment (beds, measuring tables, scales, etc.) that the new and existing health facilities needed to support these protocols; and intensify its existing system of supervisory missions to support the newly revised nutrition protocols.
- The second IR (**IR2**) was designed to help “*households practice appropriate health and nutrition behaviors*” needed to prevent malnutrition and to access the improved health services being developed under IR1. To achieve this, all the mothers who were eligible to receive PM2A rations under IR3 were required to join a beneficiary group that included 10-15 PM2A beneficiaries. Each group elected a Leader Mother (LM) who attended a bi-monthly Care Group¹¹ training program promoting key nutrition and hygiene behaviors mothers need to maintain child health and nutrition.
- The third IR (**IR3**) was designed to ensure that “*eligible women and children have increased intake of diverse foods*” by providing a blanket distribution of PM2A food rations during pregnancy and the child’s first two years of life, and promoting the use of appropriate local foods in addition to the Food for Peace (FFP) ration.

The program was implemented in a total of 268 *collines* (literally “hills”) in the 12 communes of Cankuzo and Ruyigi Provinces (Figure 1.1). These border provinces historically have some of the highest malnutrition rates in Burundi. It was executed by a consortium of non-governmental organizations (NGOs)—Catholic Relief Services (CRS), Food for the Hungry (FH), and International Medical Corps (IMC)—that are all leaders in the field of community-based malnutrition and health and food security programming.

¹¹ “A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with NGO program staff for training and supervision. Each of these volunteers then go out at least monthly to do health promotion with a small cohort of mothers of young children. They are different from typical mothers’ groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned, and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication (BCC). They also provide the structure for a community health information system that reports on new pregnancies, births, and deaths detected during home visits. The model was created by World Relief in 1995, and pioneered and championed by FH and World Relief since then.” <http://www.caregroupinfo.org/blog/>

Figure 1.1. Location of Ruyigi and Cankuzo Provinces in Burundi



Source: Tubaramure Monitoring and Evaluation (M&E) Office.

Tubaramure was a pioneer program that pilot tested many new methodologies for preventing malnutrition. It was:

- The first to pilot test the PM2A concept in Sub-Saharan Africa; and
- The first to pilot the concept of Care Groups in relation to PM2A behavior change communication (BCC) strategies worldwide.

For these reasons, there was a great deal of national and international interest in the program. The total program cost to FFP to date is US\$43,133,600 million, including \$9,989,050 million in Section 202(e) cash¹² and international transport, storage, and handling (ITSH); \$6.9 million in commodities for monetization; and the rest in commodities for distribution. The program, which targeted having an impact on 51,075 mother-child pairs under IR2 and IR3 and 100% of the health centers in both provinces under IR1, began implementation in July 2009 and is scheduled to be completed in November 2014.

2.0. Early Evolution of the Program

The consortium carried out a baseline study at the beginning of Tubaramure in March 2010, which set the determination of reference data and targets for performance indicators for the duration of the program.

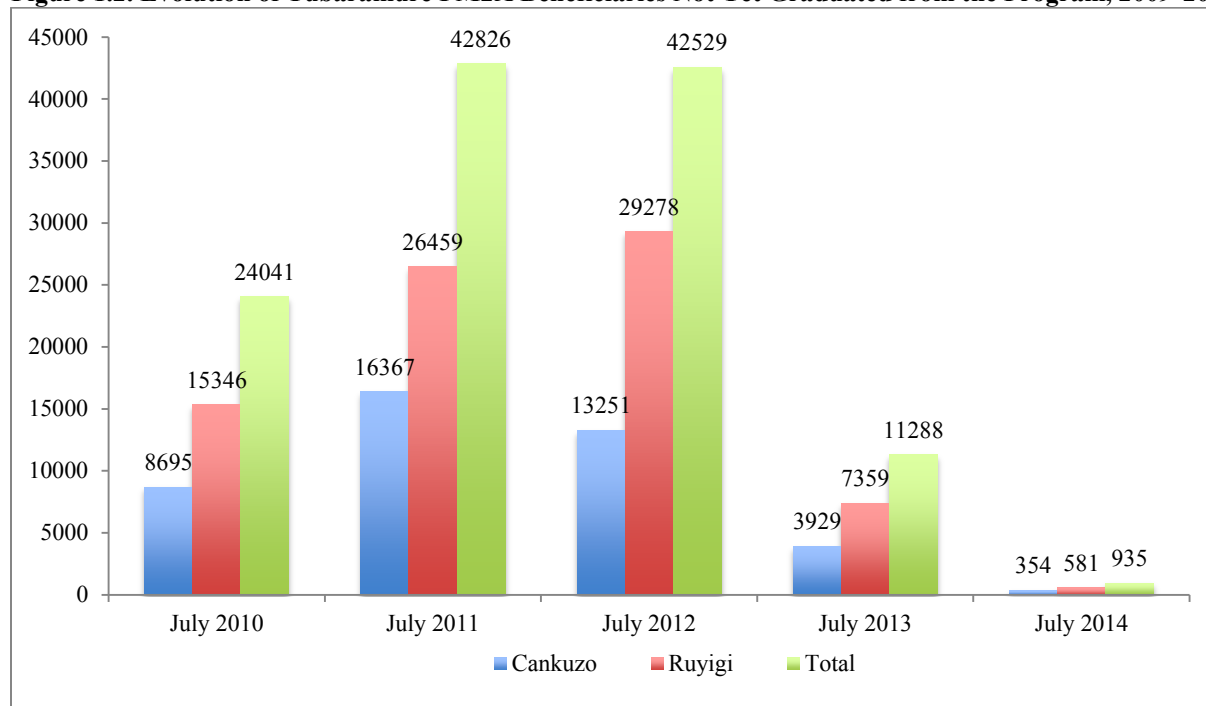
The mid-term evaluation was conducted in May and June of 2012,¹³ when the program was still at its peak number of beneficiaries and only a small number of women had started to graduate (i.e. were no longer eligible to receive PM2A rations) because their children had reached 2 years of age (Figure 1.2). The general consensus of the mid-term evaluation report was that the program was, “*well on its way toward meeting the majority of its objectives and targets and has already achieved visible results in terms of people trained, changes in behavior at the household and community level, improved services at health facilities, and better nutritional status among young children.*”¹⁴ There was, however, increasing evidence that many of the mothers were dropping out of the Care Groups after they graduated (i.e. once they were no longer required to participate as a condition for getting PM2A rations). There was also a growing concern with developing a more realistic hand-off plan to the MoH.

¹² 202e: Cash resources made available to FFP partners for enhancing programs.

¹³ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. (July 2012).

¹⁴ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. (July 2012). Pg.1.

Figure 1.2. Evolution of Tubaramure PM2A Beneficiaries Not Yet Graduated from the Program, 2009-2014¹⁵



Source: Tubaramure M&E Office; August 2014.

Based on the mid-term evaluation report’s analysis and recommendations, the program:

- Added a wing of activities designed to help beneficiary mothers and LMs develop income-generating activities (IGAs) to “*provide incentives for these groups to remain active;*”
- Began working in close concert with local partners to develop a concrete, detailed exit plan;
- Moved forward with its original plan to pilot test a new system for community-based growth monitoring (GM) to track the mothers and children who had graduated from the ration distribution activities in the 12 *collines*; and
- Strengthened the program’s outreach to and involvement of the beneficiary mother’s husbands.

During the same time period, the IFPRI/ Food and Nutrition Technical Assistance (FANTA) project completed its initial analysis of the program’s baseline data on malnutrition, which was presented to the team in a workshop just after the mid-term evaluation. The Tubaramure team followed up on these recommendations, as well as those made by the mid-term evaluation report as part of its routine program reporting.

¹⁵ The official total number of direct beneficiaries is listed as 49,650. These figures indicate the number of beneficiaries that have not yet graduated from the PM2A distribution.

3.0. Expected Program Outputs, Outcomes, and Impacts

The Tubaramure Program design was very simple and intended to be highly interactive, with each sub-component affecting the other. Although the initial impetus for belonging to a Care Group was to get rations, it was expected that the mothers would maintain the new behaviors once they saw the impact on their children's health and nutrition. *And it did*—based on the results of the program's final quantitative household surveys (Text Box 1.1), and verified by the focus group discussions and key informant interviews during the final evaluation. The Tubaramure Program expected that the higher-quality services in the health centers would increase the number of local people making use of the local services and raise the provincial-level rankings of the local health departments. *And it did*. Although the principal focus of the program was the PM2A beneficiaries, the same program was expected to have a wide variety of spread effects into the general population. It was expected to have a population-based impact that could be tracked through the program's outcome and impact indicators. *And it did*. The program was expected to provide a backdrop to a separate, autonomously financed research study by IFPRI and FANTA on 60 communities within the broader program area that would help the international community better understand the strengths and weaknesses of the PM2A model as a development approach that could be compared with similar research in Haiti and Guatemala. This separate research program has been ongoing and is slated to continue its mainstream activities through December 2014 and possibly beyond.

Text Box 1.1. Evidence for Tubaramure Population-Based Impacts on Nutrition

As anticipated in the program document, the Tubaramure Program has had a significant population-based impact on malnutrition.

The recently completed (May 2014) *Institut de Statistiques et d'Etudes Economiques du Burundi* (ISTEEBU) study of a stratified random sample of 1,200 households in 40 *collines* in both provinces found statistically significant reductions ($p < 0.05$) in the rate of acute malnutrition (from 8.4% in 2010 to 4.8% in 2014) and the percentage of children classified as underweight (from 46.7% in 2010 to 22% in 2014).

The same study showed a decrease in the number of children classified as stunted from 52.3% in 2010 to 50.5% in 2014, but this difference was not statistically significant. A disaggregated analysis by province shows that Tubaramure Program had a higher impact on stunting in Cankuzo (38.9%) than Ruyigi (57.2%). The Tubaramure final household survey showed a remarkable 13-point decrease in the prevalence of stunting—from 52.3% in 2010 to 38.9% in 2014—that was statistically significant ($p = 0.000$).

This significant reduction in the rate of malnutrition (acute malnutrition and underweight) was confirmed using other information gathered during the final evaluation focus group discussions and key informant interviews.

Most of the beneficiary focus group discussions stated:

- The program had a significant impact on children's health and well-being; and
- The majority of women continue to follow the program's recommendations for child nutrition and improved hygiene even after graduation.

Every one of the LMs, MoH staff, Community Health Workers, and local authorities in the communities where the team conducted the focus group discussions concluded (Annexes IV and V):

- The Tubaramure Program had considerably improved the health and hygiene status of children;
- In addition to receiving the PM2A rations, the women had learned new ways to prepare nutritious meals using local foods; and
- Most of the beneficiary mothers have continued to use the improved nutrition and hygiene practices (hand washing and latrines) for the new children born after their PM2A graduation.

Source: Chapters 2, 3, 4, and 5 of this report.

In sum, the Tubaramure Program in Burundi was an experiment that had significance both at the national and international level. This accounts for the relatively unique focus of the evaluation on lessons learned for future programs.

4.0. Evaluation Objectives and Methodology

4.1. Objectives

Per FFP requirements, the principal objectives of the final evaluation were to determine:

- The relevance, effectiveness, efficiency, and acceptability of processes and outputs;
- The factors affecting the implementation and the degree of adherence to the terms of initial agreement;
- What and why results (outcomes/impacts) have/have not been achieved; and
- The sustainability of the results.

The final evaluation was also expected to describe the outcomes and impact (intended and unintended) of the program's activities; how contextual or program-related factors contributed to

greater or less positive outcomes; and factors that promote/threaten the sustainability of positive impact after the program ends.

Changes of greatest interest were those related to:

- Women's diets;
- The use of health services during pregnancy and lactation;
- Men's and women's knowledge and practices related to hygiene and caring for young children;
- Household diets; and
- Gender equity in the community and at home.

In addition, the team was expected to examine the strengths and weaknesses of the program's design, implementation, and outputs, considering how well it has:

- Been appreciated by the community;
- Contributed to positive outcomes;
- Avoided unintended negative outcomes; and
- Prepared its exit strategy and left sustainable results.

4.2. Relationship to the IFPRI/FANTA Evaluation

A separate evaluation of the IFPRI/FANTA research study is scheduled for December 2014. This study aims to better understand and document the impact, cost, and cost effectiveness of PM2A programs, and to generate institutional knowledge for the United States Agency for International Development (USAID)/FFP about how PM2A programs should be designed and implemented to maximize their impact and cost effectiveness. Examples of the questions that the evaluation of the IFPRI/FANTA study—as opposed to the current evaluation—will address include:¹⁶

- How much food is needed (individual vs. household ration)?
- What types of food/products are best?
- Should micronutrient supplements be used in place of individual food rations? and
- What is the best timing and duration of exposure to a PM2A program?

4.3. Specific Objectives and Key Questions from the Evaluation Scope of Work

In addition to the general objectives of the evaluation, the evaluation outlined seven specific objectives for the evaluation and 11 key questions for IR1; and 11 specific objectives for the evaluation and 25 specific questions for IR2 and IR3. A complete list of the questions is provided in Annex I.A to facilitate a cross-reference to where the questions are addressed in the main text. When questions are addressed, they are also noted in the text's footnotes.

4.4. Methodology

4.4.1. Principal Data Sources. The approved scope of work (SOW) anticipated that the evaluation would be based on three types of data:

¹⁶ Annex I.B, Page 2.

- **Quantitative survey:** A quantitative, population-based survey that would be comparative with the Tubaramure Program’s baseline survey conducted in March 2010;
- **Focus group discussions:** A series of focus group discussions with Tubaramure beneficiaries and non-program beneficiaries and community leaders in a representative sample of communities; and
- **Key informant interviews:** A series of open-ended interviews with key informants, including program staff associated with CRS, FH, IMC, and Caritas; key MoH partners at the provincial and commune levels; as well as local government authorities at the provincial and commune levels.

The same SOW anticipated that the evaluation would be led by a team of two external consultants¹⁷ and a senior member of the MoH’s staff tasked with setting up all of the government-level key informant interviews.¹⁸ To ensure its independence, the team was expected to recruit and hire its own set of enumerators.

4.4.2. Quantitative Final Survey. The principal quantitative database for the final survey was the program’s final quantitative survey, which was conducted in May 2014 by the same government statistical service that conducted the baseline. This survey conducted a stratified random sample of 1,200 households in 40 *collines* in Cankuzo and Ruyigi provinces that included 1,196 women and 1,784 children under 5 years. The study was population-based and intended to measure the program’s global impact on malnutrition and health behaviors in both provinces. Sixty-two percent of the women interviewed were beneficiaries; only 160 (fewer than 20%) had been Tubaramure LMs (Table 1.2).

¹⁷ **Dr. Della E. McMillan** (based in Gainesville, Florida) is a livelihoods specialist with an extensive background in gender and capacity building, most recently as the gender consultant for the Millennium Challenge Corporation (MCC) Compact-funded projects in Burkina Faso. She has worked on the design and evaluation of Title II food security programs in Mali, Niger, Burkina Faso, Chad, Guinea, Ethiopia, and Uganda. She is the co-author of two publications in the CRS online monitoring and evaluation publication series.

Dr. Sidibe Sidekiba (based in Conakry, Guinea) is a Doctor of Medicine (MD) with a specialization in pediatric nutrition (University of Conakry), with a Master of Science (MS) in Epidemiology (University of Bordeaux) and a MS in health statistics (University of London). He has extensive experience in the design of qualitative and quantitative surveys for Title II programs in Guinea, Rwanda, Mali, Burkina Faso, and Chad. As the senior health advisor of Africare’s Title II program in Guinea, he pilot tested one of the Hearth model programs for the rehabilitation of moderately malnourished children in francophone West Africa. As a MYAP coordinator in Rwanda, Dr. Sidibe pilot tested a series of highly innovative programs for HIV/AIDS-affected households.

¹⁸ **Dr. Evelyn Ngomirakiza** (MD, University of Burundi; MS Nutrition, Makerere University) is director of the Burundi MoH Nutrition Unit, and was an external observer on the team who represented the Government of Burundi.

Table 1.2. Quantitative Households Survey Sample, Baseline, and Endline

Variables	Baseline 2010	Endline 2014
Number of <i>collines</i>	20	40
Number of households	1,255	1,200
Number of children under 5 years of age	1,454	1,784
Number of non-direct beneficiary households	N/A	450
Number of women interviewed who were LMs	N/A	169

Source: *Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)*; 2014. *Rapport Final Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A Tubaramure (Provinces Cankuzo et Ruyigi)*. Bujumbura: ISTEEBU; August 2014.

4.4.3. Key Informant Interviews. Dr. Della E. McMillan and Dr. Evelyn Ngomirakiza conducted the key informant interviews of program staff and MoH staff.

4.4.4. Community-Level Focus Group Discussions and Key Informant Interviews. The qualitative survey was designed and executed by Health and Nutrition Specialist Dr. Sidibe Sidikiba. The same survey included key informant interviews with 16 staff members associated with the area's commune-level health centers.

The focus group discussions were conducted by six enumerators in Kirundi and then translated from Kirundi to English by two translators. The final choice of enumerators and translators was made by the consultants during the first week in country from a pool of eligible candidates who had worked for *Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)* and other programs. Three of the enumerators were from the department of psychology, and three from agricultural fields. All of them had experience with other quantitative and qualitative surveys in Burundi. None of the enumerators—most of them recent graduates of the university—had any previous association with Tubaramure or the implementing partners (CRS, FH, Caritas, and IMC). All of the enumerators received a two-day training during which the questionnaire was translated and pilot tested in one of the survey villages. The six enumerators were divided into two teams. To ensure the quality and consistency of the enumerator's work, either Dr. Sidibe or one or both of the translators accompanied each team. Each enumerator was responsible for conducting the initial transcription of his interviews in Kirundi, which was then turned into one of the two translators and Dr. Sidibe for a group team review and discussion. The summary of these meetings was typed up daily by the two translators under the direct supervision of Dr. Sidibe (see Annexes IV and V).

4.5. Schedule

4.5.1. Step One: Evaluation Set Up (July 4-12, Bujumbura). During the first week in country, the evaluation consultants focused on key informant interviews; meeting with ISTEEBU staff to finalize the analyses in the quantitative final evaluation; developing a list of focus group guides; selecting the enumerators and translators; and conducting the first round of key informant interviews.

A four-part strategy was adopted to ensure that a representative sample of *collines* was included in the qualitative survey:

- *Preparation of a List of Program Activities by Community:* With input from the Bujumbura-based Tubaramure staff, the evaluation team developed a sample list of program activities by IR;
- *Qualitative Ranking of the Activities in Each Colline:* Based on this initial list, the two provincial program managers were asked to facilitate a group discussion with their program staff from the Cankuzo and Ruyigi provinces, during which the staff would conduct a qualitative ranking of the principal activities for each IR based on their current level of performance and the prospects of this performance being sustained at its current level after the program ended. To facilitate this group exercise, the teams were asked to rank each activity in each *colline* on a scale of 1-3, with 1 being the highest and 3 being the lowest. This assessment was then color coded¹⁹ and reviewed by all of the senior technical staff in each province;
- *Qualitative Ranking of the Collines by Their Performance on Key Activities:* Based on this number, Dr. Sidibe grouped all of the communities into three clusters (Table 1.3). The first cluster included the villages where the staff’s ranking of the activities indicated that most of the activities were classified as performing well (level 1) with levels of community and technical support that made it likely that they would be sustained at current levels once the program funding ended. The second cluster included villages where most of the activities were ranked at level 2. The third cluster included villages where most of the activities were ranked at level 3; and
- *Selection of Sample Collines from the Clusters:* Based on this initial cluster, the lead consultant for nutrition and health identified a sample of 21 *collines* from the different clusters—13 from Ruyigi and eight from Cankuzo (Table 1.3).

Table 1.3. Retroactive Qualitative Classification of Tubaramure Villages Used to Determine the Sample Frame for the Final Qualitative Survey Focus Group Discussions

<i>Colline</i> Clusters	Ruyigi/Cankuzo	
	All <i>Collines</i> ²⁰	<i>Collines</i> Surveyed
Performing well/results most likely to be sustained at current levels even after the program funding ends	63 (26.5%)	6 (28.6%)
Average performance/ results likely to be sustained but at lower than current levels	151 (63.5%)	12 (57.1%)
Poor performance/results least likely to be sustained	24 (10.0%)	3 (14.3%)
Total	238	21

Source: Tubaramure Program Final Evaluation; August 2014.

4.5.2. Step Two: Initial Enumerator Training, Focus Group Discussions, and Key Informant Interviews (July 14-23, 2014, Ruyigi). The second week, the team moved to Ruyigi. During the first two days, the enumerators reviewed the initial translation of the questionnaire. This enabled the team to adjust the formulation of certain questions and to determine the most appropriate composition of the focus groups. The enumerators—under the direct supervision of Dr. Sidibe with assistance from the two translators for supervision and quality control—conducted the interviews in 13 *collines*. An initial stakeholder debriefing was conducted on July 23 in Ruyigi.

¹⁹ Activities that were ranked level 1 were color coded green; those ranked level 2 were color coded yellow; and those ranked level 3 were color coded red.

²⁰ Excludes the 60 *collines* included in the IFPRI/FANTA survey.

Working with Dr. Sidibe each evening, the enumerators prepared summary testimonials and analyses by category of informant that were then transcribed into English (See Annex III for a blank copy of the focus group discussion guides in their original format (French); Annex IV for a typed summary of the interviews in English; and Annex V for exemplary testimonials given by different categories of beneficiaries during the focus group discussions in English).

4.5.3. Step Three: Enumerator Training, Focus Group Discussions, Key Informant Interviews, and Partial Stakeholder Debriefing (July 23-29, 2014, Cankuzo). The team started the focus group discussions and key informant interviews in Cankuzo on July 24 and conducted a second stakeholder debriefing on July 29 in Cankuzo.

4.5.4. Step Four: Analysis and Write Up, Follow Up Key Informant Interviews, and Three Stakeholder Debriefings (July 30-August 7, 2014, Bujumbura). On July 30, the team returned to Bujumbura, where the activities focused on finalizing some of the missing quantitative analyses based on the final quantitative survey and conducting three additional stakeholder analyses.

4.5.5. Step Five: Final Write Up and Editing (August 2-24, 2014). Based on input from the stakeholder debriefings and the results of the focus group discussions and quantitative survey, the consultants developed an English version of the draft. Final editing was conducted by the consultants in collaboration with editor Lynn Hurtak.

4.6. Total Number of People Interviewed During Final Evaluation

The team interviewed 657 persons in 50 focus groups (Table 1.4); another 113 during key informant interviews in the two provinces; and 19 with program, government, and USAID staff in Bujumbura (Table 1.5). In addition to this, the team conducted five debriefing sessions and one ‘up-briefing’ of the methodology attended by 116 persons (Table 1.6). The debriefing sessions provided useful feedback on the quantitative analyses, lessons learned, and recommendations.

Table 1.4. Number of People Interviewed in the Tubaramure Final Evaluation Focus Groups, July 2014

Category of Community-Based Beneficiary	Ruyigi				Cankuzo			
	# Focus Groups	# Persons Encountered			# Focus Groups	# Persons Encountered		
		Male	Female	Total		Male	Female	Total
Care Group/LMs	6		80	80	4		43	43
Graduated mothers	7		138	138	7		85	85
Saving and Internal Lending Community (SILC) members	5	8	58	66	6	19	40	59
Agro-pastoral groups (<i>groupements</i>)	3	5	24	29	4	14	45	59
Husbands of beneficiary group members/fathers of beneficiary children	4	64		64	4	34		34
Total	25	77	300	377	25	67	213	280

Source: Tubaramure Program Final Evaluation; August 2014.

Table 1.5. Number of Key Informant Interviews in the Tubaramure Final Evaluation, July 2014

Category of Key Informant	Ruyigi	Cankuzo	National and International
Local <i>colline</i> authorities	10	4	
MoH personnel: nurses/ medical assistants/medical doctors/Public Health Technicians	21	10	
Technical staff of Tubaramure Program, including the Tubaramure Health Promoters	18	12	
MoH Community Health Workers	9	6	
Other government partners (governor, technical services)	13	10	
ISTEEBU			1
MoH national staff			1
CRS national program current and former staff			7
FH national program staff			4
IMC national program staff			2
Caritas program staff			2
USAID/Burundi			2
Total	71	42	19

Source: Tubaramure Program Final Evaluation; August 2014.

Table 1.6. Approximate Number of People Who Attended Workshops Associated With the Final Evaluation of the Tubaramure Program

Date	Location	Total Number of Staff and Government	Total Number of Consultants, Enumerators, and Translators
July 23, 2014	Ruyigi	22	11
July 29, 2014	Cankuzo	13	11
August 1, 2014	Bujumbura	36	2
August 4, 2014	Bujumbura	11	2
August 5, 2014	Bujumbura	34	2
Total		116	NA

Methodology: Based on the official meeting records that were summarized by the Tubaramure M&E office.

Source: Tubaramure M&E Office; August 2014.

5.0. Organization of the Report

Chapters Two-Four provide a brief overview of the major findings of the evaluation as outlined in the approved SOW.²¹ To facilitate a cross-examination of the major findings between the chapters, each chapter follows the same basic format that examines the following for each of the program's three IRs:

- *Original Strategy:* The 'theory of change' that the activities were designed to address;
- *Evolution of Activities (Years 1-5):* The evolution of the program's activities related to that particular IR before the mid-term evaluation and any changes that were introduced afterward;

²¹ As indicated in Section 4.3 of this chapter, in addition to the general objectives of the evaluation, the evaluation outlined seven specific objectives for the evaluation and 11 key questions for IR1; and 11 specific objectives for the evaluation and 25 specific questions for IR2 and IR3. A complete list of the questions is provided in Annex I.A to facilitate a cross-reference to where the questions are addressed in the main text. When questions are addressed, they are also noted in the text's footnotes.

- *Evidence of Results*: The early evidence of achievement of the principal program outputs and outcomes for that particular output, and some of the key factors that affected these outputs and outcomes—i.e. the results and effects of the different activities, the effectiveness of the implementation process, and the likelihood that the outputs and outcomes would be sustained; and
- *Lessons Learned and Recommendations*: The major lessons that can be learned from the experience for future programs in Burundi as well as other PM2A programs in other countries.

Chapter Five evaluates the overall program impact of the principal program outcomes and the outcomes that are most likely to be sustained once program funding ends.

This is followed by six annexes that present:

- The cross-cutting questions that the final evaluation team was asked to address, as well as the final approved scopes of work for the team leader/evaluation specialist and the nutrition specialist on the team (Annex I);
- The final Indicator Performance Tracking Table (IPTT) for the program (Annex II);
- The interview guides used in the qualitative survey (Annex III);
- A summary of the major results of the qualitative survey for each guide (Annex IV);
- As well as key testimonials (Annex V); and
- Additional tables for each of the main chapters (Annex VI).

Chapter 2

Intermediate Result 1: Women and Children Under 5 Access Quality Nutrition and Health Services

1.0. Global Strategy

1.1. Expected Outputs

The activities under the first intermediate result (IR1) of the Tubaramure Program were designed to strengthen the capacity of the Ministry of Health (MoH) facilities and volunteer Community Health Workers to deliver high-quality general health and nutrition services. The program was designed to support MoH’s efforts to improve the quality of health services—including Integrated Management of Childhood Illness (IMCI), growth monitoring (GM), and Community-Based Management of Acute Malnutrition (CMAM)—and to break the barriers to access.²² The activities were designed to achieve four outputs (Table 2.1). International Medical Corps (IMC) is the technical lead for this IR.

Table 2.1. Major Outputs Designed to Achieve the Tubaramure Program’s IR1

IR1. Women and children under 5 access quality nutrition and health services.
Output 1.1. Pregnant and lactating women access pre and postnatal care services.
Output 1.2. Implementation of national Integrated Management of Childhood Illness (IMCI) plan is supported.
Output 1.3. Health facilities supported in providing growth monitoring (GM).
Output 1.4. Severe acute malnutrition (SAM) is detected and referred for treatment.

Source: CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS.

1.2. The Original Intervention Model

To achieve these four outputs, the Tubaramure Multi-Year Assistance Program (MYAP) outlined a three-pronged strategy for IR1 that focused on:

- **Training:** Teaching the MoH’s clinical (i.e. health center-based) and volunteer Community Health Workers and their supervisors (the MoH Public Health Technicians) the basic principles of nutrition and the tools (e.g. pre and postnatal care, growth-monitoring promotion, integrated management of childhood diseases, and the Community Health Worker integrated manual) they would need to diagnose, treat, and prevent malnutrition;
- **Material Support:** Helping the new and existing centers offer better clinical support for both malnutrition prevention and treatment, as well as general services; and
- **Monitoring and Supervision:** Providing logistical and technical training for:
 - *Supportive supervision* by the Tubaramure IR1 technical staff to promote on-the-job training of MoH staff (those who were trained as well as those who were not);
 - *Joint supervision* by Tubaramure IR1 and MoH staff for routine tracking, as well as the implementation of the new protocols being revised under IR1; and
 - *Coordination meetings* that bring together the different government and non-governmental organization (NGO) actors involved in community-based health and nutrition activities in both provinces.

²² CRS; 2009. *Tubaramure Multi-Year Assistance Program (MYAP) Proposal*. Bujumbura: CRS.

2.0. Activities^{23 24}

The Tubaramure program facilitated and supported the training of MoH personnel and Community Health Workers using the MoH's available protocols, trainers, and training materials.

2.1. Trainings

2.1.1. Technical and Logistical Support to Update and Revision of Existing MoH Modules. All of IR trainings of MoH were designed to complement one of the existing MoH protocols (Annex VI.A.1 and VI.A.2). In 2009-2010, the program worked in close collaboration with the MoH to update most of the protocols and their training modules. Two types of support were provided (Table 2.2):

- Simple technical support to revise the protocols in ways that would best take into account the decentralization and new innovations being recommended by the World Health Organization (WHO), United Nations Children's Fund (UNICEF), or other international donors; and
- Logistical support to support various workshops associated with the conception, elaboration, revision, and validation of the protocols.

²³ **SOW Key Question 1:** Are the health component activities being implemented according the Detailed Implementation Plan (DIP)? What are the obstacles and the delays observed? What recommendations can be done for future programs?

²⁴ *SOW Specific Objective 1:* Assess the overall achievements of the health component of the program (IR1).

Table 2.2. Technical and Logistical Support Provided by the Tubaramure Program for the Revision of the Major Protocols that Supported the MoH's Nutrition Strategy, 2009-2014

Major MoH Protocols to Which the Tubaramure Staff Contributed	Technical Support and Period Provided	Logistical Support for Workshops at Different Level of the MoH
Clinical-Level Trainings		
IMCI or <i>Prise en Charge Intégrée des Maladies de l'Enfance</i> (PCIME) ²⁵	2009-2012	2010-2012 (national and provincial)
CMAM or <i>Prise en Charge Communautaire de la Malnutrition Aigüe</i> (PCMA) ²⁶	2010	2010-2012 (provincial)
GM or <i>Suivi Promotion de la Croissance</i> (SPC) ²⁷	Not yet completed	2010-2011 to review the draft (provincial)
Prenatal consultation (CPN) ²⁸	CPN 2011	2010-2012 (national and provincial)
Postnatal consultation (CPoN) ²⁹	CPoN 2012	2010-2012 (national and provincial)
Community-Level Trainings		
IMCI/CMAM/GM/CPN/CPoN (<i>community based</i>) ³⁰	2010 (module in Kirundi)	2010 (provincial)
The Integrated Manual for Community Health Workers (<i>Manuel Intégrer des Agents de Santé Communautaire</i>) ³¹	2012 -2013	2012-2013 (provincial)
Management Trainings		
Data management and reporting	N/A	May 2011

Source: IMC Country Director Basile Ndumbi, IMC Program Manager Hervé Ketsobou, and IMC Site Manager Jean Paul Cubaka; August 5, 2014.

In addition to the four core areas—IMCI, CMAM and severe acute malnutrition (SAM), GM, prenatal consultation/postnatal consultation (CPN/CPoN)—the MoH organized complementary trainings at the request of the MoH provincial offices on:

- The *Manuel Intégré des Agents de Santé Communautaire*, popularly known in Kirundi as the *Guide Dagadaga*, for the 534 existing and 633 new MoH Community Health Workers recruited in 2012-2013;³² and
- The *Programme National Intégré d'Alimentation et de Nutrition* (PRONIANUT) manual on management and reporting to help guide the provincial-level health officials in

²⁵ **Training manual used for clinical-level training of doctors and nurses:** MSPLS; 2012. *Prise en Charge intégrée des maladies de l'enfant (PCIME) Livret des Tableaux*. Bujumbura: IMC for Tubaramure. **Training manual used for training of the community-level workers** (MoH Public Health Technicians and Community Health Workers, and Tubaramure Health Promoters): MSPLS.2010. *Livret des tableaux Dagadaga à l'usage de l'agent de santé communautaire*. Bujumbura: IMC for Tubaramure.

²⁶ **Training manual used:** MSPLS; 2010. *Protocole national de prise en charge intégrée de la malnutrition aigüe*. Bujumbura: IMC for Tubaramure.

²⁷ Protocol is in the process of being revised.

²⁸ **Training manual used:** MSPLS; 2011. *Module de formation des prestataires sur la consultation prénatale recentrée*. Bujumbura: IMC for Tubaramure.

²⁹ MSPLS. 2012. *Module de formation des prestataires en santé sur la consultation postnatale*. Bujumbura: IMC for Tubaramure.

³⁰ **Training manual used:** MSPLS; N.D. *IMCI/CMAM/CPN/CPoN community based*. Bujumbura: IMC for Tubaramure.

³¹ **Training manual used:** MSPLS; 2012. *Manuel Intégré des Agents de Santé Communautaire*. Bujumbura: IMC for Tubaramure.

backstopping the head doctors (*médecins chefs*) in the newly created health districts in 2011.

2.1.2. Training of Trainers. The program used the MoH trainers to conduct the trainings both at the district and provincial levels. Prior to each training on each protocol, referred to as ‘activities’ in the health centers, the Tubaramure Program trained at least one trainer on it. Some of these training-of-trainer sessions were organized at the national level; others were organized in the two provinces. Most of the trainers were doctors, though a number of district and provincial-level MoH supervisors were also trained as trainers. Most training-of-trainer sessions were conducted one to two weeks before the training sessions started. The length of training varied according to the theme.

2.1.3. Clinical Trainings. The Tubaramure Program document anticipated two cycles of training over the course of the program: in 2010-2011 and 2012-2013 (Annex VI.A.3). Each cycle included two sessions during which one person from each health center was trained on all four core areas that the program supported—IMCI, CMAM, GM, CPN/CPoN. This planning was respected for all of the protocols except for GM, where the course was offered only in the first session since the MoH protocol was never validated. Based on feedback from the MoH in conjunction with the preparation of the program’s exit strategy, a third cycle of CMAM training³³ was offered in 2014.

2.1.4. Community-Level Trainings. All community training followed a cascade model in which the Tubaramure trained the MoH Public Health Technicians and local managers for each health center (*les Titulaires*). The training was conducted by MoH trainers from the PRONIANUT office. Each Public Health Technician was then expected to train the Community Health Workers through a series of community-level trainings.

In addition to this cascade training on the basic protocols, each of the Public Health Technicians and Tubaramure Health Promoters were trained on how to use a combined module—which is commonly referred to as *Guide Dagadaga* in Kirundi (known officially as the IMCI/CMAM/GM/CPN/CPoN module) or the *Manuel Intégré des Agents de Santé Communautaire*³⁴—that summarized all the community-level nutrition activities being conducted in the communities. Each MoH Public Health Technician was then expected to continue to train and retrain the Community Health Workers that he or she supervised in conjunction with the regular meetings they held with the volunteers at the local health centers.

In 2012, the MoH increased the number of Community Health Workers from 534 to 1,167. Once this happened, both MoH provincial offices asked the Tubaramure Program to help train the health workers on the newly validated *Dagadaga*.

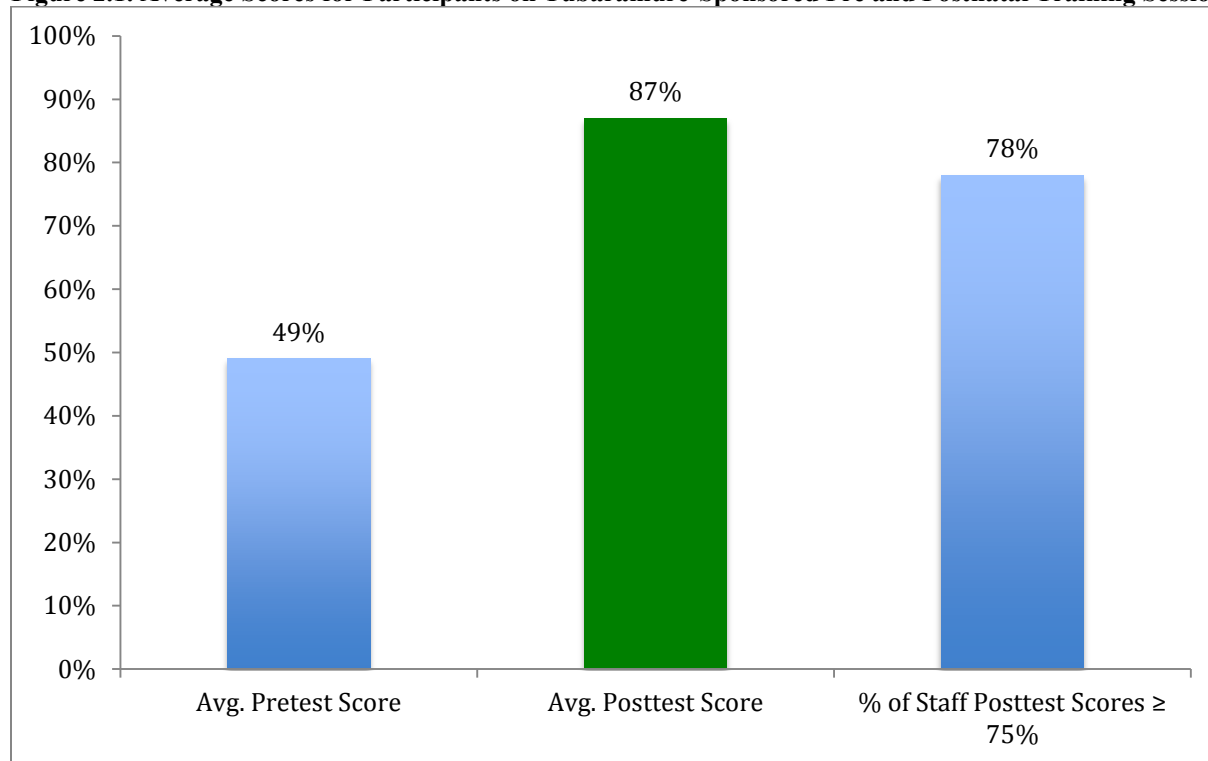
2.1.5. Pre and Posttest and Final Report. All trainings included pre and posttests. All pre and posttest scores were monitored by the monitoring and evaluation (M&E) officer of the Tubaramure technical lead for IR1. In addition, a separate report was generated on each training session by the technical lead for IR1. Based on the raw data on individual pre and posttests

³³ One nurse and one support staff member.

³⁴ MoH; 2012. *Manuel Intégré des Agents de Santé Communautaire*. Bujumbura: IMC for Tubaramure.

for 106 participants in one category of training (CPN and CPoN) that the IR1 leads felt was representative of the others, the evaluation team calculated that the average student score increased from 49% (out of 100) at baseline to 87%; and that 78% of the trainees scored higher than 75% (Figure 2.1).

Figure 2.1. Average Scores for Participants on Tubaramure-Sponsored Pre and Postnatal Training Sessions



Methodology: Based on the scores recorded for pretest and posttests of 106 trainees from sessions organized in Ruyigi and Cankuzo in September 2010, January 2011, February 2011, and March 2011.

Source: Analysis by Sidibe Sidikiba from data provided by IMC; October 15, 2014.

2.1.6. *Total Number of People Trained.* This system of training enabled the MoH to train 1,167 people at every level of the system (Table 2.3).

Table 2.3. Number of People in Different Target Groups Trained by the Tubaramure Program in Different Protocols, 2009-2014

Training Area	Category of Participants	Total Number Trained (2009-2014)
IMCI clinical	Doctors	9
	Nurses	250
	Medical assistants	0
CMAM	Nurses	229
	Doctors	8
	Medical assistants	215
GM	Doctors	0
	Nurses	105
	Medical assistants	93
CPN/CPoN	Doctors	0
	Nurses	236
	Medical assistants	0
IMCI/CMAM/GM/CPN/CPoN (community-based)	Doctors	6
	Nurses	9
	MoH Public Health Technicians	23
	Tubaramure Health Promoters	35
	MoH Community Health Workers	534
Management and reporting	Health information systems agents (SIS agents)	9
Supervision	Doctors	20
	Nurses	20
Integrated Manual for Community Health Workers	Nurses	58
	MoH Public Health Technicians	26
	MoH Community Health Workers	1,167

Source: IMC Program Manager Hervé Ketsebou and IMC Site Manager Jean Paul Cubaka; August 5, 2014.

2.1.7. *Link Between Training and the Program's IR2 Activities.* Most of the Tubaramure Health Promoters who were hired before 2013 were trained in all four modules as well as the Care Group Model (see Chapter 3). It was expected that they would then train the Tubaramure Leader Mothers (LMs) as well as the MoH Community Health Workers in the local communities. In June 2014, the program conducted the baseline training of all the MoH Public Health Technicians who supervised the Community Health Workers. The technicians were trained in the IR2 modules as they rolled out. Given the high rates of turnover in MoH staff, the program conducted a single comprehensive training on the five IR2 modules in a joint session with the Tubaramure Health Promoters as part of the program's closeout plan in July 2014.^{35 36}

³⁵ All of the Tubaramure Health Promoters had extensive baseline training and retraining on the modules earlier in the program.

³⁶ Since the five modules were not validated at the national level by the MoH as official training documents for the MoH Community Health Workers, they were not part of the standard approved (i.e. 'validated') set of modules for the MoH public workers during the program.

2.2. Material Support

From the beginning, the Tubaramure Program anticipated donating medical and non-medical equipment and supplies to each of the new and established health centers (*centres de santé* or CDSs). Each center was asked to identify their priority needs within a certain budget limit. Staff encountered during the final evaluation reported that the equipment helped them improve service quality.³⁷ The impact of this material support was especially pronounced in the new centers, many of which were more-or-less non-functional before the support was given (Table 2.4).

2.3. Monitoring and Supervision

2.3.1. Supervision Missions. Two types of supervision missions were planned to strengthen the program's clinical and community-based programs:

- *Supportive supervision missions:* Each IR1 provincial coordinator was expected to conduct a routine supervision mission in each of the centers twice a month; and
- *Joint supervision missions:* Each quarter, the IR1 provincial coordinator organized joint supervision missions with the district and provincial-level MoH doctors to every health center in their jurisdiction. Several national-level health specialists in the MoH participated in these missions.

Table 2.4. Qualitative Assessment of the Early Impact of PM2A Donations to Health Centers in Cankuzo and Ruyigi Provinces

Sanitary Infrastructure	Total	Supported	Rendered Functional Due to Support	Where Support Helped Considerably Improve Quality of Health Services
Cankuzo				
CDSs in 2009	23	23	3	23
CDSs in 2014	28	28	8	28
Ruyigi				
CDSs in 2009	27	27	All were already functional	27
CDSs in 2014	33	33	All were already functional	33

Source: IMC Country Director Basile Ndumbi, IMC Program Manager Hervé Ketsebou, and IMC Site Manager Jean Paul Cubaka; August 5, 2014.

During the final-evaluation key informant interviews, most staff stated that the interviews were helpful at two levels (Annex VI.A.4):

- They enabled the staff and IR1 technical advisors to correct certain errors in the application of the revised protocols that were being taught during the training exercises; and
- Local supervisors participating in the supervision missions helped involve them in the execution of the activities being supported under each protocol.

2.3.2. Assistance with the Creation and Analysis of Indicators. To strengthen the reporting on the MoH's protocols, the program organized a series of trainings on data management and reporting

³⁷ Given the expected wear and tear on the equipment, the program planned to re-equip all of the centers with new material to ensure that all of it was operational when the program ended. This occurred in August 2014.

in 2010. In addition to this training, Tubaramure provided short-term technical support to the provincial MoH offices and health districts for the elaboration of routine reports on nutrition. This assistance was greatly appreciated by some of the staff that the evaluation team interviewed, who stated that it helped them better understand some of the new indicators and reporting forms (Text Box 2.1).³⁸ There is also a great deal of qualitative evidence from the interviews with senior MoH staff at the district, provincial, and national level that this training increased the quality of the data received and the speed with which the MoH was able to report on some of the required indicators for nutrition.

Text Box 2.1. Lesson Learned: Critical Importance of Building MoH Capacity for Nutritional Data Collection and Analysis—a Win-Win for Program Planning

During the first year, the Tubaramure staff realized that the MoH service providers had very little background in either the collection, analysis, or reporting of MoH's required indicators for nutrition. Since 2010, the local MoH health centers have been required to report on these indicators.

To overcome this situation, the Tubaramure Program trained all of the district and provincial-level health information system agents in the collection, analysis, and reporting of nutritional data. The trainers were staff from the national MoH PRONIANUT office that backstops all of the MoH's nutrition programs. It was anticipated that the health information systems staff would then train the health center providers with technical backup from the Tubaramure IR1 staff during their routine monthly supportive supervision and quarterly joint coordination missions.

These combined efforts helped to improve the quality of the collection and interpretation of the nutrition indicators at the level of the health centers, health districts, and provinces. Since some of the same indicators were being reported by the national government as part of their internal MoH and performance-based financing (PBF)³⁹ indicators, this assistance helped strengthen the provincial and district-level interest in executing and sustaining the Tubaramure activities in the health centers.

Source: IMC Program Manager Hervé Ketsebou; August 2014

2.4. Coordination Meetings

The program was instrumental in helping the MoH start a number of inter-agency coordination meetings through IR1 support. One that was especially important was a quarterly meeting of all the health sector actors, including all of the 'vertical' and NGO⁴⁰ health and nutrition actors in

³⁸ **SOW Key Question 6:** How the mid-term evaluation recommendations were taken into account for improving the program implementation?

³⁹ In 2005, the Government of Burundi (GoB) decreed that all health services for children under the age of 5, pregnant women, and women with postnatal complications linked to pregnancy should be free. There were, however, a number of problems linked to delays in reimbursing the health structures (for example, overbilling for medical services, overburdened health personnel with decreased motivation to provide good services, and lack of medicines and equipment), all of which delayed the effective implementation of this government initiative. To deal with the difficulties, the MoH decided to fund a performance-based financing (PBF) system for financing the free health package that linked funding to performance. The PBF has thus become a system for funding health services that is based on results and a contractual relationship between different actors in the GoB's health services. Health centers are reimbursed based on their performance on a group of pre-determined indicators. This system was pilot tested in three provinces in 2006, then extended to the entire country after April 1, 2010.

⁴⁰ NGOs in Cankuzo province include: World Vision, *Federation Luthérienne Mondaile* (FLM) at Cankuzo, and Catholic Organization for Relief and Development Aid (Cordaid); NGOs in Ruyigi province include: International Red Cross (IRC), Action Aid, Food for the Hungry (FH), Catholic Relief Services (CRS), Croix Rouge, Maison Shalom, and Swaa Burundi.

the province, as well as the governor or his representative and the local authorities. These quarterly meetings have met regularly since the second year (Annex VI.A.5).

Given the critical importance of these meetings in facilitating the coordination between different health sector actors, the Tubaramure IR1 exit plan started a progressive phase out of its support to these meetings in June 2013, in which one of the other sector actors (like World Vision) would be asked to support the costs of the meeting for every two meetings that Tubaramure supported. In 2012, the MoH, with Tubaramure support, started two additional coordination meetings designed to strengthen the province's community-level health in nutrition services (Annex VI. A.5):

- A quarterly community-level health coordination meeting that brought together the different government and NGO actors (including Tubaramure) working on community-based health approaches; and
- A monthly commune-level meeting during which the MoH Community Health Workers were expected to present their reports to their supervising MoH Public Health Technician.

The evaluation team met with governors and most administrators, who cited coordination meetings as an example of a best practice that helped improve the coordination between the different sector actors. The coordination meetings were attended by people at every level of the public health service, and by the most active local and international NGOs that worked on health and nutrition programs.

The same meetings helped to clarify different aspects of the Tubaramure Program, including the progressive graduation of the beneficiaries and clarification of various issues—like why some of the test villages in the International Food Policy Research Institute/Food and Nutrition Technical Assistance Project (IFPRI/FANTA) study were not eligible for food and why the district-level ambulances might sometimes be needed to transport a severely malnourished child to a stabilization center (Text Box 2.2). The evaluation team also noted that the quarterly meetings held with the support of the program allowed the various stakeholders in the health and nutrition programs to discuss the health problems and to find possible solutions together (Text Box 2.2).

Given the importance of these meetings, the Tubaramure Program exit strategy planned for a withdrawal of its logistical and technical support for the meetings. Since July 2014, one of the other area donors (like World Vision) has supported one of the quarterly meetings for every meeting funded by Tubaramure. Unfortunately, the commune-level meetings stopped in January 2014, since no donor is willing to cover the costs.

Text Box 2.2. Lesson Learned: Case Studies of How the Tubaramure Program’s Support to the Quarterly Coordination Meetings Helped Increase Program Efficiency, Impact, and Sustainability

- 1. Improved coordination of activities with the program:** During one quarterly planning meeting, the health authorities and the participants realized that both World Vision and Tubaramure (IR1) were planning to support community-based monitoring in the same *colline* (community). Based on these discussions, Tubaramure decided to move their community-based GM to another *colline*. Given the progressive scale up of community-based GM programs to sustaining the Tubaramure achievements, this was an example of good coordination in the field that avoided duplication of activities.
- 2. Better control over fraud:** In the meeting discussions, the participants identified a number of cases where the local MoH Public Health Technicians had committed fraud during the 2013 recruitment campaign to increase the number of Community Health Workers. Based on the evidence that was presented during the meetings, the offending Public Health Technicians were transferred and the process for recruiting the Community Health Workers was re-opened in the affected *collines*. This type of transparent nomination of the Community Health Worker volunteers is critical to sustaining the Tubaramure Program’s activities, especially those of the LMs, who were often applying to be Community Health Workers.
- 3. Improved access to critical complementary support like ambulances:** The transfer of patients across the province for emergency treatment is always a challenge, especially in terms of cost for the operation of the ambulance. For this reason, some emergencies—like those related to transporting malnourished children—were not eligible for this support when the program started. One output of the quarterly meetings was to build the local authorities’ understanding of local needs. In February 2012, a decision was made that each household would contribute to a commune-level fund that would pay the cost of emergency transport for at-risk children as well as other urgent cases in a timely manner.

Source: Jean Paul Cubaka; August 2014; and IMC Program Manager Hervé Ketsebou; February 2012. *Rapport de la réunion de coordination des partenaires en santé*. Bujumbura: IMC for Tubaramure. Pg 6.

3.0. Evidence of Results

3.1. Output 1.1: Pregnant and Lactating Women Access Quality Pre and Postnatal Services⁴¹

The Tubaramure IR1 strategy for increasing pregnant and lactating women’s access to quality pre and postnatal services focused on increasing the quality of the prenatal consultation services by:

- Improving service quality;
- Increasing the demand for women’s understanding of why prenatal consultations are important through the IR2 BCC activities; and
- ‘Jumpstarting’ women’s willingness and ability to attend the government’s recommended package of prenatal and postnatal consultations a requirement for remaining eligible for PM2A food rations.

3.1.1. Activities (2010-Mid-Term). By mid-term, about half of the total number of health centers had at least two staff members who had completed the pre and postnatal program in-service training, and that number remained constant even with high levels of staff turnover. One direct impact of the high rates of MoH staff mobility and the limited opportunities for training new staff (since the training was only offered twice during four years) was that the total number of health centers never achieved the program target of 75% trained (Table 2.5).

⁴¹ **SOW Key Question 3:** What interventions have been more or less successful in meeting targets?

Table 2.5. Tubaramure PM2A Program Indicators Used to Track MoH Capacity and Community Demand for Pre and Postnatal Consultations, 2010-2014

IR1 Key Program Indicators	Baseline* 2010	Mid-Term 2012	Endline 2014*	Life of Activity (LOA) Target*
Output Indicators				
1.5. Percentage of women registered for prenatal service by the sixth month of pregnancy	80.1*	N/A	95.1*	95.0
1.6. Percentage of health facilities with two or more staff who completed in-service training in pre/postnatal services	0.0	46.0	57.0	75.0
Outcome Indicators				
1.1. <i>Original Indicator:</i> Percentage of women completing the package of four prenatal visits	28.9	64.1**	50.3	98.0
1.1. <i>Mid-Term Revision of Indicator:</i> Percentage of women completing the package of three prenatal visits	N/A	94.0**	83.4	98.0
1.2. <i>Original Indicator:</i> Percentage of women completing the package of three postnatal visits	5.0	19.1**	3.1	75.0
1.2. <i>Mid-Term Revision of Indicator:</i> Percentage of women completing the package of two postnatal visits	N/A	33.2**	11.1	75.0

*Population-based (i.e. measured in the baseline household survey and final)

**For PM2A beneficiaries only.

Source: Tubaramure Indicator Performance Tracking Table (IPTT) (Annex II) and *Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)*; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A-Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014).

3.1.2. Mid-Term Evaluation Recommendations. The mid-term evaluation report found that: “Despite increased efforts, only 61% of pregnant women are completing four prenatal visits, and only 12% are completing three postnatal visits. [Based on this information] a suggestion was made by the Tubaramure team to lower the end of program targets. [However, the mid-term evaluation team concluded] it is better to keep the targets high (i.e. at 98% for prenatal consultations and 75% for postnatal consultations) and revert instead to the original indicators of three prenatal and two postnatal visits.”⁴²

In response to one of the mid-term recommendations, the program conducted a barrier analysis in conjunction with its routine performance evaluation to see why the rate of prenatal and postnatal consultations was not increasing.⁴³ This study made seven recommendations to the program for increasing the rate of prenatal and postnatal consultations (Text Box 2.3).⁴⁴ In response to these recommendations, the program worked with the MoH to intensify the existing efforts to promote pre and postnatal consultations. These efforts, which were often commented on in the key informant interviews during the final evaluation, included:

⁴² Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure (July 2012). Pg. 14.

⁴³ *Tubaramure Equipe de Suivi Evaluation*; 2012. *Etude sur les Obstacles à l'Adoption des Bonnes Pratiques en Matière de Santé, Nutrition et Hygiène, dans les provinces de Ruyigi et Cankuzo. Rapport Final*. Bujumbura: Tubaramure M&E Office (December 2012). Pp. 6-8.

⁴⁴ The percentage of women who complete the recommended package of prenatal consultations is one of the PBF indicators, so it is one that is monitored very closely by the national MoH.

- A concerted effort by the MoH to encourage all the supervising head doctors to become directly involved in helping their clinic and community-level staff to understand the critical importance of pre and postnatal consultations;
- An effort by the program to get all of the civil authorities (at the province, commune, and *colline* levels) involved in promoting pre and postnatal consultation;
- An intensified discussion of pre and postnatal consultation in the Care Group training sessions that included specific guidelines for the promotion of pre and postnatal consultation by the LMs in the beneficiary groups they supported; and
- On-site promotions by the Tubaramure Health Promoters at the food distribution sites.

Text Box 2.3. Principal Recommendations of the 2012 Study on Obstacles to the Adoption of Good Practices on Health, Nutrition, and Hygiene for Increasing the Rate of Pre and Postnatal Consultations

Recommendations for increasing the rate of pre and postnatal consultations:

- Strengthen the development of more innovative public awareness programs on CPoN. It is important for women to dispel the common belief that they must take off all their clothes during a post-natal consultation.
- Replicate the types of beneficiary level public awareness campaigns that are done for CPN for CPoN. The Community Health Workers conduct intensive public awareness campaigns for CPN but not for CPoN. These public awareness programs need to be added to the work program for the Community Health Workers.
- Involve the commune-level administrators in order to ensure that these public awareness activities are sustained after the program ends.
- Improve the quality of the CPoN services in the MoH health centers. The Health Centers need to be more user friendly. They need to encourage women to participate in the CPoN activities. It is imperative that each CPoN have a strict protocol that clarifies the required number post-natal visits that a woman should have.
- Strengthen the husbands general understanding of the CPoN activities so that they understand them better and are involved in supporting them.
- Encourage the mothers to take the recommended dosage of Vitamin A and iron supplements. Most important, encourage all women coming in for CPoN activities to use mosquito nets.
- Lobby the MoH to make the CPoN activities free.

Source: Tubaramure M&E Office; 2012. *Etude sur les Obstacles a l'Adoption des Bonnes Pratiques en Matière de Santé Nutrition et Hygiène dans les Provinces de Ruyigi et Cankuzo*. Bujumbura: Tubaramure M&E Office.

3.1.3. Results.

3.1.3.1. Percentage of Women Completing Four Prenatal Visits. The national MoH protocol recommends pregnant women complete four prenatal visits. The final quantitative survey showed a 21-point increase in this indicator (population-based result) that was statistically significant ($p = 0.000$) (Table 2.4).

The same study showed the increased the number of mothers with children under 2 years of age who are able to recognize at least two of the four danger signs for pregnant women to 71.3% (population-based result).⁴⁵

3.1.3.2. Percentage of Women Completing Three Prenatal Visits. The number of women who completed the recommended number of prenatal visits is even higher if one measures the number

⁴⁵ Indicator 2.6; Annex II.

of women who completed at least three prenatal visits—which was the recommended revision of this indicator, 83.4% (population-based result) (Table 2.5). This quantitative data from the final household survey concurs with the qualitative information from the focus group discussions, which suggest that (Annex VI.A.6; Annexes IV and V):

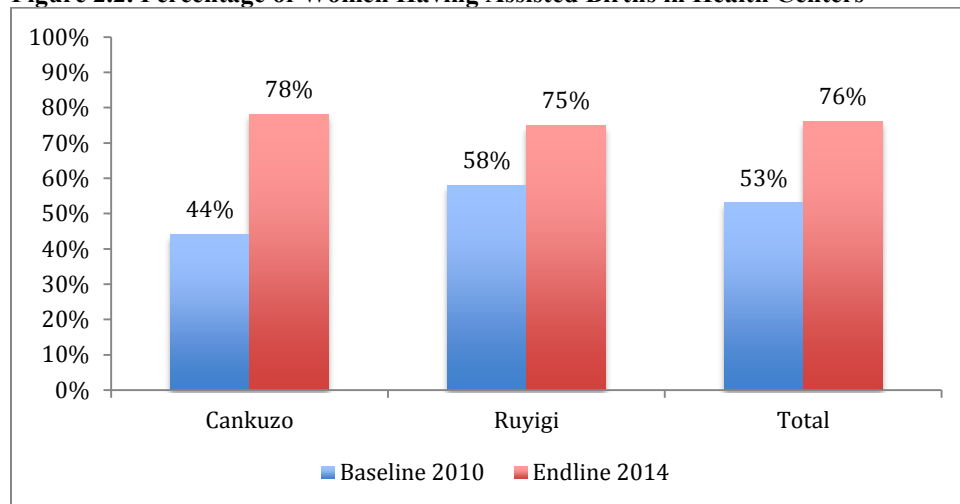
- The PM2A women graduates are motivated to continue attending the prenatal consultations at the health centers for new pregnancies even after graduation; and
- Non-beneficiary mothers (i.e. women who were not eligible to receive PM2A rations during the program) have also increased their attendance at prenatal consultations.

3.1.3.3. Percentage of Women Giving Birth in Health Center. The additional women coming to the health clinics for prenatal consultation increased the percentage of pregnant women choosing to give birth in the health centers (Figure 2.2). This data was confirmed by the health workers' qualitative assessments as well as the focus group discussions with both beneficiary and non-beneficiary women (Annexes IV and V). One focus group discussion in the Nyamasenga colline in Ruyigi summarized this, “*Women now do pre and postnatal consultations. This was not done before the program. Before, most mothers would deliver their babies at home. Many women suffered from fistulas and ignored why. Now most of the women deliver in health facilities because they are encouraged to during their prenatal consultations. Because of this, there are not as many cases of fistulas, and if there is one, the woman receives timely care. We have this knowledge because of the training that the program developed for us.*”

3.1.3.4. Percentage of Women Completing Recommended Number of Postnatal Visits. In contrast, the percentage of women who completed the recommended number of postnatal consultations remained very low, at 11.1% (Table 2.5). One of the most important reasons reported by the MoH and program staff is that postnatal consultation is not one of the top MoH priorities, either in terms of national health strategy or the indicators being tracked. This issue was confirmed in the focus group discussions with both beneficiary and non-beneficiary women (Annexes IV and V).

- In Kigamba colline, for example, the women said that none of the health agents they encountered when giving birth emphasized the importance of returning for any sort of postnatal consultation: “*After giving birth, none of the delivery agents told us to return for any postnatal consultation; even the LMs didn't emphasize this;*”
- Some women said that when they came to the health centers for postnatal care, they were made to wait for hours while the nurses dealt with more urgent curative consultations. Many of the mothers also complained that they only received advice with out any additional medication, food, vitamins, or other support; and
- Many of the women interviewed stated that if they felt they were in good health after childbirth and they did not see any need for a postnatal consultation. And if there was no apparent reason to go (in terms of rations or ill health), their husbands would not like the idea of them taking the time off from field and house work to attend the postnatal consultation.

Figure 2.2. Percentage of Women Having Assisted Births in Health Centers



Source: ISTEEBU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A-Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pg. 34.

3.2. Output 1.2: Implementation of National IMCI Plan is Supported⁴⁶

CRS's previous MYAP suggested that children were frequently suffering bouts of diarrhea, acute respiratory infections, and malaria, which contributed to the burden of malnutrition. To address this issue, the Tubaramure IR1 strategy focused on:

- Increasing the number of MoH staff trained in IMCI;
- Training at least 50 LMs together with the Community Health Workers in Community-Based Integrated Management of Childhood Illness (C-IMCI); and
- Reinforcing the potential for the MoH staff and LMs to working together.

It was expected that the LMs trained in C-IMCI would refer children to a facility before an illness led to more severe malnutrition requiring in-house hospitalization or rehabilitation.

3.2.1. Activities (2010-Mid-Term). By mid-term, about half the health centers (46%) had at least two staff members trained in the new IMCI protocols, and 100% of the Community Health Workers on a simpler version of the protocols (Table 2.6). Although this represents a 31-point increase over the baseline, it was less than 50% of the original mid-term target for this indicator, which was 100% (Annex II). The program's below-average achievement on this indicator was attributed to the progressive installation of new health centers, understaffing of the new health centers, and high rates of staff turnover.

Although the mid-term evaluation report showed that the program had successfully increased the accuracy with which the health centers were diagnosing and treating children under 5 (Table 2.6), there was concern about the way this indicator was being measured.

⁴⁶ **SOW Key Question 3:** What interventions have been more or less successful in meeting targets?

Table 2.6. Evolution of Key Indicators Tracking MoH Capacity for IMCI Support at the Clinic and Community Level, 2009-2014

IR1 Key Program Indicators	Baseline 2010	Mid-Term 2012	Endline 2014	LOA Target
Output 1.2. Implementation of national IMCI plan is supported				
Output Indicators				
1.7. Percentage of health facilities with two staff members trained in IMCI protocol through MoH's IMCI office	15.0	46.0	72.0	100.0
1.8. Percentage of <i>collines</i> with two or more Community Health Workers trained in C-IMCI in target areas through MoH's IMCI office	0.0	100.0	100.0	70.0
Outcome Indicator				
1.4. <i>Original Indicator</i> : Percentage of health providers (facilities/ CHW) accurately assessing a child using IMCI protocols	0.0	55.0	48.0	80.0
1.4. <i>Mid-term Revision of Indicator</i> : Percentage of nurses accurately diagnosing and treating children under 5	0.0	N/A	100.0	80.0

Source: Tubaramure IPTT (Annex II of this report).

3.2.2. *Mid-Term Evaluation Report Recommendations (2012)*. The mid-term evaluation report recommended changing Indicator 1.4 to, “*Measure the nurse’s ability to diagnose and treat children under 5 correctly*” by either performing a test (similar to the posttest used during the training modules) at semi-annual intervals or looking at the number of nurses who have correctly completed their five algorithms out of all the nurses in the 50 clinics. The mid-term evaluation report also recommended the program, “*See whether the MoH’s IMC office provides training through the nursing schools and whether they might need support from the Tubaramure Program*” as a mechanism for increasing the supply of nurses with the necessary skills that the MoH needed to support its newly expanded nutrition programs.⁴⁷

3.2.3. Results.

3.2.3.1. *Percentage of Nurses Accurately Diagnosing and Treating Children Under 5*. To measure the impact of the MoH IMCI training programs, the IR2 technical lead developed a tool that it used to measure the accuracy with which the health center-based nurses were able to use the standard ‘algorithms’ (checklists) in the protocol.⁴⁸ Based on this indicator, all of the nurses interviewed were familiar with and able to use the algorithms by the end of the program, which is a significant over-achievement of the original target of 80% (Table 2.6). This information from the official tracking system corroborates the qualitative data from the key informant interviews with the nurses. Most of them stated that the basic training and supervision services they received under the program increased the quality of the diagnostic and treatment services they were able to offer (Text Box 2.4). The nurse’s chief complaint (from the key informant interviews) was that they did not receive a certificate to recognize their participation in the formal training sessions.

⁴⁷ Kathy Tilford, Ange Tingbo and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure: Pp. 27 and 20.

⁴⁸ This tool measured the competencies of a random sample of nurses—both those who had received the Tubaramure-sponsored training and those who had not. When asked whether they felt the measurement tool presented a very accurate assessment of their competencies, both the MoH and IMC staff responded, “yes.” This impression was further validated by the health and nutrition specialist on the final evaluation team.

Text Box 2.4. MoH Staff Members' Perceptions of the Impact of the Tubaramure Program on Their Capacity and Service Delivery

“Program officers through IMCI often came to work with us to support us in the work of prenatal consultation and prevention of malnutrition. We have received material (such as [mid-upper arm circumference] MUAC, food and recipe posters, flip charts, and a scale) through the PM2A program, which we use to monitor the growth of children and the weight of the pregnant women. Before, the nurses had no training on clinical IMCI. Thanks to the training received, we have become very knowledgeable and the quality of service and care have been greatly improved.”
Manager for the Nyagutoha Health Center.

“Before Tubaramure, I didn't have enough training in nutrition, especially for identifying malnutrition and treating it. After the training organized by our partners (IMC) and their supervision missions, we have been able to improve our center's systems for identifying malnourished children and referring the most severe cases to the stabilization centers for treatment. For moderate cases, we try to build the mother's awareness of the Essential Nutrition Actions (ENA) that we promoting with help from the Tubaramure Program.” Health staff member at the Ruyigi Health Center.

Source: Tubaramure Final Evaluation focus group discussions; July 2014.

3.3. Output 1.3: Health Facilities Supported in Providing GM^{49 50}

When the Tubaramure Program started, only about 40% of children under 5 participated in GM activities, and there were no community-based growth monitoring programs.

The Tubaramure consortium strategy for growth monitoring focused on:⁵¹

- Helping the MoH revise and finalize its 2009 draft protocol of facility-based GM;
- Supporting the MoH's “*anticipated roll out of community-based growth monitoring;*”⁵² and
- Incorporating key messages around the health center-based GM into the LM training under IR2.

3.3.1. Activities (2010-Mid-Term). Since the MoH never completed the projected revision of the draft protocol, the Tubaramure Program's activities focused on encouraging the active participation of mothers in the center-based GM program by training staff in improved techniques for measurement; upgrading the GM equipment for the centers (Table 2.7); and promoting the concept of GM through the community-based behavior change communication (BCC) programs.

Since participation in the center-based growth monitoring was a condition for getting PM2A rations, it is not surprising that the program's internal performance study showed an immediate and direct impact in percentage of beneficiary children⁵³ 0-36 months who attended growth

⁴⁹ **SOW Key Question 3:** What interventions have been more or less successful in meeting targets?

⁵⁰ *SOW Specific Objective 6: Evaluate the relevance, the effectiveness, and the performance of the implemented growth monitoring system, with regards to the national protocol.*

⁵¹ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS for Tubaramure. Pp 10-11.

⁵² CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS for Tubaramure. Pp. 10.

⁵³ The 2010, 2011, 2012, and 2013 figures in the IPTT for this indicator track the attendance of the PM2A beneficiary children in GM; they are not population based.

monitoring in a two month period (as recorded on a card): from 16% at baseline to 66% in 2012 at mid-term. The mid-term target was 75% (Annex II, Outcome Indicator 1.3).

Table 2.7. Tubaramure PM2A Program Indicators Used To Track Clinical and Community-Based Capacity for Growth Monitoring, 2009-2014

IR1 Key Program Indicators	Baseline 2010	Mid-Term 2012	Endline 2014	LOA Target
Output 1.3. Health facilities supported in providing GM.				
1.9. Number of communes with at least one functioning community-based GM center after Year 3	0	6	12	12
1.10. Percentage of health facilities with upgraded GM equipment	0.0	100.0	56.0	75.0

Source: Tubaramure IPTT (Annex II).

3.3.2. *Mid-Term Evaluation Recommendations (2012)*. One of the key concerns of the mid-term evaluation team was whether or not the beneficiary and non-beneficiary mothers would continue to bring their children in for GM once they were no longer eligible for PM2A rations. This was a legitimate concern since some of the mothers quit attending the beneficiary group meetings and Care Groups after they were no longer eligible to receive PM2A rations. To facilitate the transition and the program’s endline target of 90%, the evaluators made two recommendations, both of which were implemented by the program after the mid-term:⁵⁴

- Combine the health center-based GM with immunization days; and
- Execute all 12 pilot community-based GM programs that were envisioned in the original Tubaramure MYAP proposal.

Starting in 2012, the Tubaramure Program worked through the MoH Public Health Technicians to develop a pilot program in community-based GM. No additional training was given to the Public Health Technicians before starting the community-based GM because the basic training in GM was part of the training that the Public Health Technicians and Community Health Worker had already received on the new integrated manual. The Tubaramure IR1 specialists did, however, try to supervise the execution of the GM sessions during their monthly supervision visits.

3.3.3. Results.

3.3.3.1. *Percentage of Children 0-50 Months Attending GM*. One major impact of the Tubaramure Program’s integrated⁵⁵ program strategy for promoting GM was a very significant population-based increase in the percentage of children attending the health center-based GM system from 16% to 57.3%, even after the women were no longer eligible for PM2A rations.⁵⁶

⁵⁴ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure (July 2012). Pg. 29.

⁵⁵ The final evaluation team has decided to use the term ‘integrated’ to highlight the fact that a series of program supports and activities were focused on achieving the same output. These included making growth monitoring a condition of receiving rations under IR3; promoting growth monitoring through the BCC programs under IR2; and building MoH support for the activity under IR1.

⁵⁶ This represents an increase of 41.3 percentage points compared to the baseline (2009), giving a very statistically significant increase of over 258% (p = 0.000).

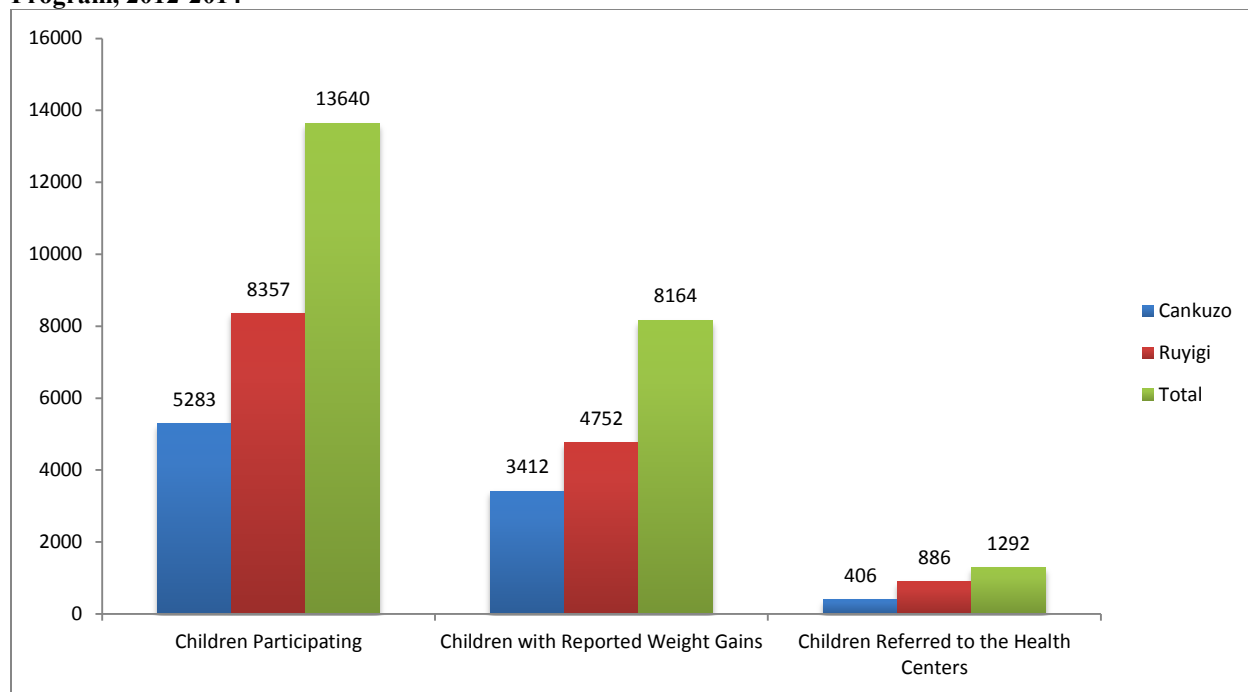
Although this represents a significant increase, it is still far less than the original Life of Activity (LOA) target of 90%. This is in large part because:

- The government never finalized its protocol for community-based GM; and, as a result,
- The concept of community-based GM (which Tubaramure supported) was never scaled up to all of the *collines* with appropriate support from the MoH and other donors.

3.3.3.2. Pilot Program for Community-Based GM.

Increased Referrals. The short-term impact of 12 pilot programs for community-based GM was a substantial increase in the number of children referred for either medical or health reasons from the 12 *collines* that were targeted by the activity. Most of the mothers in the affected *collines* who were interviewed in the focus groups stated that having community GM increased their willingness and ability to bring their children in regularly (Text Box 2.5.) Unfortunately, there was very little tracking data on the pilot study, other than what is presented in Table 2.8 and Figure 2.3, so it is difficult to document the actual recorded increase in the rate of enrollment that was associated with the community-based programs versus communities where all GM was clinic based.

Figure 2.3. Summary Data Collected on the 12 Pilot GM Sites Created Under the Tubaramure PM2A Program, 2012-2014



Source: Table 2.8.

Table 2.8. Summary Data Collected on the 12 Pilot Growth Monitoring Sites Created Under the Tubaramure PM2A Program, 2012-2014

Periods	Province	Data from the 12 Pilot Community-Based Growth Monitoring Programs		
		Children Participating	Children with Reported Weight Gains	Children Referred to the Health Centers
April-June 2012	Cankuzo	309	279	64
	Ruyigi	469	403	13
	Total	778	682	77
July-September 2012	Cankuzo	264	177	14
	Ruyigi	403	261	39
	Total	667	438	53
January-March 2013	Cankuzo	506	353	12
	Ruyigi	730	291	140
	Total	1236	644	152
April-June 2013	Cankuzo	1128	507	132
	Ruyigi	2532	922	352
	Total	3660	1429	484
July-September 2013	Cankuzo	818	815	58
	Ruyigi	1584	1080	80
	Total	2402	1895	138
October-December 2013	Cankuzo	807	447	18
	Ruyigi	1077	762	48
	Total	1884	1209	66
January 2014	Cankuzo	284	145	6
	Ruyigi	271	183	14
	Total	555	328	20
February 2014	Cankuzo	209	120	9
	Ruyigi	251	187	12
	Total	460	307	21
March 2014	Cankuzo	476	197	71
	Ruyigi	288	192	14
	Total	764	389	85
April 2014	Cankuzo	246	188	7
	Ruyigi	346	211	114
	Total	592	399	121
May 2014	Cankuzo	236	184	15
	Ruyigi	252	146	39
	Total	488	330	54
June 2014	Cankuzo	0*	0*	0*
	Ruyigi	154	114	21
	Total	154	114	21

*The evaluation team was not able to explain why this data was a 0.

Source: IMC, Burundi; August 20, 2014.

Text Box 2.5. Testimonials from Mothers About the Impact of the Pilot Community-Based Growth Monitoring Program from the Final Evaluation Pilot Study

Kirasira Village (Ruyigi)

My name is Beatrice NIBIGIRA. I'm 30. I live in Kirasira Village, Butezi Commune in Ruyigi Province, and I am a mother of three daughters. I would like to give a testimony on the growth monitoring of my children.

The first child was born before Tubaramure Program. She weighed 2.1 kg at birth; at 1 month, 2.5 kg; after 2 months, 3 kg; three months later, 3.5 kg. After 1 year, the child was 8 kg. I gave up monitoring the weight of the child after 1 year 6 months, because I did not know its significance.

After Tubaramure implantation, I was pregnant with the second child who weighed 3.7 kg at birth; 4 kg after a month; 5 kg after 2 months; 6 kg after 3 months; and 7 kg after 4 months. A year after the birth, she had reached 10 kg. When I became a graduated woman, I gave birth to the third child, who weighed 3.6 kg at birth; 4.5 kg after 1 month; and 5.5 kg after 3 months. The child reached 8 kg after 1 year. The child did not increase in weight because of malaria. I continue to monitor my children's growth because the second child, who is 4 years old, weighs 15 kg.

I thank Tubaramure Program for its training on children growth monitoring because the weighing is a real indicator of children growth.

Itahe Colline, Ruyigi

I'm Gloriose Niyonkuru, aged 42. I live in Itahe Village, in Gisuru Commune of Ruyigi Province. I'm married with five children; four sons and one daughter. However, among the five children, I lost one.

Before Tubaramure, children's growth was not at all good in our community, starting with that of my children. Further to malnutrition, I gave birth to underweight children. Example: My first child was born with 2 kg; they told me that I had given birth to a mouse. The nurse demanded me to breastfeed the child for 6 months without giving him any other food. However, with housework that I had to do, I didn't follow the advice. I started to feed him at the age of 4 months with foods for adults but his weight didn't increase. Every time I went for his immunization, I noticed that the increase in weight ranged between 500 g and 1 kg.

My second child was born with 2kg 100g. At one year, he had kwashiorkor⁵⁷ due to malnutrition. I saw his belly swelling, and I thought he was suffering from intestinal worms. Unfortunately, he died at the age of one year and three months. The third child and fourth child were born with the same weight of 2 kg 200. I followed medical advice, but at 5 months, I had given them poor-nutrient foods. They were growing underweight; their weight ranged between 1 kg and 2 kg.

My fifth child is a girl born when I was in Tubaramure. The program began when I was pregnant for two months. I was put in the program at 6 months. I followed the training program on good nutrition and health practices.

I went for prenatal consultations and postnatal consultations; I ate three or four times a day. I was really fat, and my health had improved. I then gave birth to a child of 4 kg. I breastfed her for 6 months without giving any other food or another drink. I practiced growth monitoring every month. At 6 months, I began to give her porridge and some fruits. She had 7 kg 900 g. At 7 months, I began to give her food for adults; for example bean puree and potato. When I weighed her, she had 8 kg 500 g. I continued to feed varying the diet until now where she has 1 year 6 months; she weighs 13 kg.

I appreciate the growth of my child through Tubaramure Program. If I had not participated in this program, my last child would not have had this good growth.

⁵⁷ Kwashiorkor is a form of severe [protein-energy malnutrition](#) characterized by [edema](#), irritability, [anorexia](#), ulcerating dermatoses, and an enlarged liver with fatty infiltrates. Sufficient calorie intake, but with insufficient [protein](#) consumption, distinguishes it from [marasmus](#). Kwashiorkor cases occur in areas of famine or poor food supply.

Source: Tubaramure Final Evaluation focus group discussions and key informant interviews; July 2014.

National Policy. Although the scale of the 12-*colline* pilot study was insufficient (only 12 *collines* out of 268) to have an important population-based impact on the entire province, the pilot study ended up having a more broad-based policy than the one that was intended in the original Tubaramure MYAP proposal. This impact occurred because the preliminary results of the pilot—i.e. the few results that were tracked (Table 2.8), as well as some of the individual case studies from specific *collines*—were presented at several national health workshops that were organized for other purposes. These presentations ended up convincing some of the senior MoH staff about the importance of moving forward with the community-based growth monitoring protocol that had been stalled for over five years.⁵⁸ When asked to extrapolate some of the important lessons learned from the pilot studies for this broader policy debate, the Tubaramure staff and the national director of the MoH nutrition unit stated that the pilot studies:

- Showed how having an effective network of community-based GM programs could dramatically increase the percentage of children that could be seen; and
- Provided some of the first qualitative data to the provincial and national MoH offices about some of the key factors that would need to be addressed for these programs to be successful, including:
 - Increasing the number of Public Health Technicians and providing them with the means to access the villages for regular supervision missions (i.e. gas money, transportation and per diem);
 - Building a strong working relationship with the local authorities (both at the commune and *colline* levels) to promote their understanding of the process;⁵⁹
 - Anticipating the need for linking these programs to community-based programs (like Positive Deviance [PD]/Hearth or *Foyer d'Apprentissage et de Réhabilitation Nutritionnelle* [FARN]) that could help rehabilitate the large number of moderately malnourished children that a successful community-based GM program would likely identify (see Table 2.8);⁶⁰
 - Providing each *colline* with the materials that the Tubaramure Program provided them (e.g., scales, measuring tapes) needed to conduct GM, as well as appropriate training modules (like those developed by Tubaramure) for the Community Health Workers who would be in charge of the programs and their Public Health Technician supervisors; and
 - Creating a user-friendly system for tracking the effectiveness of the community-based GM that the Community Health Workers and their supervisors could use to report the

⁵⁸ This type of policy impact was anticipated in the proposal as a support to the MoH's ongoing discussions about the need to add a national protocol for community-based GM. In the original proposal, it was anticipated that Tubaramure would host a one-day workshop to discuss this issue. (See CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS for Tubaramure. Pp 9-12).

⁵⁹ The Tubaramure IR1 staff stated that this was one of the key factors that distinguished the villages with the most active local participation and benefits from the pilot activity.

⁶⁰ As discussed earlier in this chapter (Section 3.4), even the health center-based GM programs identified a large number of moderately malnourished children who were not eligible for the hospital-based SAM rehabilitation programs. Although the Burundi MoH health policy recognizes FARNs, they were not supported by the Tubaramure Program due to the program's technical and research focus on preventing malnutrition, not treating it.

results to the health centers to avoid the kind of under-documentation that occurred during the Tubaramure GM pilot activities.⁶¹

⁶¹ This under-documentation limited the program's ability to provide meaningful data-based feedback on the comparative value of community-based GM versus clinic-based GM.

3.4. Output 1.4: Severe Acute Malnutrition is Detected and Referred For Treatment^{62 63}

When the Tubaramure Program started, the United Nations Children's Fund (UNICEF) supported the MoH for commodities, medicine, and anthropometric equipment to local facilities to support the scaling up of CMAM with Plumpy'Nut.⁶⁴ For this reason, the Tubaramure strategy focused on:⁶⁵

- Developing a community-based referral plan for malnutrition;
- Using mid-upper arm circumference (MUAC) to identify children with malnutrition through door-to-door campaigns or community-wide events such as fairs or market days;
- Mobilizing and training LMs to engage in MUAC screenings with assistance of parents;
- Using home visits to follow children after graduation;
- Training Community Health Workers and LMs in C-IMCI and counseling skills; and
- Training Community Health Workers and LMs on messages to prevent severe acute malnutrition (SAM) and chronic malnutrition.

3.4.1. Activities (2010-Mid-Term). The Tubaramure Program's multi-pronged approach to building the local community's capacity to identify and refer malnourished children resulted in a fairly immediate increase in the total number of referrals. Unfortunately, however, at the end of 2010 the World Food Program (WFP) started to close its nutritional supplement series in Cankuzo and Ruyigi because the rate of moderate and acute malnutrition had decreased to the point that the MoH offices in these provinces were no longer eligible for the WFP rations for treating moderate and acute malnutrition. This shift in the macro-policy context of the SAM activities in both provinces had important implications for the children that the Tubaramure GM activities in the health centers identified as needing rehabilitation help.

Specifically, the changes meant:⁶⁶

- *Acute malnutrition with complications:* Children suffering from acute malnutrition with complications got referred to the specialized centers (linked to a hospital) that benefitted from the UNICEF Plumpy'Nut support; and
- *Moderate malnutrition without complications:* Unless they were in one of the few centers supported by the WFP, the children who were identified as moderately malnourished by the clinic-based GM program got sent home with no treatment other than the advice and counsel of the Community Health Workers and the LMs.

Although the WFP reopened its support for moderate malnutrition treatments support in seven

⁶² **SOW Key Question 3:** What interventions have been more or less successful in meeting targets?

⁶³ *SOW Specific Objective 7: Assess the effectiveness and the performance of the detection and referral of SAM's cases.*

⁶⁴ Plumpy'Nut is a peanut-based paste in a plastic wrapper for treatment of severe acute malnutrition manufactured by French company Nutriset.

⁶⁵ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS.

⁶⁶ A total of 282,816 children were monitored by the clinical-based growth monitoring between January 2011 and May 2014. Many of them are double and triple counted in the total figure since they attended several growth monitoring sessions. These GM sessions identified 3,848 children as suffering from severe malnutrition. These children were referred to the nutritional rehabilitation centers backstopped UNICEF. Another 4,375 were identified as moderately malnourished and eligible for the WFP rations if the health centers had them. Once the health centers no longer had the rations, these sick children were sent back the village.

health centers in Ruyigi in 2011, this did not cover the entire province.

3.4.2. *Mid-Term Evaluation Report Recommendations (2012)*. One of the key recommendations from the Tubaramure mid-term evaluation report was that children with moderate or mild malnutrition are also identified, registered, and followed up in the community (Table 2.9) as originally envisioned in the Tubaramure PM2A MYAP proposal⁶⁷ and reiterated as a critical constraint in the Tubaramure Program’s mid-term evaluation report.

Table 2.9. The Original Tubaramure MYAP Plan For Treating Children With Moderate and Mild Malnutrition Whose Non-Realization Was Identified as a Critical Constraint to the Achievement of Output 1.4 in the Absence of Community-Based FARNs

Presenting With Moderate or Mild Malnutrition, Not Receiving PM2A Supplements	Presenting With Moderate or Mild Malnutrition Enrolled in <i>Tubaramure</i> (Mother or Child had Received PM2A Supplements)
<p>Children 0 to 24 months with moderate or mild malnutrition at start of <i>Tubaramure</i> (mothers were not pregnant or lactating at program start-up, therefore the children are not enrolled)</p> <ul style="list-style-type: none"> • Detection • Home visits by Community Health Workers and MLs with specific messages for catch-up feeding • IMCI screening and referral to HF for other services including CMAM 	<p>Children 0-24 months with moderate or mild malnutrition (mother started in <i>Tubaramure</i> at time of pregnancy)</p> <ul style="list-style-type: none"> • Detection • Home visits by Community Health Workers and MLs • Use of Title II food <ul style="list-style-type: none"> – Use of additional foods during illness – Counseling on hygiene – Counseling on home management of illnesses • IMCI screening and referral to other health services
<p>Children 25 to 59 months with moderate or mild malnutrition at start of <i>Tubaramure</i></p> <ul style="list-style-type: none"> • Detection • Referral for CMAM • Home visits by Community Health Workers and MLs with specific messages for catch-up feeding • IMCI screening and referral to HF for other services 	<p><i>Tubaramure</i> graduates 25 to 59 months with mild or moderate malnutrition</p> <ul style="list-style-type: none"> • Detection • Home visits by Community Health Workers and MLs <ul style="list-style-type: none"> – Reinforcing learning from <i>Tubaramure</i> – Use of additional foods during illness – Counseling on hygiene and home management of illnesses

Source: Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure (July 2012). Pp. 21-22.

3.4.3. *Results*. Since none of the villages had community-based systems for rehabilitation of moderately malnourished children (other than the LMs’ recipes that were taught and supported under IR2 and IR3):

- There were no major shifts in the program’s SAM activities after the mid-term; and
- The program performance on the two indicators tracking this continued to be low (Table 2.10).⁶⁸ Specifically, after a short-term increase during the first two years of the program’s field activities (Table 2.10):
 - The percentage of children with malnutrition referred from the community who were enrolled in the MoH nutrition services dropped from 92.0% at mid-term (when the majority of the children 0-24 years of age were receiving PM2A rations) to 32%; and

⁶⁷ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: Tubaramure Program. Pg. 20.

⁶⁸ Stakeholder review of the first draft of the Tubaramure Program Final Evaluation; September 28, 2014.

- The percentage of children released from the clinic-based program who were visited at home by a Community Health Worker also dropped from 75.0% to 25.2%.

Table 2.10. Tubaramure PM2A Program Indicators Used to Track Identify, Refer, and Monitor Follow Up on Children with Severe and Acute Malnutrition, 2010-2014

IR1 Key Program Indicators	Baseline 2010	Mid-Term 2012	Endline 2014	LOA Target
Output 1.4. SAM is detected and referred for treatment				
1.11. Percentage of children with malnutrition referred from the community who are enrolled in nutrition services	72.7	92.0	32.0	85.0
1.12. Percentage of children recovered from acute malnutrition visited at home by the Community Health Workers at least twice a month for three months	7.1	75.0	25.2	90.0

Methodology: The figures in this table are based on health center records for both PM2A and non-PM2A beneficiaries.

Source: Tubaramure IPTT (Annex II).

4.0. Factors Which Contributed to and Detracted From Program Relevance, Effectiveness, Efficiency, and Acceptability of Processes, Outputs, and Implementation

4.1. Relevance

In 2009, the health system was just at the beginning of a formal decentralization process that was finalized during 2012-2013. The new system, which was formally rolled out at the end of 2012, was designed to increase the quality of the clinical-based health services in Burundi. This included:

- Strengthening the MoH’s management and supervision of the health centers;⁶⁹
- Developing a plan for progressively increasing the number of health centers in both provinces; and
- Granting legal recognition to the volunteer Community Health Workers.

The same decentralization process gave legal recognition to the volunteer Community Health Workers (thus making them a formal part of the health system eligible to train in a more cohesive fashion) and increased their numbers more than three fold (Table 2.11). The Tubaramure Program was highly valuable to this process because it provided a series of training, equipment, and management supports for this system as it transformed. The program’s flexibility—like its willingness to provide some technical and logistical support for the revision of key protocols and to add a training module for the Community Health Workers (once they were trained), the module on data entry and management (to promote better reporting on the performance-based financing [PBF] and MoH indicators), and the module on supervision—helped the MoH improve both service quality and demand by:

- Training staff, improving supervision, and providing essential equipment (under IR1);
- Providing technical and logistical support for updating and/or developing certain key protocols that are requested and supported by the MoH (under IR1); and

⁶⁹ Under the new system, the management of the health districts was separated from the management of the hospital. Instead of one doctor managing the entire district, there were now two.

- Building the local communities' demand for these services through the Tubaramure BCC activities (under IR2).

Table 2.11. Evolution in the Number of MoH Staff and Health Centers and Tubaramure Staff Working on IR1 Activities in the Ruyigi and Cankuzo Provinces, 2009-2014

MoH Staff and Infrastructure	Project Zone		Cankuzo		Ruyigi	
	2010	2014	2010	2014	2010	2014
Nurse	221	907	128	451	93	456
Clinical assistant	69	308	43	153	26	155
Public Health Technicians ⁷⁰	24	26	9	13	15	13
Community Health Workers	712	1167	176	407	536	760
Tubaramure Program Staff						
Doctors	5	43	5	10	0	33
Tubaramure Health Promoters	36	22	15	9	21	13
Tubaramure IMCI IR1 staff	10	12	5	6	5	6
MoH Infrastructure						
Health centers	50	60	23	28	27	33
Hospitals	6	8	2	2	4	6

Source: IMC, Bujumbura, Burundi; August 2014.

4.2. Effectiveness

The program was effective in achieving all of the major output IRs through the training, equipment, and supervision programs that increased the overall quality of health services (Text Box 2.6). The main exception was the IR focused on SAM for reasons beyond the Tubaramure Program's control. By the program's mid-term, both provinces were no longer eligible for the WFP rations for children with mild and moderate malnutrition (Section 3.4 of this chapter). This meant that large numbers of children who were identified as moderately or mildly malnourished were sent back to the local communities where there was little community-level support for their treatment other than the PM2A and local food-based treatments that the LMs and Community Health Workers could provide. The key challenge remains as signaled at mid-term and in the original proposal to develop better community and clinical-level systems for ensuring that children with moderate or mild malnutrition are identified, registered, and followed up with in the community.

⁷⁰ Including the MoH Public Health Technician Coordinator for each province.

Text Box 2.6. Sample Testimonials from the MoH About How the Tubaramure Increased Their Capacity to Deliver Quality Clinic-Based Services

“Before the program, I did not have sufficient training in nutrition, especially for screening. Now we have improved our center’s systems for nutritional screening and referral of severe cases to other health facilities. For the mild cases of malnutrition that we identify, we try to train the mothers on essential nutrition actions.”

“We see a clear difference between the IMCI-trained agents and those who have not had the training. The health agents who received the IMCI trainings are more efficient and competent in the management of childhood illness compared to those not trained in this approach.”

“We now have a functional system for archiving our tracking data through workbooks and worksheets.”

“Tubaramure has helped our supervisors to support us in our prenatal consultation work and prevention of malnutrition. The material we received from the program (the MUAC measuring tape, the nutritional posters, the flip charts and scales) has helped us with growth monitoring and monitoring the weight of the women we see during the prenatal consultations.”

Source: Final evaluation key informant interviews and focus group discussions; August 2014. Annex IV.

The government’s decision to formally recognize the national network of MoH volunteer Community Health Workers at the end of 2012 increased the effectiveness of all the MoH’s community-based programs by increasing the number of MoH volunteer Community Health Workers from 537 in 2009 to 1,167 in 2014. Since the health workers are the official *colline*-level agents of the MoH, they will continue to work after the Tubaramure Program ends.

The chief factors that decreased the effectiveness of the Tubaramure Program’s IR 1 activities were:

- Only a few health centers had rations for treating the children who were identified as having moderate malnutrition (which affected the achievement of Output 1.4); and
- The MoH never revised, updated, and validated its GM protocol (which affected the achievement of Output 1.3). It is important to note, however, that even without the protocol, the achievements on growth monitoring were major and appear very likely to be sustained beyond the duration of the program given the increased community-level demand for GM, which is a direct reflection of Tubaramure’s BCC activities under IR2.

4.3. Efficiency

The IR1 component of the Tubaramure Program has been very efficient in its use of program resources to build the MoH’s capacity to prevent and treat malnutrition in the two provinces. With very few technical staff in the field, they have supported 61 health centers that serve the entire population of the province and 1,167 Community Health Workers.

The program’s efficiency was increased because the activities responded to MoH priorities and needs to execute the four main clinical and community-level protocols that undergird its new nutrition policy. This increased efficiency by increasing the productivity of the MoH’s existing intervention structures, which lowered the unit costs of delivering health services and increased sustainability.

The fact that the national-level MoH required the health districts and provinces to track a number of indicators that were likely to be affected by the successful execution of the program was also very important (Annex VI.A.7). First, it meant that the health districts and the provincial-level staff had a vested interest in the success of the effort because it would reflect well on their national tracking systems that were linked to donor disbursement. Second, it made them more receptive to exploring the Tubaramure-recommended changes, which focused on both malnutrition prevention (a familiar theme) and malnutrition treatment (a more established part of the protocols).

4.4. Sustainability^{71 72}

The IR1 component of the program is very well embedded in the Burundian health system and structure, and there is a strong emphasis on capacity building and systems strengthening. All of this increases the likelihood that these activities will continue once the Tubaramure Program funding stops.

4.4.1. Progress Toward the Execution of the IRI Exit Strategy. During the second half of the program, IMC designed an exit strategy together with the MoH. This exit strategy included scaling down contributions in fuel and other material support to the MoH. A major strength of the exit strategy was its simple format, which provided a clear illustration of who was responsible for different handover and scale-down activities (Annex VI.A.8). The same exit strategy—which was discussed with the two provincial-level offices of the MoH in June 2013—provided the basis of a revised memorandum of agreement with the MoH that was signed in July 2013. The combination of a clear, simple exit strategy and a memorandum of agreement to co-execute it is an example of best practice for future programs.

4.4.2. Priority Issues for Follow Up. The MoH is likely to face five priority issues for follow up on the Tubaramure Program’s IR1 activities in the coming year (Table 2.12):

- Continuing to monitor the nutrition and health of the women and children who graduated from the PM2A program, as well as new children born after the start of the program, since only a small percentage of the communities have community-based systems for GM and none of them have the PD/Hearth programs for rehabilitating any children that are identified as being moderately malnourished;
- Continuing to train new staff in the core protocols and manuals. The high rates of staff turnover in MoH staff have reduced the percentage of local health centers that have at least two staff trained in all of the key protocols with Tubaramure support. For example, as of July 2014, only 18% of the doctors currently on staff have been trained in IMCI and only 12% in CMAM; 26% of the nurses have been trained in IMCI, 34% in CMAM, 20% in growth monitoring and only 21% in CPN/CPoN (Table 2.13). This means that the province will need to rely on its internal resources to train and retrain the staff using its own resources and those of donors that might be interested in supporting the same area.

⁷¹ *SOW Specific Objective 10: Assess the issues of sustainability both at the institutional, the community, and the households’ levels.*

⁷² **SOW Key Question 7:** To what extent program activities were financially supported and how will they be sustained at the institution and the community levels, after the program closure?

The fact that the Tubaramure Program trained with existing protocols and trainers will increase the efficiency (and lower the cost) of this training;

- Combating the weak logistical support given to the MoH Public Health Technicians and Community Health Workers, which makes it difficult for them to perform their current slate of duties even without taking into account their projected attempts to better connect the Tubaramure-trained LMs to these activities;
- Combating the weak motivation of the MoH Community Health Workers since they receive no direct compensation for their employment; and
- Combating the low rates of postnatal consultation in both provinces.

Table 2.12. Priority Issues for Follow Up to Capitalize on the Results of the Tubaramure Program’s IR1 Activities

Priority Issues for Follow Up	For the MoH	For Other Donors Working in Health and Nutrition and Food Security in the Two Provinces
1. Continue to monitor the health and nutrition of the PM2A graduates and new children born after the program started.	- Strengthen the capacity of the local communities to treat the children that are identified as moderately malnourished -Strengthen the current plans for expanding community-based growth monitoring by linking it to a strategy (like the PD/Hearth model) for community-based rehabilitation of moderately malnourished children	Support ongoing efforts of the MoH to develop community-based GM and community-based programs to rehabilitate moderately malnourished children based on the PD/Hearth model.
2. High rates of staff turnover	-Develop a simple system for monitoring the number of staff and volunteers trained in the different protocols for each health center, which can help the MoH better plan future trainings -Anticipate the need for an annual training and retraining courses on the core nutrition modules using the existing base of MoH trainers who got additional training-of-trainers training under Tubaramure	Support ongoing MoH efforts to promote baseline training and retraining of MoH staff on key protocols at the clinical and community level
3. Logistical constraints for community-based programs that include: 1) An insufficient number of MoH Public Health Technicians to supervise the expanded number of Community Health Workers; which is compounded by the 2) insufficient logistical support (transportation, gas) given to the MoH Public Health Technicians and Community Health Workers to conduct their activities	-Consider extending the pilot test currently under way in two other provinces to strengthen the MoH Public Health Technicians and Community Health Workers’ ability to support to community-based nutrition and health programs -Brief new and existing donors on Tubaramure achievements in the provinces that they can strengthen and/or maintain through their existing or new activities in both provinces -Continue to organize the three types of inter-agency coordination meetings developed under Tubaramure	-Support MoH efforts to implicate the Public Health Technicians and Community Health Workers in the design and execution and monitoring of all community-level activities -Consider ways to support the MoH’s ongoing efforts to prevent malnutrition -Solicit new technical and logistical support partners for coordination meetings, formative and joint supervision missions
4. Weak motivation of the Community Health Workers since their job is voluntary	-Help the MoH Community Health Workers develop income-generating activities (IGAs) by linking them to Savings and Internal Lending Communities (SILCs) and <i>groupements</i>	Encourage new NGO partners to support these initiatives

Priority Issues for Follow Up	For the MoH	For Other Donors Working in Health and Nutrition and Food Security in the Two Provinces
	-Encourage the Community Health Workers to organize themselves into associations so that they can be better helped by the government and link to outside development partners who can help them develop income-generating micro programs	
5. Low rates of postnatal consultations	-Capitalize on the large number of women bringing their children in for vaccinations during the first 45 days of the child's life to conduct a postnatal consultation for the mother to help mothers avoid multiple trips to town -Continue to involve all MoH agents and local authorities in promoting prenatal and postnatal consultations	Encourage new NGO partners to support these initiatives

Source: Tubaramure Final Evaluation; August 2014.

Table 2.13. Number of Current MoH Staff Trained Under Tubaramure, 2014

Staff Category	Total (June 2014)	Number of Staff in This Category Who Have Been Trained (%=% of Total Staff)						
		IMCI Clinical	CMAM	GP	CPN/CPoN	IMCI/CMAM/GM/CPN/CPoN (community based)	Integrated Community Health Workers Manual	Mgt. & Reporting
MoH Staff								
Doctors	34	6 (18%)	4 (12%)	N/A	N/A	2 (6%)	N/A	N/A
Nurses	413	107 (26%)	142 (34%)	83 (20%)	107 (26%)	6 (1.4%)	51 (12%)	N/A
Public Health Technicians	34	N/A	N/A	N/A	N/A	27 (79%)	27	N/A
Community Health Workers	1,167	N/A	N/A	N/A	N/A	Fewer than 543 ⁷³ (47%)	1,167	N/A
Medical assistants	127	0	83 (65%)	68 (54%)	N/A	N/A	N/A	N/A
Health Information Systems Agents	7	N/A	N/A	N/A	N/A	N/A	N/A	6 (86%)
Tubaramure Program Staff								
Tubaramure Health Promoters	24	N/A	N/A	N/A	N/A	100%	N/A0	N/A

Note: N/A means training not relevant for this category of individuals.

Source: IMC, June 2014 Census Data, transmitted to final evaluation team August 2014.

To address the first issue—which is a national problem, not one that is limited to the two provinces—the MoH is accelerating the finalization of the draft protocol for community-based GM and is encouraging the rapid expansion of the PD/Hearth model in the same communities. World Vision is one of several NGOs that is planning to expand its support for both the PD/Hearth model and GM program in both provinces over the next year.

⁷³ Exact figure is not known.

The second issue can be addressed by the provincial MoH’s getting some of the new donors moving into the area to support community-based GM and rehabilitation programs to also support staff training.

To date, none of the MoH Public Health Technicians has ‘official’ motorcycles, and with the demise of Tubaramure Program, most of them will lose access to any special allowance for gas to operate any private motorcycles they might use to circulate. None of the MoH Community Health Workers have official bicycles. These transportation constraints place a real crimp on the abilities of MoH staff, which oversees all of the community-level health and nutrition activities, to do their jobs.

The third and fourth issues are under reflection at the national level since they affect every aspect of the MoH’s community outreach. One option is to consider new ways that the MoH can help equip the MoH Public Health Technicians and the volunteer Community Health Workers to get bicycles. Two pilot programs to test a new mechanism for achieving this area already underway. Another option that is also under discussion is to consider various ways that the MoH can help the Community Health Workers to develop income-generating activities (IGAs) by joining Savings and Lending Communities (SILCs) or creating economic associations (*groupements*).

Several options for increasing the rate of postnatal consultation are under consideration including the recommendation putting greater emphasis on vaccination in the months just after birth to encourage the mothers to come for postnatal checkups.

5.0. Lessons Learned and Best Practice Checklist

Table 2.14. Tubaramure Program IR1 Lessons Learned and Best Practice Checklist

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH) ⁷⁴	Future Donor-Funded Activities	Future PM2A and Food Security Programs
IR1: Women and children under 5 access quality nutrition and health services.			
Lesson 1. <i>Training programs that contribute to the preparation and revision of existing protocols for the MoH and/or other partners are more likely to be effective, efficient, and sustainable.</i>			
1. Build training programs to prevent malnutrition on existing MoH protocols and training modules.	X	X	X
2. Train all MoH staff in the key nutrition treatment and preventions protocols (at the provincial, commune, and community levels) from the start of the program in order to build the roots for sustainability.		X	X
3. Include a flexible budget for technical and logistical support to update and revise critical MoH protocols and training manuals.		X	X
4. Build the capacity of the existing MoH trainers in the provincial and district-level health centers to execute training programs for the key protocols being supported.		X	X

⁷⁴ This column refers to MoH activities that are critical to maintaining or sustaining the Tubaramure-supported activities once program funding ends. If there is no X in the column, it should be assumed that the MoH is already supporting this activity.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH) ⁷⁴	Future Donor-Funded Activities	Future PM2A and Food Security Programs
5. Anticipate the need to train and equip Community Health Workers from the start.		X	X
6. Anticipate the need for a flexible budget line to support formative supervision missions to follow up on basic training of staff in all health centers.		X	X
7. Anticipate the need for baseline, mid-program, and end-of-year training programs on all of the key modules in order to accommodate staff turnover.		X	X
8. Offer certificates to individuals who complete the training to validate their new knowledge to themselves and their managers.		X	X
9. Strengthen systems for monitoring program and staff performance on critical protocols that are underperforming.			
Lesson 2. <i>Providing material support to health centers can help motivate the staff and strengthen their capacity to offer higher-quality health and nutrition services.</i>			
10. Anticipate the need for a flexible line item of equipment for all local health centers that provide technical support to community-based nutrition and health programs.		X	X
11. Anticipate the need to update and renew this equipment in the last year of the program.		X	X
12. Give assistance that is ‘demand driven’ by a health center list of priority needs and MoH norms.		X	X
Lesson 3. <i>The implication and good collaboration with local authorities and NGO partners is essential for the efficient execution and mainstreaming of nutrition interventions into local development plans.</i>			
13. Strengthen the existing system and/or create MoH-managed quarterly meetings that bring together the different health and nutrition actors in the program intervention areas.	Maintain	Maintain	X
14. Strengthen the existing systems for collaborative planning between the MoH Public Health Technicians and Community Health Workers.	Yes	Yes	X
15. Offer training courses to the nurses who manage the local health centers to help them better manage the centers’ nutrition activities and better connect these activities to the other actors (like the MAE), as well as the provincial and commune-level development planning processes that affect their centers.	X	X	X
16. Provide technical and logistical support for local development plans that local governments can use for strategic planning processes as soon as possible in order to ensure that the malnutrition prevention programs are mainstreamed.	X ⁷⁵	X	X
Lesson 4. <i>Program systems that build on and strengthen the MoH’s existing supervision, monitoring, and evaluation systems help supervisors provide on-the-job training in technical issues that improve service quality and</i>			

⁷⁵ In the case of Burundi, the timing for this should be no later than the mid-term of the new 2013-2014 Commune Community Development Plans (PCDC)—which should be in 2017—to ensure that the NGOs facilitating these processes and the local administrators are well-versed in the ongoing community-based nutrition and health programs. Early and consistent implication of local administrators in the program’s activities should increase but not guarantee (due to turnover) a more sophisticated and useful analysis of the most critical constraints and planning issues.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH) ⁷⁴	Future Donor-Funded Activities	Future PM2A and Food Security Programs
<i>ownership of results.</i>			
17. Facilitate joint supervision missions that permit national, provincial, and district-level supervisors to monitor the execution of the activities being supported by the program.	Maintain	Yes	X
18. Harmonize future program's M&E systems with those of the health centers for the key protocols being supported in order to avoid duplication.		X	X
19. Strengthen the MoH's district-level systems for the collection and analysis of nutrition data.	X	X	X
20. Build MoH capacity for more decentralized nutrition data entry and analysis.	X ⁷⁶	X	X
21. Support MoH efforts under way in 2014 to add nutrition and community-level sanitation indicators to the list of performance-based financing indicators being tracked by the government to give greater visibility to MoH efforts to promising clinical and community-based new initiatives to prevent malnutrition.		X	
22. When conducting pilot studies/tests of new initiatives, develop careful tracking systems that allow comparisons of the new initiatives with existing initiatives.		X	X

Source: Tubaramure Final Evaluation; July-August, 2014. Revised based on feedback to the first draft; September 25-October 5, 2014.

⁷⁶ Train and retrain the provincial and district-level staff in data entry, analysis database creation, and management to avoid labor-intensive hand entry of the MoH and donor forms, which can create costly duplications of effort for M&E and technical staff.

Chapter 3 Intermediate Result 2: Households Practice Appropriate Health and Nutrition Behaviors

1.0. Global Strategy

1.1. Major Outputs

A major strength of the Tubaramure Program was its conceptualization of a broad cross-cutting intermediate result (IR) related to behavior change. The activities under this IR were expected to help the local beneficiaries, households, and communities understand what types of behavior changes will be needed to sustain the nutritional and health improvements associated with the IR1 and IR3 activities. Specifically, the activities were designed to achieve three outputs (Table 3.1).

Table 3.1. Major Outputs Designed to Achieve the Tubaramure Program’s IR2

IR2: Households practice appropriate health and nutrition behaviors.
Output 2.1. Households (HHs) adopt Essential Nutrition Actions (ENA).
Output 2.2. Households adopt Essential Hygiene Actions (EHA).
Output 2.3. Households adopt prevention and management behaviors for maternal and childhood illnesses

Source: CRS; 2009. *Tubaramure Multi-Year Assistance Program (MYAP) Proposal*. Bujumbura: CRS.

Food for the Hungry (FH) was the technical lead for this IR and implemented the Care Group approach as a primary conduit for behavior change. The Care Group Model is a community-based strategy for achieving widespread and lasting household and community-level behavior change. Care Groups are comprised of volunteer Leader Mothers (LMs) selected by their neighbors to conduct health promotion with women who are pregnant or have children 0-23 months of age. All beneficiary mothers were expected to participate in a beneficiary group (under the leadership of a LM) as one of the conditions of getting the Preventing Malnutrition in Children Under 2 Approach (PM2A) rations distributed under IR3.

1.2. The Original Intervention Model

To achieve these three outputs, the Tubaramure Multi-Year Assistance Program (MYAP) Proposal outlined a three-prong strategy that focused on:

- The creation of Care Groups;
- Formative research to develop, pilot test, revise, and finalize a group of five behavior change communication (BCC) training models; and
- A system of cascade training in which the Tubaramure Health Promoters would use the five training modules to train the LMs, who could use them to train the beneficiary groups.

To complement the Care Group Model, the program added a parallel set of activities that supported:

- **Hygiene and Sanitation Improvements:** A series of community-level demonstrations on how to construct some of the key hygiene and sanitation innovations illustrated in the

BCC training modules (i.e. drying racks, improved latrines, hand washing stations [Tippy Taps], garbage pits, and other low cost innovations); and

- **Radio Emissions:** A series of national and regional-area broadcasts that reinforce the BCC messages.

2.0. Activities

2.1. Program Start Up to Mid-Term

Once the initial beneficiary assessment was conducted in 2009, all of the women eligible for PM2A rations were organized into beneficiary groups comprised of 10-12 members and selected a LM to represent them. Once this happened, the LMs became the principal conduit for Tubaramure Program information to and from the beneficiaries for the BCC activities under IR2, as well as the food distribution and culinary demonstrations under IR3.

When the program started, there was no national curriculum for the MoH Community Health Workers, so the training material had to be adapted based on formative research and a local artist needed to adapt the images based on the Burundi context. One unintended consequence of the program developing its own BCC modules was the inevitable delays that were linked to, *“The sheer number of steps involved in developing quality, tested materials; locating a qualified artist for the illustrations; and finding a competent printing house that would respect the contractual requirement.”*⁷⁷ Further delays were created by the inevitable delays involved in scheduling review sessions with the Ministry of Health (MoH) committees charged with oversight.

Other delays were created by the heavy workloads of the Tubaramure Health Promoters who worked across all three IRs and had a number of responsibilities in addition to their BCC activities. As a result, *“attendance at the second set of monthly meetings (Tubaramure Health Promoters with LMs, and LMs with beneficiaries) is always lower. Sometimes the meeting is not held at all due to scheduling conflicts, competing priorities for the Health Promoters or bad weather. As a result, some Care Groups covered only one lesson per month.”*⁷⁸

This meant that not all of the beneficiaries were able to hear all of the lessons in the five core modules before they graduated from the PM2A program (i.e., were no longer eligible for food rations since their child had turned 24 months of age) since some trainings did not occur until 2013 (Annex VI.B.1).

To address this issue the consortium created an ‘age-specific card’ which is a shorter, separate module synthesizing all the key maternal and child health messages organized according to the stage of pregnancy or the age of the child. Starting in November 2010, this card was distributed to all LMs and many beneficiary mothers during the Tubaramure Health Promoter training sessions. Although the age-specific card provided a brief overview of the other themes, this was considered more in the spirit of information dissemination rather than core BCC training.

⁷⁷ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pp. 30-31.

⁷⁸ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pp. 30-31.

2.2. Early Impact of the First PM2A Graduation, Care Group Participation, and Tubaramure Cascade Training Model⁷⁹

In November 2011, the first group of PM2A beneficiaries (8,000 mother/infant pairs) graduated from the program (i.e., their children turned 24 months of age at the same time). Once their involvement in the beneficiary groups was no longer a condition for getting rations, many LMs and beneficiaries dropped out and/or became more irregular in attendance. The principal reason given for this drop out was lack of motivation (i.e. concrete compensation for her time).

To encourage the beneficiary mothers to introduce the new crops and livestock that they would need to continue having a more diversified diet after graduation, the program distributed its first round of vegetable seeds,⁸⁰ fruit trees, and poultry to the LMs in late 2011, and encouraged beneficiaries to consider forming economic *groupements*.⁸¹ This assistance catalyzed a small number of the LMs to start organizing their own *groupements* in the six months before the mid-term evaluation.⁸²

When some of the initial investigations of beneficiary dropout showed that many women's husbands were encouraging them to drop out of the program once they were no longer eligible for rations, some Tubaramure Health Promoters encouraged their Care Groups to select Leader Fathers (LFs) who attended trainings and were expected to organize their peers for individual and group BCC activities.⁸³

2.3. Principal Conclusions and Recommendations From the Program Mid-Term

The July 2012 mid-term evaluation report concluded that although the program had made significant progress toward the three outputs for IR2, a number of issues would need to be addressed to sustain this performance and reach the end-of-program targets, including:

- Determining how to fine-tune messages promoting the need for a variety of foods as important for young children, but also other Infant and Young Child Feeding (IYCF) recommendations such as frequency of small meals, consistency/digestibility of food depending on age, and sufficient quantity of food for age;

⁷⁹ **SOW Key Question 16:** How are graduated and current beneficiaries in the community coping with the end of food distribution?

⁸⁰ One of the most critical constraints on agricultural production in both provinces is the limited access to improved seed. Although a number of seed cooperatives have organized to produce good (though not officially certified) rice seed, there seem to be very limited sources of improved seed for vegetables and almost no national option for the soy bean seed, which is critical to the preparation of the weaning broths that the LMs promote. For this reason, most of the LMs identified improved seed as their top priority for follow-up help on strengthening their production activities.

⁸¹ The distribution of these 'motivations' was counted as an IR3 support activity in the hopes of encouraging them to promote more diversified diets.

⁸² Based on the information in the recently created Tubaramure monitoring and evaluation (M&E) database on the *groupements*, nine of the current *groupements* were created in 2010; 49 in 2011; and 138 in 2012, both prior to and after the program's mid-term (Tubaramure M&E Office; August 2014).

⁸³ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 33.

- Determining the most effective ways to prevent diarrhea and manage it at home, and promote these behaviors through the Care Group trainings through closer collaboration between FH (the technical lead on IR2) and International Medical Corps (IMC, the technical lead on IR1);
- Encouraging a renewed emphasis on, “what can be done at the household and community level to prevent and manage” malaria;⁸⁴ and
- Exploring various ways to strengthen and sustain the Tubaramure Care Group model by:
 - Reducing the workload of the Tubaramure Health Promoters so that they have more time to focus on the BCC component of their work;
 - Motivating the LMs to continue attending Care Group meetings after graduating since this was deemed critical to their staying informed and connected to the MoH;
 - Strengthening the program’s collaboration with the MoH on the design, execution, and monitoring of the BCC activities, “other than including visits to Care Groups in the program for joint supervisions;” and
 - Helping men, “*especially husbands and fathers, to contribute to behavior change.*”⁸⁵

2.4. Impact of the Mid-Term on IR2 Strategies and Activities⁸⁶

2.4.1. *Barrier-Analysis Studies to Help Reorient the IR2 Strategy.* To address these concerns, the program commissioned two barriers-to-behavior-change studies in the six months after the mid-term evaluation. The first study was designed to:⁸⁷

- Better understand the barriers-to-behavior-change reasons for the dropout rate among beneficiaries and LMs; and
- Examine various options for building men’s support for their wives’ continued participation in the Care Groups.

This first study made eight recommendations for sustaining the Care Groups and four for building more men’s participation in the program (Annex VI. B.2).

The second study focused on examining the barriers to behavior change for five critical behavior changes being targeted by the program—exclusive breastfeeding, postnatal consultation, growth monitoring (GM), construction and use of latrines, and the construction and use of handwashing stations⁸⁸ (Annex VI. B.3).

⁸⁴ A FH barrier analysis of the use of insecticide-treated nets (ITNs) in June 2011 provided the basis for this recommendation.

⁸⁵ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pp. 39-40.

⁸⁶ **SOW Key Question 5:** To what extent recommendations from the mid-term evaluation have been incorporated into the nutrition and health sector?

⁸⁷ Leonie Niyonkuru; 2012. *Etude sur la Pérennisation des Care Groups et les Activités Genre dans le Program Tubaramure*. Bujumbura: Tubaramure. (November 2012).

⁸⁸ Tubaramure PM2A Program M&E Team; 2012. *Etude sur les Obstacles a l’Adoption des Bonnes Pratiques en Matière de Santé, Nutrition et Hygiène, dans les provinces de Ruyigi et Cankuxo. Rapport Final*. Bujumbura: Tubaramure M&E Office.

2.4.2. *Stronger Emphasis on Gender and Supporting the Beneficiaries Developing Groupements.*

Two of the major changes after the mid-term evaluation report were:

- The program's creation of a series of activities targeting men, as well as activities that strengthened men's participation in the Care Groups; and
- A targeted set of activities designed to help the beneficiary groups and LMs develop the types of registered economic groups (*groupements*) needed to receive any type of economic assistance from the government and/or local or international NGOs.

The goal of Tubaramure support to the *groupements* was to create a mechanism for the LMs to continue to meet with a portion of their beneficiary group by creating new income-generating activities (IGAs) that they managed as a group. Key activities included (Table 3.2):

- Informal training by the Tubaramure Health Promoters (under the supervision of the IR2 supervisors in both provinces) on how to create and manage a *groupement*;
- Help with registration; and
- The distribution of seed, small numbers of animals, and training in keyhole gardens.

Table 3.2. Evolution of the Program's Complementary Support Given to the Tubaramure-Facilitated Groupements Under IR2 and IR3

Support	Lead Partner	Collaboration	Number of Groupements			
			2011	2012	2013	2014
Created			58 ⁸⁹	138	572	4
Supported (2/colline)			NA	NA	508	508/434
Support given to individual LMs	FH		X			
• Fruit trees	FH		X			
• Roosters	FH		X			
Support given to groupements						
• Organization	FH			X		
• Registration	FH	Commune		X	X	X
• Training on and technical support keyhole gardens ⁹⁰	CRS	DPAE (informal)		X	X	X
Seed distributions		DPAE (informal)				
• Vegetables	CRS			X	X	indirect ⁹¹
• Soy beans ⁹²				24 groups	48 groups	434 groups
• Maize				X	X	
Goats		FH	DPAE (informal)		24 groups	48 groups ⁹³
Grinders and other equipment to help promote food processing activities	CRS					434

Acronyms: DPAAE: *Direction Provinciale de l'Agriculture et de l'Elevage* (Provincial Directorate for Agriculture and Livestock); X: Yes, but no precise figures are available; CRS: Catholic Relief Services.

Source: Tubaramure IR3 National Coordinator Regine Pacis Nohoreho, IR3 Coordinator for Tubaramure (Ruyigi) Ezéchiél Kabwebwe, and Tubaramure Provincial Coordinator (Cankuzo) Edmond Twagirayezu; July 2014.

The Tubaramure staff executed most of the activities with some assistance from the commune-level agronomists and veterinarian assistants for keyhole garden training (2012 and 2013) and the selection of the animals for distribution to the groups (2013 and 2014).

As of August 2014, the Tubaramure Program has created a total of 874 *groupements*,⁹⁴ 713 (82%) of which are registered (i.e. have completed the papers necessary for them to register with the government), which is a prerequisite to working with the Ministry of Agriculture and Livestock (*Ministère d'Agriculture et d'Elevage* or MAE) (Figure 3.1).

⁸⁹ Nine of the current *groupements* were created in 2010; 49 in 2011.

⁹⁰ The initial training of trainers of Tubaramure supervisors was facilitated by CRS/Lesotho in 2011.

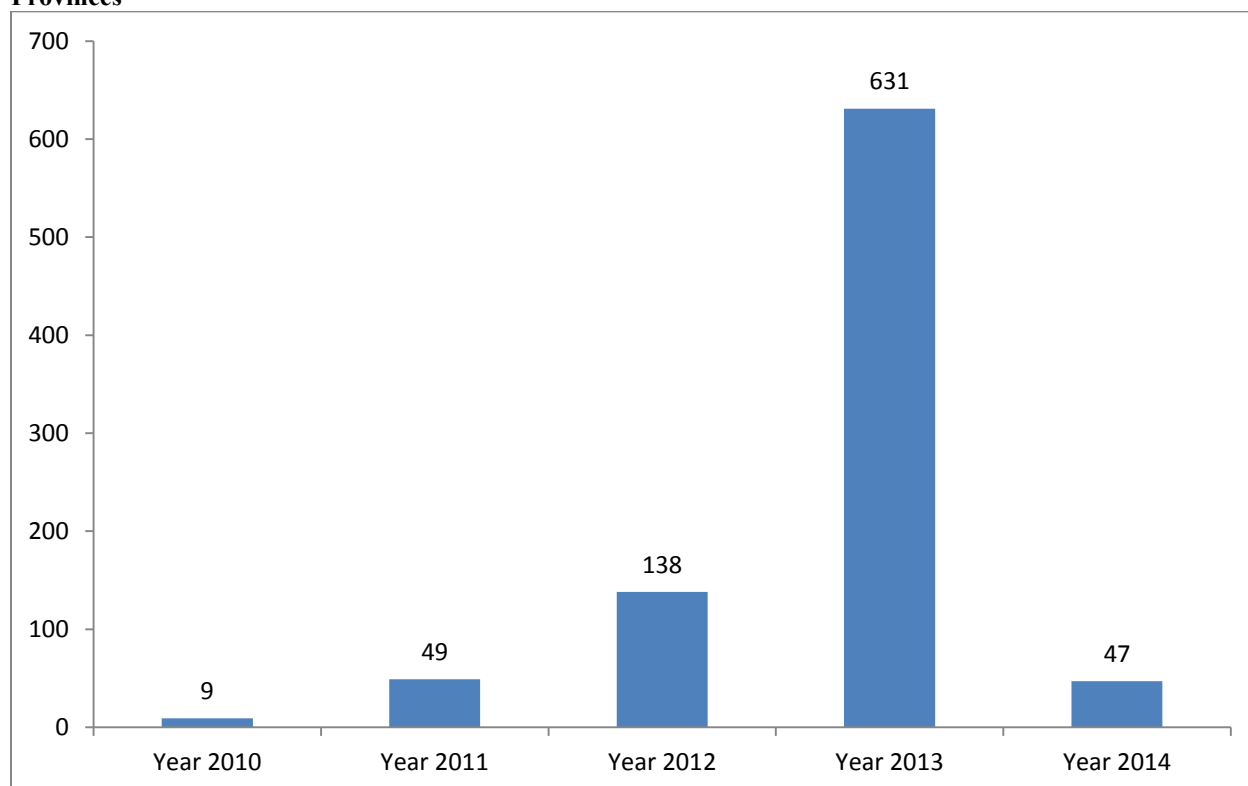
⁹¹ Although the program did not distribute vegetable seeds in 2014, several *groupements* requested assistance with purchasing the seed in Bujumbura, many of them with funds generated by the Savings and Internal Lending Communities (SILCs) (See IR3, Chapter 4).

⁹² The initial training of trainers and seed for this activity was facilitated by CRS/Rwanda in 2011.

⁹³ The pilot distributions gave one goat to two persons in a more limited number of groups. This meant that the beneficiary *groupements* each received between 15 and 16 animals. During the second distribution, the program gave two goats per group (including those who had received goats the first time). Since the program supported only two *groupements* per *colline* this meant approximately 44 animals per *colline*.

⁹⁴ During the month of March 2014, the CRS M&E Office conducted its first comprehensive census of the Tubaramure-facilitated *groupements*. This census was turned into a database that is regularly updated by the Tubaramure M&E staff (Annex VI.B.4). These figures were based on an analysis of this database.

Figure 3.1. Year the Current Base of Tubaramure *Groupements* Were Created in Ruyigi and Cankuzo Provinces



Source: Tubaramure M&E Office; August 23, 2014.

About 58% of the groups (508⁹⁵ out of the 874) received the total package of assistance (organizational training, technical training, seeds, goat distributions, etc.). Out of this number, the program chose 434 of the assisted *groupements* (outside the International Food Policy Research Institute/Food and Nutrition Technical Assistance Project [IFPRI/FANTA] research area) that are the focus of the program’s principal livestock development and soy processing activities in 2014 (Table 3.2). This assistance has indeed helped motivate a relatively high percentage of the LMs to continue to attend the Care Group sessions even after graduation. It has also created a new conduit for the LMs to instruct the beneficiary mothers and other members of the community.⁹⁶ In the first *groupement* census in March-May 2014:

- 54% of the *groupements* in Ruyigi and 67% of the *groupements* in Cankuzo reported that they routinely incorporated some Essential Nutrition Actions (ENA) instruction by the LMs into their meetings; and
- 73% of the *groupements* in Ruyigi and 55% of the *groupements* in Cankuzo reported including some Essential Hygiene Actions (EHA) instruction into their routine meetings.

⁹⁵ This figure of 508 *groupements* is based on the following calculation: 269 *collines* covered by the program – 15 test villages where no Tubaramure activities were conducted = 254 x 2 *groupements* by community=508). Since the exact number of *groupements* targeted by different activities varied, this figure could go up and down.

⁹⁶ *Equipe de Suivi Evaluation CRS-Burundi*; 2014. *Quelques Résultats du Travail mené sur les Groupements (Associations) de PM2A dans les Provinces de Ruyigi et Cankuzo*. PowerPoint Presentation. (March-May 2014). Pp. 4-5.

The same baseline census estimated that 54% of the *groupements* in Cankuzo and 35% of the *groupements* in Ruyigi also have Savings and Internal Lending Communities (SILCs), which increases their chances of being sustained.⁹⁷

3.0. Evidence of Results^{98 99}

The program's output indicators were measured annually and, during the critical start-up period (2011), quarterly by the Tubaramure monitoring and evaluation (M&E) department based on a random survey of 400 beneficiary households. This annual performance survey provided real-time feedback to the implementing partners and their local government partners on which behaviors were changing most rapidly.

The same activities were expected to have a population-based impact through secondary adoptions of the new behaviors. The program's M&E plan set targets for these final population-based impacts and measured its progress toward achieving this through the final quantitative survey, in which 37.6% of the households were non-beneficiaries (i.e. did not receive PM2A rations from the Tubaramure Program).¹⁰⁰

3.1. Output 2.1. Households Adopt Essential Nutrition Actions

The Tubaramure BCC strategy focused on the promotion of six ENAs (Table 3.3). The principal mechanisms for promoting these behaviors were:

- Care Group training programs using the five BCC modules;
- LMs' and Tubaramure Health Promoters' supervision visits to individual homes; and
- Tubaramure-sponsored radio programs.

⁹⁷ *Equipe de Suivi Evaluation CRS-Burundi; 2014. Quelques Résultats du Travail mené sur les Groupements (Associations) de PM2A dans les Provinces de Ruyigi et Cankuzo.* PowerPoint Presentation. (March-May 2014). Pg. 7.

⁹⁸ **SOW Key Question 6:** With regards to the ENA and EHA (for IR1), Integrated Management of Childhood Illness (IMCI) (for IR1), and the food intake and diversity (for IR3), are beneficiaries adopting desired practices or behaviors? Are there some secondary adopters?

⁹⁹ **SOW Key Question 8:** To what degree are behavior changes continued by graduated program beneficiaries, for example changes that improve the nutrition of children over the age of two and changes that impact subsequent births?

¹⁰⁰ 42.1% of the total households in the survey (1,196) were PM2A graduates; 18.1% had a mother that was still receiving PM2A rations; 2.2% had a mother who had abandoned the program; and 37.6% had never been in the program. About a quarter (24.8%) of the women interviewed were LMs. ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A-Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pp. 17, 41.

Table 3.3. Percentage of Households Adopting the Main ENA and EHA Practices Promoted by the Tubaramure Program in Ruyigi and Cankuzo Provinces

Actions	Baseline	Final
	N=1,255	N=1,200 All
Output Indicator 2.4 <i>Percentage of households observed carrying out four or more ENA actions at time of household visit (observed or reported)</i>	N/A	69.8 ¹⁰¹
EBF: Percent of babies < 6 months exclusively breast-fed in last 24 hours	69.4	87.9
Four Food Groups: Consumption of at least four food groups by children	74.2	77.8
IBF: Immediate breastfeeding after birth	88.1	90.2
Iodized Salt: Consumption of Iodized Salt		58.4
GM: Child weighed and measured during the last four months	16.0	57.3
Pregnancy Diet: Increased food consumption by mother during pregnancy	N/A	32.0
Output Indicator 2.5 <i>Percentage of households observed carrying out four or more EHA actions at time of household visit (observed or reported)</i>	N/A	58.5
HW: Hand washing	N/A	36.0
Latrine: Latrines responding to norms	18.4	59.8
Clean Yard	N/A	95.8
Pit: Existence of a compost pit	N/A	64.2
Platform: Existence of a drying rack for washed dishes	9.0	48.5
Water Purification: Practices water purification	10.6	47.1
ITN: Use of insecticide-treated net	61.3	48.6

Source: Tubaramure Indicator Performance Tracking Table (IPTT) and *Institut de Statistiques et d'Etudes Economiques du Burundi* (ISTEEBU); 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014). Pp. 38-39.

The community-level results of the activities for the PM2A beneficiary households were tracked through a series of internal surveys of 400 randomly chosen beneficiary program households.¹⁰² This real-time feedback provided evidence that the beneficiary households were adopting most of the ENA actions.¹⁰³

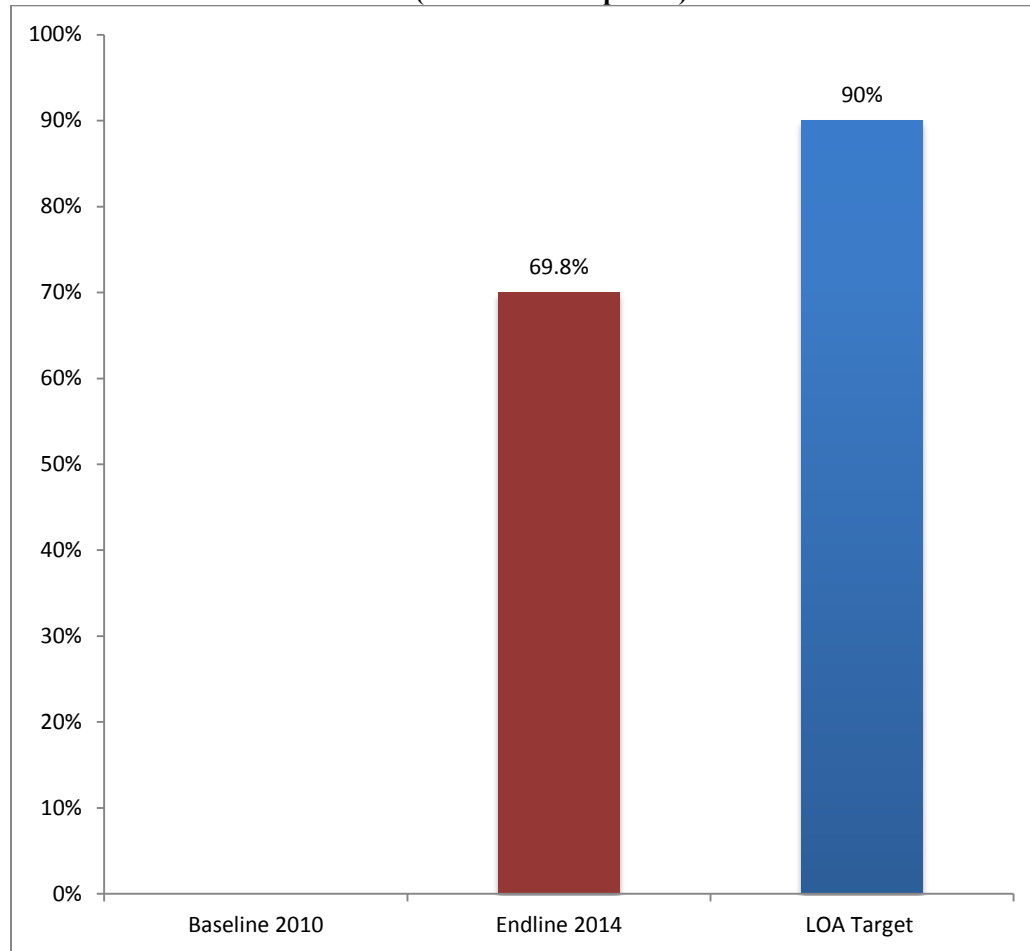
The final quantitative survey estimated that 69.8% percent of the households had adopted four or more of the Essential Nutrition Actions (Table 3.3; Figure 3.2). Since this indicator was not measured during the baseline quantitative survey, there is no way of knowing if the impact is statistically significant.

¹⁰¹ The indicator 2.4 on page 19 of the *Institut de Statistiques et d'Etudes Economiques du Burundi* (ISTEEBU) report is incorrectly labeled as EHA; it is for ENA. The indicator 2.5 on page 19 of the ISTEEBU report is incorrectly labeled ENA; it is EHA.

¹⁰² The initial surveys in 2010 were conducted bi-annually. After this time, they were conducted annually, and some of the data used to track the IPTT.

¹⁰³ Since the Tubaramure Program never developed the community-based systems for growth monitoring that were envisioned in the proposal, there was very limited motivation for the mothers to bring their children to the health center-based growth monitoring programs once they were no longer receiving rations (see Chapter 2, IR 1 discussions of growth monitoring).

Figure 3.2. Output Indicator 2.4. Percentage of Households Observed Carrying Out Four or More ENA Actions at Time of Household Visit (Observed or Reported)



Source: Tubaramure IPTT (Annex II).

It is important to emphasize that some of these practices were virtually unknown before the program started. Based on the focus group discussions during the final evaluation (Annexes IV and V), the evaluators concluded that most of the beneficiary mothers are continuing to practice the health behaviors they learned during the Tubaramure Program (Text Box 3.1).

Text Box 3.1. Testimonials from the Beneficiary Mothers about the Impact of the Program's IR2 BCC Activities

“Before Tubaramure, when the women didn't understand the infants nutritional needs, they gave breast milk as well as supplementary food from an early age. There were a lot of children's illnesses caused by dirty hands like diarrhea. Our children were underweight and often sick. Many births were also underweight (i.e. less than 2.5 kilograms). Since the Tubaramure Program started, most children are fed only breast milk during the first six months before being given broths. Thanks to the training we received and the adoption of improved hygiene practices, the percentage of children with diarrhea has decreased. The children have also gained weight. After graduation (i.e. after no longer being eligible for PM2A rations), I became pregnant and continued to use the good practices for me and after giving birth to the new child who I nursed exclusively during the first six months. Since my new baby is now over six months, I am continuing to look after him using the improved practices by feeding him a nutritious broth made from locally produced food.”

“Before the women didn't know how to prepare the foods that the program recommended. There were also lots of local taboos about certain nutritious foods not being good for you—like the idea that consuming liver would create dental problems in the child after birth or that eggs should only be sold to rich persons. One output of the program has been that women are starting to consume these products. The fact the mothers didn't know how to prepare balanced meals, increased the rate of malnutrition in our areas. Now the women are better able to follow the improved practices. The distribution of the family posters, which promote locally grown foods and dishes made with these foods, has also helped.”

Source: Final Evaluation focus group discussions in Nyagutoha colline; July 2014.

The same final evaluation focus group discussions made it clear that the level of understanding and practice of the recommended ENA was much higher for the direct beneficiary mothers (who were taught by a LM) than for non-beneficiary mothers who were not.

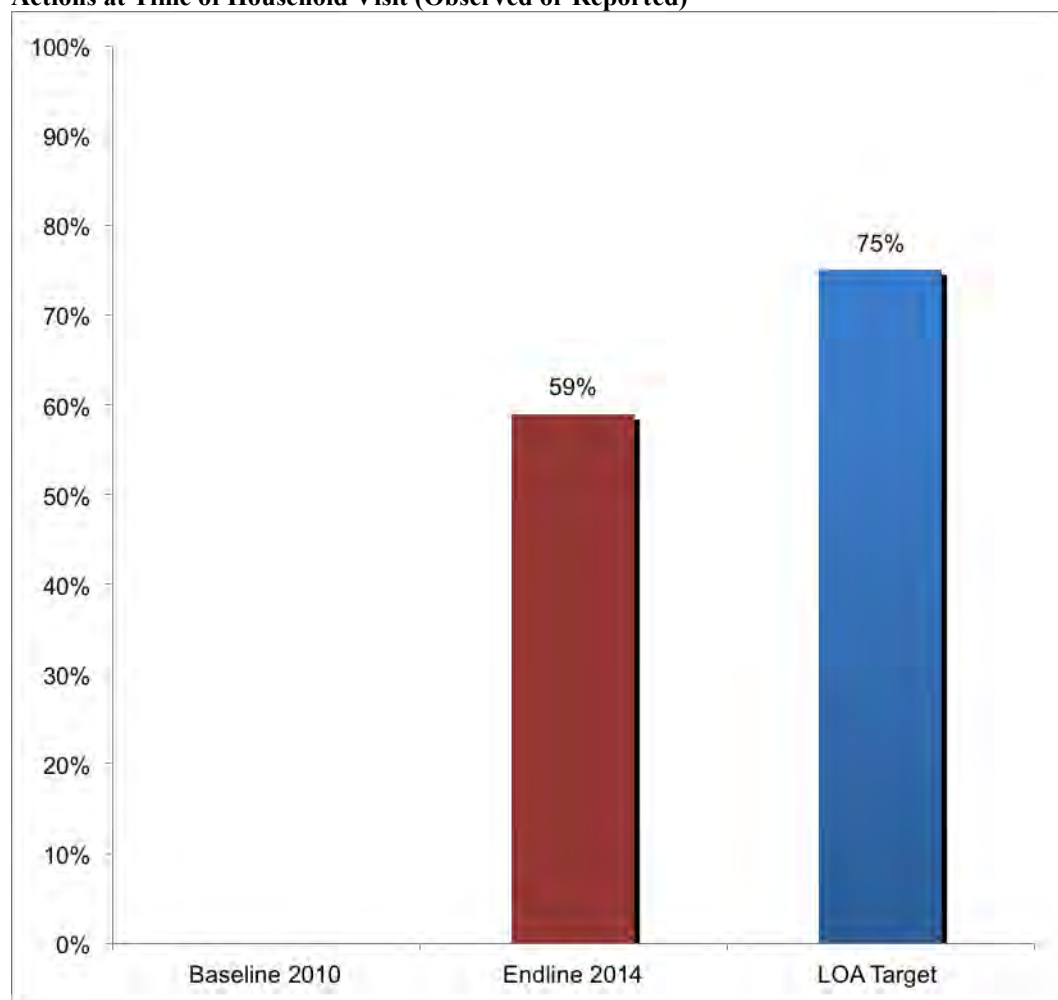
3.2. Output 2.2. Households Adopt Essential Hygiene Actions

The Tubaramure BCC strategy focused on the achievement of seven EHAs (Table 3.3; Figure 3.3). Although there was widespread agreement that these activities supported the IR1 outputs, these were not activities that were being tracked by the Community Health Workers. The principal mechanisms for promoting these behaviors were the same as those for promoting the ENAs:

- LM training programs;
- LM and Tubaramure Health Promoter-facilitated home visits; and
- Tubaramure-sponsored radio programs.

The final quantitative survey estimated that 58.5% percent of the households had adopted four or more of the EHAs (Figure 3.3). Since this indicator was not measured during the baseline survey, there is no way of knowing if the impact is statistically significant.

Figure 3.3. Output Indicator 2.5. Percentage of Households Observed Carrying Out Four or More EHA Actions at Time of Household Visit (Observed or Reported)



Source: Tubaramure IPTT (Annex II)

Many women who attended the focus group discussions stated that the practice of open-area defecation had considerably decreased in response to the training they received. When asked about which practices were the easiest to adopt, most of the beneficiaries mentioned construction of the drying racks, hand washing, latrine use, and regular bathing. One of the common observations made during the focus group discussions was that, *“Before, we all (children and adults) defecated in the open area. After the Tubaramure Program trained us on the importance of using latrines, we constructed latrines in our homes. Most children and adults no longer defecate out of doors.”*

Key factors that appear to have sustained and even increased these behaviors after the mid-term evaluation were the Tubaramure Program’s:

- Commitment to a lower-cost norm for latrines that could be built and sustained with local materials;¹⁰⁴

¹⁰⁴ Based on evidence from the mid-term focus group discussions and the 2012 barrier-to-behavior-change study, the program shifted to a lower cost mode of latrine construction based on locally available materials and made a

- Efforts to promote greater involvement of the beneficiaries’ and non-beneficiaries’ husbands in the sanitation activities; and
- The implication of the local commune administrators, as well as other high-ranking members of the community (including the two governors) in promoting the new sanitation behaviors in speeches and site visits.

It is indicative of the successful impact of the program’s efforts to involve local authorities in building a more widespread base of local support (from men, women, and local chiefs) that most of the commune and provincial-level authorities interviewed during the final evaluation were able to describe the various EHA and ENA activities. Many of the same commune authorities and both governors were also able to show ways that they supported these activities (Text Box 3.2).

Text Box 3.2. Lesson Learned: Critical Importance of Involving Local Authorities in BCC Campaigns

“One of the main impacts of the Tubaramure Program has been to improve sanitation and health practices throughout the province. I was very impressed by the ones I was shown when I participated in the joint supervision site visits with the program. It is an impact that is very much appreciated by the local people and one I support. Since then, I have sought opportunities to include these themes into the speeches I give at various colline and commune-level meetings. This afternoon I am scheduled to give such a speech and I will find a way to incorporate something about how proud I am of that community’s efforts to improve its sanitation and health practices and how important it is to continue to support these.”

Source: Key informant interview with Ruyigi Province Governor Cyriaque Nshimirimana; July 2014.

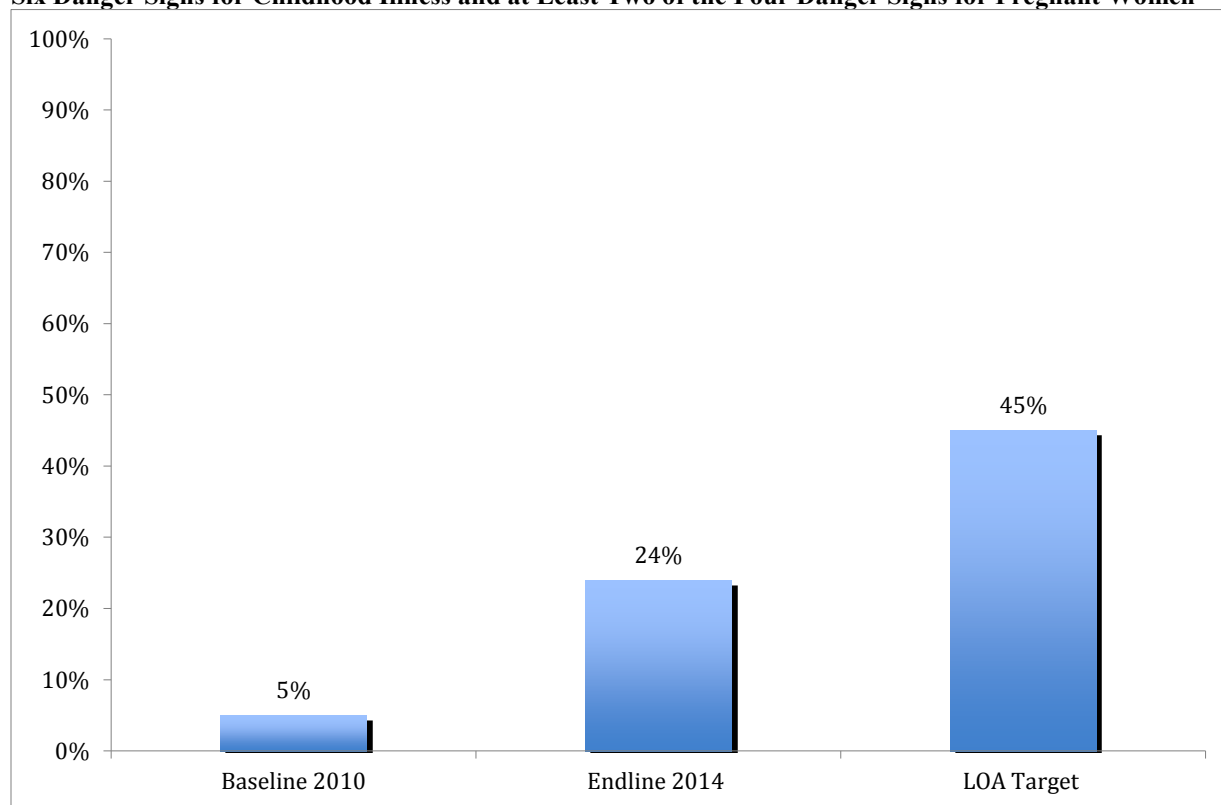
In contrast to the ENA actions—which are directly linked to the community-level activities under IR1—the Tubaramure Program’s sanitation activities are, by and large, not currently being tracked by either the Community Health Workers or the health centers as part of the performance-based financing (PBF) indicators that they track for the MoH. Informal discussions with the IR1 technical (IMC) staff during the final evaluation suggest that the MoH is lobbying to add a number of EHA indicators to the PBF indicators, which they consider essential to the successful achievement of its wider curative and preventive mission.

conscious effort to increase the involvement of men, and local and provincial-level administrators in building public awareness and support for these efforts. This shift in focus resulted in a sharp population-based impact in latrine use that was confirmed by the final quantitative study.

3.3. Output 2.3. Households Adopt Prevention and Management Behaviors for Maternal and Childhood Diseases¹⁰⁵

The final quantitative survey showed a 19-point increase in the percentage of mothers with children under 2 who could state at least four of the six danger signs for childhood illnesses, and at least two of the danger signs for pregnant women (Figure 3.4).¹⁰⁶ Although this increase was statistically significant, it was still half the expected population-based target of 45%.

Figure 3.4. Indicator 2.6. Percentage of Mothers With Children Under 2 Who Can State at Least Four of the Six Danger Signs for Childhood Illness and at Least Two of the Four Danger Signs for Pregnant Women



Source: Tubaramure IPTT (Annex II).

The principal reason for this much lower (than the target) population-based impact appears to be the program’s exclusive focus on the target beneficiary households, which limited the impact of the program on the wider population.

The final evaluation focus group discussions with beneficiary and non-beneficiary women¹⁰⁷ confirmed that substantial progress has been made in identifying and managing several major

¹⁰⁵ The original indicator for this output was “Percentage of households with children under 2 with a reserved package of [Oral Rehydration Salts] ORS at time of household visit.” At mid-term, the decision was made to change the indicator for several reasons, including the fact that the ORS packets were not available commercially. Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 38.

¹⁰⁶ There was no major difference between Cankuzo and Ruyigi in this indicator—26.7% vs. 23.1%, respectively.

¹⁰⁷ In the later years, it appears that some non-beneficiary women joined these groups—especially after graduation when the principal focus of the groups shifted to the SILC and economic *groupement* activities.

childhood diseases, but that the level of understanding of the danger signs was much lower for the non-beneficiary women.

The same focus group discussions showed an almost universal commitment of the LMs and beneficiary mothers to continuing to use these skills to manage their own children's illnesses, as well as those of neighbors and family who came to them for consultation. Since this capacity to identify the danger signs is critical to sustaining the MoH's goals for clinical and Community-Based Integrated Management of Childhood Illness (C-IMCI)—and to the MoH's maintaining the substantial increase in these indicators that resulted from the Tubaramure Program—there is a clear need for a joint strategy with the MoH on how to continue to build the capacity of local households to identify, manage, and prevent the province's most prevalent childhood diseases. Although Tubaramure made a good start, this is an area that needs to continue to be supported.

One output of the Tubaramure-sponsored barrier analysis on the use of insecticide-treated nets (ITNs) in June 2011 was a more committed focus on what could be done at the household level to prevent and manage malaria. This activity was strengthened by Caritas's distribution of bed nets to the LMs to use as demonstration tools during Care Group presentations. By May 2014 (when the final quantitative survey was conducted), 50.7% of the children were sleeping under mosquito nets—45.4% in Ruyigi and 60% in Cankuzo.¹⁰⁸ Based on interviews with MoH staff and the focus group discussions, this appears to be an important increase though the evaluation could not document it quantitatively since it was not measured during the baseline survey.

3.4. Evidence of Differential Impacts on Certain Groups¹⁰⁹

3.4.1. Beneficiary vs. Non-Beneficiary Women. The focus group discussions indicated that there was a significant difference between the beneficiary and non-beneficiary mothers' ability to state the six danger signs for the principal childhood illnesses and most of the adoption of the recommended EHA and ENA practices (Annex IV).

Unfortunately, only one of the program's internal IR2 indicators—the percentage of children who slept under mosquito nets the previous night—was disaggregated by beneficiary and non-beneficiary households, so it is not possible to compare this using the quantitative survey's results.¹¹⁰ The steep drop in the “percentage of households observed carrying out four or more EHA actions at time of household visit” between 2012 and 2013 (74.3% and 70.1% respectively), when the indicator was measured for beneficiary households only, and 2014 (58.5%), when the indicator was based on the population survey, was attributed to the lower rates of adoption by non-beneficiary households that were not counted in the 2012 and 2013 survey (Annex II).

¹⁰⁸ ISTEEBU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A-Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pg. 16.

¹⁰⁹ **SOW Key Question 7:** Are there certain groups within the population with lower rates of adoption and why?

¹¹⁰ That analysis stated, “that a higher percentage was noted for the mothers still in the program and a lower percentage for the children of mothers who had not been in the program.” ISTEEBU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). In fact, the figure was 64% for the mothers still in the program, 57.8% for the graduated mothers, and 40.4% for non-beneficiaries, so the disaggregated analysis did not show a big difference (Table A.11.A Pg. 85).

3.4.2. *Vulnerable Groups*. Certain vulnerable groups were less able to adopt the recommended ENA and EHA practices than others:

- Batwa: The dispersed Batwa¹¹¹ communities in Cankuzo Province and the three *collines* with the heaviest concentration of this social group;
- Female-Headed Households: Especially those located in the six *collines* near the Tanzania frontier where a high percentage of the economically active men are migrant workers in Tanzania for the majority of the year.¹¹² Staff reported that once this issue was identified (through Tubaramure Health Promoter feedback to supervisors) the supervisors tried to encourage the *colline* chiefs to organize group labor to assist these vulnerable women with some of the more labor-intensive innovations like constructing latrines and building compost piles; and
- Vulnerable Households Living in *Collines* with Insufficient Drinking Water: It was difficult for them to adopt many of the ENA and EHA practices. In the short-term, one of the most immediate problems will be for the MoH to work with its new and existing partners moving into both provinces to increase access to potable water. The lack of potable water is a critical constraint in 48.2% of the communities in Ruyigi and 54.9% percent of the communities in Cankuzo.¹¹³

Two other groups that staff noted as facing differential constraints in adopting the new BCC messages were:

- Landless: Who represent from 7-10% of the population by most MAE estimates; and
- HIV/AIDS-affected households.

3.5. Evidence of Impact on Local Institutional, Community, and Household Capacity¹¹⁴

3.5.1. *Creation of a Base of Trained LMs*. To date, the program has trained 4,920 LMs in both provinces. The program estimates that 60% of the 4,920 LMs are still actively involved with the program, in the sense that they still attend the Care Group meetings that Tubaramure organized during the program's last quarter. Based on the focus group discussions, most LMs still practice the improved behaviors they were trained in and continue to extend some of these messages to their neighbors (Annexes IV and V). This trained force of volunteer LMs can continue to increase the effectiveness of the mainstream MoH community-based BCC programs.

3.5.2. *Increased the Number of Women Organized Into Registered Groupements*. The Tubaramure Program has helped created 874 *groupements*. In contrast to most of the other *groupements* supported by the two Provincial Directorates for Agriculture and Livestock

¹¹¹ Staff estimates that the Batwa represent a small percentage of the population—estimated by most staff as between 2-5%. Historically the Batwa have been migratory with few permanent settlements and more limited integration into the national health system.

¹¹² Staff reported that the *collines* with the highest incidence of migrant labor tended to be along the border with Tanzania.

¹¹³ Estimates are based on the initial qualitative classification of the *collines* that was conducted as a basis for choosing the *collines* for the interviews.

¹¹⁴ **SOW Key Question 13:** To what extent the implemented activities under IR2 and 3 have developed and strengthened the institutional, the community, and the households' capacities?

(*Direction Provinciale de l'Agriculture et de l'Elevage* or DPAEs), the majority of the members of these *groupements* are women. Although many of these *groupements* are just getting organized, they have increased the capacity of local women to lobby for women farmers and to advocate for the types of services and input they need to build household food security (Annexes IV and V). As the Cankuzo commune agronomist stated during one of the Final Evaluation key informant interviews, “*We now know they are there and that they are organized. This makes it easier to help them when new programs come. The trick, however, is to know that they exist and what crops or livestock activities they are interested in. Currently we don’t know where these groupements are and what they are working on except for the few we assisted on keyhole gardens and goat programs.*”

3.5.3. Increased Women’s Ability to Lobby for the Health and Nutrition Issues That Concern Them. One direct, but heretofore very poorly documented, impact of the Tubaramure Program has been its impact on women’s empowerment and participation. This is an impact that was noted by both governors and most of the commune authorities that we encountered. Most attributed this empowerment to a combination of factors, but most importantly the IR2 model of teaching and home supervision visits through the LMs.

Three indicators of the program’s wider impact on women, which were widely cited by the local authorities, were (Table 3.4):

- A small but important number of Tubaramure LMs (196) have been elected to the Commune Development Committees (CDCs) that are charged with executing the recently adopted Commune Community Development Plans (*Plans Communaux de Développement Communautaire* or PCDC) documents;
- 537 LMs have been elected to the commune-level women’s forums; and
- 205 LMs petitioned for and were selected to be MoH Community Health Workers.

Table 3.4. Number of Tubaramure LMs Who Have Become Community Health Workers, Commune Development Committee Representatives, or Members of the Women’s Forum

Category of Involvement	Cankuzo	Ruyigi	All
Tubaramure LMs trained	1,991	2,929	4,920
LMs selected as MoH Community Health Workers	101	104	205
LMs elected to the CDCs	107	89	196
LMs elected to the gender forum	228	308	536

Source: Tubaramure Final Evaluation based on data provided by IR3 Coordinator for Tubaramure (Ruyigi) Ezéchiel Kabwebwe and Tubaramure Provincial Coordinator (Cankuzo) Edmond Twagirayezu; July and August 2014.

3.5.4. Increased Discussion of Community-Based Health and Nutrition Issues in the PCDC Planning Processes. In the past, there has been very little real discussion or analysis of the community-based health and nutrition issues that interested women in the PCDC. One explanation of this, put forth by the chief counselor of Cankuzo Province, is the limited involvement that women have had in these *colline* and commune-level planning processes. One unintended but obvious impact of the program—which was independently noted by each of the local administrators and province-level authorities that the evaluation team met with—has been to increase women’s willingness and ability (particularly the LMs) to engage in these *colline*-level and commune-level planning processes. This increased participation was reflected in the content of the most recent generation of the PCDCs in the three Ruyigi communes where the

team had access to both the 2014 (second-generation) and 2009 (first-generation) PCDC documents.¹¹⁵

This increased visibility and mainstreaming of some of the Tubaramure achievements into the Ruyigi PCDCs was attributed to three factors:

- The increased confidence that the LMs gained from their training and BCC activities;
- The qualitative evidence from key informant interviews that many of the LMs have used their Tubaramure contacts (with the Tubaramure Health Promoters and the IR supervisors) to build their credibility with the local administrators of the communes and *colline* chiefs, who have dominated the PCDC planning process in the past; and
- The provincial coordinator and the IR2 and IR3 supervisors for the Tubaramure Program in Ruyigi participated in the initial PCDC planning meetings. Their participation in these meetings helped the commune and *colline* administrators in Ruyigi to better translate some of the recommendations coming from the *colline* general assemblies into the technical terms needed for the final PCDC planning documents.

4.0. Factors Which Contributed to and Detracted From Program Relevance, Effectiveness, Efficiency, and Acceptability of Processes, Outputs, and Implementation

4.1. Relevance

4.1.1. Critical Importance of the IR2 Activities for Sustaining the Results Under IR1 and the Program's Global Impact on Nutrition. The same IR2 activities were highly relevant because:

- They supported a series of accepted and approved protocols the MoH adopted and wanted to achieve; and
- They built the community capacity for the MoH, which led to some of its most important achievements in the key areas being targeted under IR1 (Table 3.5).

¹¹⁵ All three of the most recent PCDCs for the three communes that the team examined in Ruyigi included activities designed to support more diversified food intake and community-based programs to build and promote EHAs, whereas the previous PCDCs (from 2009) did not. The Tubaramure provincial coordinator for Ruyigi and IR2 and IR3 supervisors for Ruyigi participated in the initial PCDC planning meetings with the local commune administrators and development councilors is a contributing factor since it enabled them to better translate some of the recommendations coming from the *colline* general assemblies into the technical terms needed for the final document.

Table 3.5. IR2 Activities that Affected the Community-Level Outcomes of IR Outputs in the Tubaramure Program

IR1 Outputs and Outcomes	IR2 Activities That Contributed to IR1 Outputs and Outcomes
Outcome Indicators 1.1, 1.2, 1.3 for IR1 ¹¹⁶	-Short-term increases in desired health behaviors for prenatal counseling sustained due to mother’s understanding and wider cultural support -Short-term increases in postnatal counseling not sustained because of lower levels of appreciation and or cost/benefits of time needed to access the center level activities -Short-term increase in GM not sustained, but delayed demand created by training reflected in quick up-take in pilot programs for community-based GM in both provinces (see output 1.3 below)
Output 1.1. Pregnant and lactating women access pre and postnatal care services	IR2 training and LM support increased women’s understanding about the critical importance of prenatal care services (reflected in health center indicators)
Output 1.2. Implementation of national IMCI plan is supported	IR2 training and support from the LMs has increased the rate of children being referred to the health centers through the Community Health Workers before their illness has become critical (reflected in health center indicators)
Output 1.3. Health facilities supported in providing GM	-The fact that GM was a required activity to receive rations, combined with IR2 training and support from the Care Groups and LMs, created a short-term increase in the number of children participating in the health center-based GM (reflected in health center indicators) -Although this has not been sustained (is back to baseline levels), the increased community understanding of GM (from the Tubaramure training) is resulting in a very rapid understanding of the new community-based GM initiatives being pilot tested in 12 <i>collines</i> by the Tubaramure Program and eight <i>collines</i> by World Vision in Cankuzo
1.4. Severe acute malnutrition (SAM) is detected and referred for treatment	-Training modules have increased the LM, beneficiary, and non-beneficiary mother’s ability to identify severe and acute cases of malnutrition and to refer them to the Community Health Workers for referral to a health center for treatment (reflected in health center indicators) -IMC’s willingness to pay the costs of transporting sick children and someone to accompany the child at the hospital (under IR1) has reinforced the communities’ willingness and ability to refer children to health centers

Source: Tubaramure Final Evaluation interviews and literature review; July 2012

The Tubaramure MYAP anticipated that the program would contribute to the MoH’s ongoing consideration of the Care Group Model as a complement to its existing program. The principal reason for this was the Care Group Model was not a top priority for the MoH during this time period. Thus, although the technical lead for IR2 participated in the coalition¹¹⁷ of organizations within Burundi that were implementing Care Groups, little traction was gained.

4.2. Effectiveness

The Tubaramure BCC strategy was highly effective in raising knowledge levels and promoting behavior change of the PM2A beneficiaries as demonstrated by the measureable changes in good practices, especially for hygiene, breastfeeding, and the utilization of health services for pregnant

¹¹⁶ **Indicator 1.1.** % of pregnant women completing at least three prenatal visits; **Indicator 1.2.** % of mothers completing at least 2 postnatal visits; and **Indicator 1.3.** % of children 9-36 months attending GM visits at least once in a two-month period.

¹¹⁷ This coalition included Concern, World Relief, CRS, and FH. The members met regularly and lobbied the MoH to recognize the Care Group Model.

women and young children.¹¹⁸ There is qualitative evidence from the focus group discussions that linking PM2A programming rations made these behavior changes occur more quickly than they would have otherwise (Annexes IV and V).

The BCC strategy was less effective in achieving its population-based impact. Its effectiveness was decreased by the fact that the BCC programs focused almost exclusively on the PM2A beneficiaries and their families, especially in the first three years. This directly affected the non-beneficiary mothers' understanding of the major BCC themes. The health/nutrition specialist on the final evaluation team identified a wide gap between the basic ENA and EHA knowledge of beneficiary mothers and non-beneficiary mothers.

The model's BCC effectiveness was further decreased by the fact that the program did not implement the gender strategy that was outlined in the MYAP proposal (Text Box 3.3). Because of this, there was insufficient implication of the beneficiary's husbands—and men in general—during the first three years.¹¹⁹

Based on emerging evidence that a main reason for beneficiary drop out was the lack of involvement of the beneficiaries' husbands, the program added the concept of the Leader Fathers (LFs) in some Care Groups in 2011. After the mid-term evaluation, the IR2 technical lead worked in close collaboration with the other partners to develop a series of activities that targeted men and encouraged more participation of the beneficiaries' husbands in the Care Groups. While this was helpful, it was too late to have a major impact on the results.¹²⁰

Text Box 3.3. Gender Strategy from the Original Tubaramure MYAP Proposal

“The program will encourage men to identify and take on day-to-day tasks that promote gender equity in the home and that foster a climate of shared responsibility. The program will rely on community-level strategies for involving men in the program to help break through gender barriers/issues that unfairly burden the women by:

- Enlisting the support of husbands and male leaders for women's initiatives; and
- Utilizing men as agents of change.

Training modules will focus on:

- Practicing responsible fatherhood; and
- Creating opportunities for men to learn the skills necessary to provide care and support to women.”

Source: CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pp. 20-21.

4.3. Efficiency and Acceptability of Processes and Program Outputs

4.3.1. *Link with PM2A Food Distribution.* One factor that affected the efficiency and acceptability of the Tubaramure BCC model was the direct linkage between that program and the

¹¹⁸ This is the same observation made during the mid-term (Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 40.)

¹¹⁹ **SOW Key Question 15:** Are there any factors (barriers/constraints) that limited community participation and engagement in the program implementation?

¹²⁰ **SOW Key Question 12:** How effective is the nutrition and health sector at reaching fathers/men? What could be done in future programming to improve father/men's participation in such sectors? How can this affect sustainability?

PM2A food distribution.¹²¹ All PM2A beneficiaries were required to participate in a beneficiary group with LMs, who became an important link between the program's food tracking system and the beneficiaries.

This link between PM2A and the Care Group diminished the voluntary aspect of the Care Group. Once the original PM2A beneficiaries and LMs graduated—i.e. were no longer required to attend the meetings as a condition for getting their PM2A rations—many of the LMs and beneficiary mothers dropped out because they did not see a concrete motivation (return) for participating.

To encourage the PM2A graduates to continue participating in the Care Groups, the program developed a host of motivations for the mothers and beneficiaries in 2011. Since there was no budget for post-distribution motivations and the time was very limited, the program focused on a series of low-cost innovations that they could execute in a very short time period. The same post-graduation activities created more work for the already overloaded Tubaramure Health Promoters, which further decreased the time they had available for training the LMs and making home visits.

*4.3.2. The IR2 BCC Training Modules.*¹²² When the program started, there were no standard training modules for the MoH Community Health Workers. This forced the program to develop its own modules and conduct formative research to ensure that the materials responded to both the local and MoH needs. The fact that the program was unable to build on pre-existing MoH modular materials created a host of execution delays. Another problem was the sheer number of modules, which became an issue once the MoH validated its first integrated module for training the Community Health Workers in August 2012, coinciding with Tubaramure's mid-term evaluation (See Annex VI.A.2). Most of the MoH staff interviewed during the final evaluation felt that this Integrated Community Health Worker Training Module touched on every one of the themes that was included in Tubaramure's five BCC training modules.

Although the MoH approved the five draft modules for pilot testing, the modules have not yet been formally approved and validated for use by the MoH's personnel. Although some of the MoH Public Health Technicians that were interviewed during the final evaluation said this did not bother them—i.e. that they would continue to support the LMs using the modules—some of the other technicians said they would not.

Key challenges remaining are to develop a solid action plan for final review and validation of the modules with the appropriate MoH units. Given the need to harmonize these modules with the

¹²¹ Some of the lessons learned from the Tubaramure experience with adopting Care Groups are discussed in Annex 8 of this recent training module that was developed by Technical and Operational Performance Support (TOPS), Food Security and Nutrition Network Social and Behavioral Change Task Force. 2014. "Care Groups and the Preventing Malnutrition in Children under 2 Approach [PM2A] Annex 8." In, *Care Groups: A Training Manual for Program Design and Implementation*. Washington, DC: Technical and Operational Performance Support Program. Annex <http://fsnnetwork.org/resource-library/social-and-behavioral-change/care-groups-training-manual-program-design-and-implement>.

¹²² **SOW Key Question 24:** PM2A took a modular approach to BCC at the household and community level, and a curriculum was developed for improving health services, particularly at local health clinics. What was the impact of these modules on preventing malnutrition?

pre-existing (and validated) Integrated Community Health Worker Training Module, the MoH is likely to ask for some of them to be shortened or better harmonized with its integrated manual for the Community Health Workers. Given the long time delays that will be required, this is unlikely to happen before the end of November.

If these activities are completed along with some sort of practical module that summarizes the lessons learned from the Tubaramure PM2A Program, it will contribute to the government's ongoing discussion and review of the Care Group Model that is likely to occur over the next six months.¹²³

4.3.3. High Labor Demands on the Tubaramure Health Promoters. Even if the five BCC training modules had been available at the time they were originally scheduled for, it would have been impossible for the Tubaramure Health Promoters to teach the beneficiary groups correctly given the competing demands on their time. Earlier studies conducted by the Tubaramure IR2 lead (FH) estimated that the maximum number of Care Groups that a Tubaramure Health Promoter could manage successfully would be 11,¹²⁴ if his or her time was totally focused on their BCC activities (See Annex VI.B.5).

By the mid-term, it was already clear that many of the Tubaramure Health Promoters had many more than 11 Care Groups to supervise, and that a host of other activities (food distribution, site visits, culinary demonstrations, and support for *groupement* and SILC activities) not anticipated in the original MYAP document required time that was time taken away from their cascade training activities. One Tubaramure Health Promoter in Ruyigi had 59 *groupements* to supervise on top of her other BCC activities under IR2, and one in Cankuzo had 125. Only four of the 24 Tubaramure Health Promoters that were included in the 2014 *groupement* census had under 20 *groupements* to support; 12 of the promoters had 21-35; and 8 had over 35.¹²⁵ The issue of coordinating these different activities was complicated by the fact that the direct supervisors of the Tubaramure Health Promoters who were responsible for the IR2 BCC activities were not employees of the IR2 technical lead but rather CRS who was the technical lead for IR3.

This heavy labor burden had a direct and measureable impact on both the time and quality of the Tubaramure Health Promoters' training using the modules and home visits. There simply were not enough Tubaramure Health Promoters to cover such a large territory adequately with the competing demands placed on them and their decreasing numbers as the program is starting to wind down. One of the health promoters interviewed during the final survey currently covers 13 *collines* that are quite far from one another where he is responsible for 185 LMs, 26 *groupements*, and 17 SILCs, as well as supervising all the home visits. This huge workload from new activities decreased their efficacy in monitoring the beneficiaries, especially the LMs on

¹²³ SOW **Key Question 18:** With regards to the preventative model, what contribution will the PM2A be able to offer to the government?

¹²⁴ Actually, the recommended ration was 1:9. (see: http://www.caregroupinfo.org/docs/Care_Group_Criteria_November_12_2010.pdf). For budget reasons, the Tubaramure Program revised this figure to 1:11 (source: feedback during the final review of the draft final evaluation document).

¹²⁵ *Equipe de Suivi Evaluation* CRS-Burundi; 2014. "Quelques Résultats du Travail mené sur les Groupements (Associations) de PM2A dans les Provinces de Ruyigi et Cankuzo" PowerPoint Presentation. (March-May 2014). Pg. 1.

some of the more complex issues like identification and home-based management of childhood illnesses.

4.3.4. The Tubaramure Health Promoters' Training and Technical Capacity. The program was careful to provide short basic trainings for new Tubaramure Health Promoters that were hired after the program's baseline training; this training was usually done on a case-by-case basis by the IR supervisors. In addition to this, the promoters received an on-the-job lesson every two weeks from their supervisor that they were expected to repeat for their Care Groups. One major observation from health and nutrition expert Dr. Sidibe Sidikiba on the final evaluation team is that this amount of training was not enough given the highly technical nature of some of the nutritional training they were expected to give the LMs and technical backup they were supposed to provide the health centers. The Health Promoters performed well considering the constraints under which they were operating. The real issue is that it was unrealistic to expect one single *polyvalent* (multi-purpose) Tubaramure Health Promoter to provide technical backup to the LMs without strong technical backup and collaboration from the MoH's community-level personnel (i.e. the MoH Public Health Technicians and the Community Health Workers). Had there been the same number of trained MoH Community Health Workers in the two provinces today (1,167) in 2008, it is clear that the Tubaramure's IR2 activities would have been designed differently. Unfortunately, when the program was designed there were only 712 MoH Community Health Workers and the statute giving them full legal recognition and training was not finalized until late 2012. Thus, one cannot say that the high workload was the problem, it was simply a contributing factor given other design issues in the program start up.

*4.3.5. Lack of Collaboration Between Technical Partners.*¹²⁶ A fifth factor that affected the efficiency and the acceptability of processes and program outputs under IR2 was the fact that the MYAP proposal did not include a clear plan for how the IR1 technical lead (IMC) would backstop and coordinate with the IR2 technical lead (FH) in order to facilitate the links between the IR2 BCC activities and the community-level MoH activities. Had this been done, it might have made it easier to build the MoH support for and understanding of the Care Group Model into the program earlier.

The fact that this kind of clarification was not in the MYAP proposal probably can be attributed to the implicit assumption (by all of the partners involved in the initial design) that the MoH was on the cusp of formally recognizing the Care Groups and incorporating them into their core community intervention model. If the MOH had developed a formal protocol for the Care Groups, then the issue of building MoH support for and understanding of the Care Group Model would have never happened.

¹²⁶ **SOW Key Question 2:** What are the factors that hinder/assist the effective integration of the program components?

SOW Key Question 3: Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?

4.4. Sustainability¹²⁷

It is likely that the knowledge levels and certain practices (e.g. improved hygiene and sanitation feeding, optimal breastfeeding, utilization of health services, attendance at prenatal consultations, and dietary diversity) will remain high.¹²⁸ It is also clear from the focus group discussions with 123 LMs and 223 PM2A beneficiary and non-beneficiary mothers in the *collines*, that the vast majority of the LMs are still important health and nutrition resource persons. During the last two years of the program, the LMs were the go-to people who connected sick children to Community Health Workers, who then connected them to the health center.¹²⁹ They were also the go-to people for interfacing with Tubaramure IR1 provincial supervisors to get funds to pay for transporting sick children and supporting the adult who accompanied the sick child during his or her hospitalization.

4.4.1. *Progress Toward the Execution of the IR2 Exit Strategy.*

4.4.1.1. *Current Status.* The Tubaramure PM2A Program's 'sustainability strategy' for IR2 was based on two critical assumptions:¹³⁰

- That the Care Groups would remain functional in the Tubaramure Program area; and
- That the Care Group model would be taken to scale in the country.

If these two assumptions held, the MoH would continue working through the Care Groups and LMs to sustain the BCC messages that were developed under IR2.

Although the Government of Burundi (GoB) is still considering a formal Care Group protocol, this has not yet happened. Therefore, once the Tubaramure Program funding ends, the principal vehicle for all MoH communication with the *collines* will be the MoH Community Health Workers. Once this happens, the LMs will simply support these activities since they are not an official part of the MoH community health system. Whether or not the LMs will continue their BCC and Community Health Worker support functions in the future will depend a great deal on what they perceive as the benefits of investing their time and energy in these volunteer activities. These benefits will in part depend on if and how the MoH agents that supervise the MoH

¹²⁷ **SOW Key Question 22:** How has the topic of sustainability of program interventions been dealt with under the program, including a) how sustainability was described/defined at the outset, b) whether there were flaws in the program design that would impact sustainability, c) what mid-course corrections were made, and what were missed, in enhancing program sustainability, and d) what lessons have been learned to improve the sustainability of future PM2A programming in Burundi and elsewhere.

SOW Key Question 23: Related to the sustainability topic is how long-lasting are the interventions achieved under IRs 1 and 2? For example, do graduating families continue to apply the lessons they learned to children who a) have graduated, or b) were born after the mothers graduated?

¹²⁸ The mid-term evaluation made the same observation (Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 40).

¹²⁹ Many mothers and staff noted that the Tubaramure LMs were not able to write the script needed to refer a child to the health center. Some cited cases where a sick child was referred and denied treatment because they did not have a Community Health Worker-written referral.

¹³⁰ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pg. 22.

volunteer Community Health Workers make use of the LMs to support the other donor and non-donor supported activities that are going to be executed in both provinces in the coming years.¹³¹

In July 2014, the Tubaramure IR1 lead (IMC) completed a detailed exit strategy for its activities in collaboration with the MoH that outlined clear responsibilities for handover and bridge activities to ensure effective turnover. Unfortunately, this exit strategy did not identify the how the IR2 activities that supported the IR1 activities would be handed over or sustained.

To address this issue, the Tubaramure IR2 lead (FH) staff—working in close collaboration with IMC—organized two five-day training workshops on the five modules that were developed under IR2. This workshop was attended by all of the MoH Public Health Technicians in each province, as well as their immediate supervisors in the provincial offices of the MoH. The Ruyigi training took place over a five-day period from June 16-20, 2014; the Cankuzo training took place over the five-day period from July 7-11, 2014.

Although some of the Public Health Technicians participated in the baseline training of the MoH staff on the Care Group Model in 2009, due to high levels of staff turnover many of them had not. The principal objective of the training was to re-familiarize the MoH Public Health Technicians with the five modules that FH developed for its IR2 activities in the hopes that they will continue to support the LMs' use of the modules. A secondary objective was to discuss various options for determining how the MoH technicians might build on the LMs' trainings to support some of their existing and new activities with the volunteer Community Health Workers once the program funding ends in November 2014. Each of the provincial supervisors of the MoH technicians who were interviewed during the final evaluation said they saw the LMs as an incredible resource. To date, however, only a few isolated Public Health Technicians seem to have moved forward with the development of any sort of formal plan about how they might better connect the LMs and the MoH Community Health Workers.

To develop these plans, each MoH Public Health Technician who supervises the 1,167 MoH Community Health Workers (who were trained to support the community-level activities component of the four MoH outputs supported under IR1) needs a list of LMs and beneficiaries, as well as a list of the assisted and non-assisted *groupements* and SILCs by *colline*. These records exist and can be extremely helpful in connecting the Community Health Workers and Public Health Technicians to the MoH. When the final evaluation team was in the field, all of the program's records on the LMs were still in two separate locations:

- The register that each Tubaramure Health Promoter keeps on the *collines* that he/she supervises (i.e. one register covers three to four villages); and
- The Tubaramure Health Promoter records on the *groupements* and SILCs, which are also grouped by zone of intervention, which, like the register, regroups multiple villages.

An additional source of data on LMs, *groupements*, and SILCs is the master database that one of the Tubaramure PM2A M&E officers has just completed on each *groupement* (see Annex VI.B.4), of this chapter for a list of categories in the database).

¹³¹ **SOW Key Question 16:** How are graduated and current beneficiaries in the community coping with the end of food distribution?

4.4.1.2. *Critical Next Steps*. During the two exit strategy workshops in Cankuzo and Ruyigi in June and July, the MoH and Tubaramure representatives decided to prepare this informal exit strategy in two steps.

Step One: Joint Assessment of the Tubaramure Program’s *Colline*-Level Impacts (MOH/Tubaramure) (tentative scheduling July-August 30, 2014)

Census of Tubaramure Colline Activities Executed Through Care Groups for All 269 Collines in the Program. Each IR2 supervisor for Ruyigi and Cankuzo committed to developing a list of LMs, the trainings they have received, and their current level of activity based on the information recorded in the register. This activity is scheduled for completion in August, after which there is a tentative plan for organizing a provincial-level meeting to discuss the information and to develop a formal handover plan.

Joint Tubaramure Health Promoter/MoH Visits to Review the LMs’ Activities. During the same time period, there was a tentative agreement that each Public Health Technician would try to organize joint visits to the *collines* in order to better understand what they were doing and how they could work better with the volunteer MoH health workers. Although this is a laudable concept, it is difficult to put into practice. Although the Tubaramure Health Promoters (who have the records and know the communities) have motorcycles and a budget for fuel, not all of the MoH Public Health Technicians (who supervise the Community Health Workers) have bicycles, which limits their ability to attend meetings organized at the health centers.

Step Two: Provincial Meeting for Handover of the Registers and Lists (tentatively scheduled for September)

There was the implicit expectation in the June-July 2014 training sessions that the program would organize some sort of formal handover of the registers and *colline*-level information on the program’s activities in September 2014. This [official hand over did occur for Cankuzo and Ruyigi on October 16, 2014 in Muyinga Province. The Bujumbura official hand over is schedule for October 23, 2014.](#)¹³² This is apparently occurring on a case-by-case basis.

4.4.2. *Key Challenges the MoH and the DPAAE are Likely to Face in Sustaining the Tubaramure Program’s Results Under IR2*. The MoH and the DPAAE are likely to face priority issues for follow-up on the Tubaramure Program’s IR2 activities in the coming year (Table 3.6).

¹³² Evariste Habiyambere, Food for the Hungry; October 15, 2014.

Table 3.6. Priority Issues for Follow Up to Capitalize on the Results of the Tubaramure Program’s IR2 Activities

Priority Issues for Follow Up	For the MoH Over the Next Year	For Other Donors Working in Health and Nutrition and Food Security in the Two Provinces
Strengthen the LMs’ links to the MoH Community Health Workers and the Public Health Technicians	Strengthen MoH Community Health Workers and Public Health Technicians to identify and work with the Tubaramure-trained LMs in ways that strengthen their existing and projected community-based programs	
Strengthen the Tubaramure-facilitated <i>groupements</i> ’ links to GoB and NGO programs to increase their food security and IGAs		-Strengthen DPAE (provincial, commune, and <i>colline</i> -level) capacity -Capitalize on the existing knowledge and organization of the Tubaramure SILCs and <i>groupements</i>

Source: Tubaramure Final Evaluation; July 2014.

The first priority issue is to determine how to build a sustainable link between the LMs and other PM2A graduates who have benefitted from four years of BCC messages from the training and are clearly (based on the program’s quantitative data and the focus group discussions) practicing many of the malnutrition prevention behaviors designed by the program. This is an issue that directly affects the ability of the MoH to sustain the community-level impacts of the Tubaramure’s IR1 support, because there is a direct connection with the MoH’s mandated activities and strategies.

The second priority issue for follow-up is to better link the Tubaramure-facilitated *groupements* to the MAE agents and donor and NGO-funded programs they need to increase their food security and income-generating activities (IGAs). This second challenge is critical because it is directly linked to the achievement of the program’s global goal of reducing malnutrition because:

- It affects food access and availability of the LMs and PM2A graduates directly and, to a lesser extent, the other households in the community; and
- It affects the LMs’ willingness and ability to continue carrying out the volunteer activities they were trained to execute through the Care Groups.

5.0. Lessons Learned and Best Practice Checklist

Table 3.7. Tubaramure Program IR2 Lessons Learned and Best Practice Checklist

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	MoH	Future Donor-Funded Activities	Future PM2A and Food Security Programs
IR2: Households practice appropriate health and nutrition behaviors.			
Lesson 1. <i>Care Groups can be a powerful model for promoting the types of broad-based behavior change that are needed to sustain the short-term nutritional impacts of a PM2A program.</i>			
1. Consider how the program's CG structure will be integrated into the existing health systems from the start to ensure its sustainability once program funding ends.		X	X
2. If the national health system does not recognize the Care Group Model, consider developing the model as a complement to other activities (like the Hearth Model and community-based GM) that are recognized by existing or draft protocols; and continuing to work with the MoH to determine if and how the concept could be better recognized by the existing protocols both during and after the program.		X	X
3. Participate in national forums that review various ways that the Care Group Model can strengthen the existing models for community-level BCC.	X	X	X
4. Avoid any sort of direct linkage between the Care Group Model and eligibility for PM2A rations in order to keep the Care Group voluntary and to ensure more broad based participation.			X
5. Complement the Care Groups with mechanisms to reach the wider society with consistent BCC messages that build the wider community's support and understanding of the messages.		X	X
Lesson 2. <i>Care Groups require careful training and retraining of the implementing staff and beneficiary LMs to be effective BCC agents both during and after the program.</i>			
6. Consider adding other staff to deal with non-BCC issues (like IGAs and food distribution) and/or reducing the area of intervention to ensure appropriate backup support.		X	X
Lesson 3. <i>Encourage Care Groups to develop IGAs in order to sustain their BCC activities over time.</i>			
7. Anticipate the costs of developing IGAs and/or SILCs to support the LMs developing IGAs from the start of the program.		X	X
8. Identify the partnerships to develop and sustain the LMs' IGAs in the initial design, and monitor them so they can be adjusted as the most viable IGAs are identified.		X	X
9. Budget adequate staff/partner time needed to support these activities so that the IGA activities do not detract from Care Group and BCC trainings.		X	X
Lesson 4. <i>Anticipate the need for a gender-sensitive communication strategy that develops a wide base of community support and understanding for the BCC messages, both during and after a PM2A program.</i>			
10. Include a well-thought-out draft gender strategy in all PM2A proposals that anticipates some of the special challenges associated with PM2A that are not found in more conventional food security programs.			X

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	MoH	Future Donor-Funded Activities	Future PM2A and Food Security Programs
11. Ensure that this strategy complies with the gender strategy of the funding agency (like USAID), as well as donor expectations for gender monitoring and reporting (only recently adopted). ¹³³			X
12. Ensure that the program gender strategies are compatible with the national gender strategy, and provincial and commune-level coordination structures.			X
13. Conduct an annual review of each PM2A program's gender strategy as part of the routine annual review and planning processes.			X
14. Include internal indicators for the gender strategy that are tracked as part of the routine internal and donor tracking of the program, even if these are not in the Indicator Performance Tracking Table (IPTT).			X
15. Have a field-based gender specialist in each program intervention zone that can also function as the local capacity building and M&E officer.			X
16. Budget basic gender training and retraining of staff and all local government and NGO partner staff the program works with.			X

Source: Tubaramure Final Evaluation; July-August, 2014. Revised based on feedback to the first draft, September 22-October 5, 2014.

¹³³ The USAID gender strategy was formally adopted in March 2012 and updated in 2013 in the USAID Automative Directive System (ADS), Chapter 205 (aka ADS 205) (Integrating Gender Equality and Female Empowerment in USAID's Program Cycle, New Edition Date: 07/17/2013, Responsible Office: PPL File Name: 205_07171307/17/2013 New Edition), which outlines the expectations for staff integration of the policy into existing and future USAID-funded programs.

Chapter 4 Intermediate Result 3: Eligible Women and Children Have Increased Intake of Diverse Food

1.0. Global Strategy

The goal of the Tubaramure activities under Intermediate Result 3 (IR3) was to promote the increased food diversity and intake needed to reduce both provinces' high levels of malnutrition. The IR had three expected outputs, each with a respective set of activities (Table 4.1).

Table 4.1. Major Outputs that were Designed to Achieve the Tubaramure Program's IR3

IR3. Eligible women and children have increased intake of nutrient-rich, diverse foods.
Output 3.1. Food For Peace (FFP) rations distributed to eligible women and children at community level.
Output 3.2. Mothers and children use FFP rations appropriately.
Output 3.3. Households use appropriate local foods in addition to FFP ration.

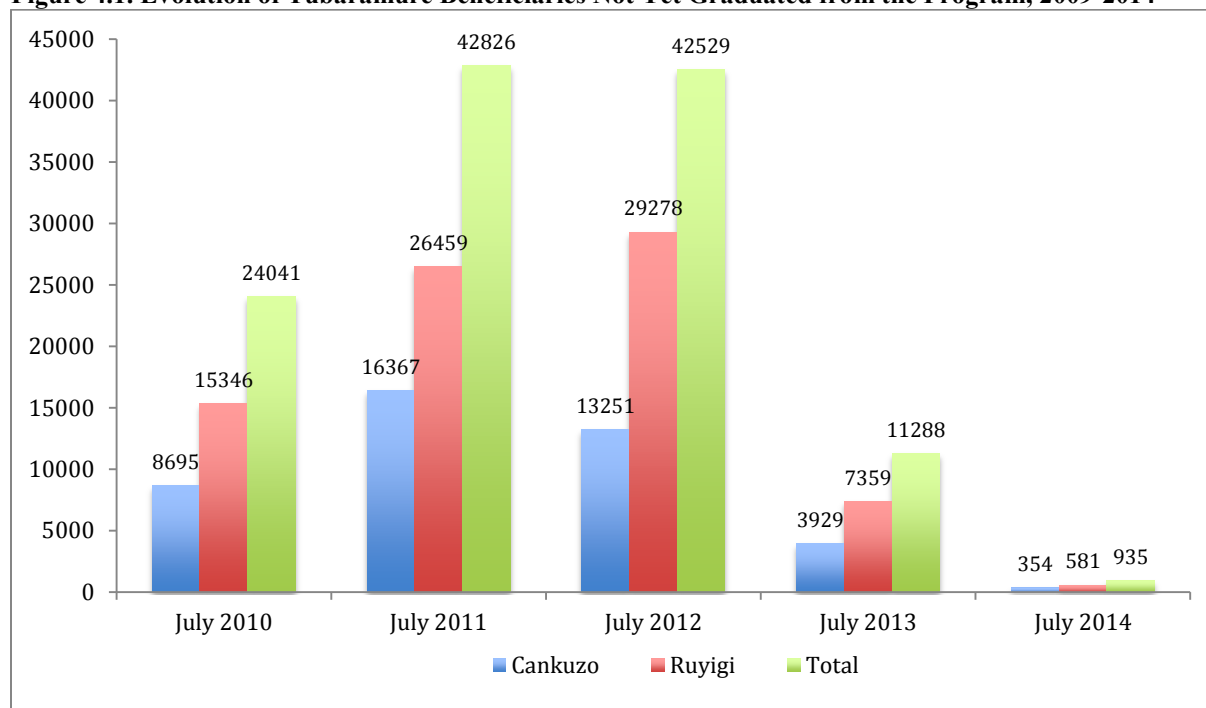
Source: Catholic Relief Services (CRS); 2009. *Tubaramure Multi-Year Assistance Program (MYAP) Proposal*. Bujumbura: CRS.

The short-term impact of the food distribution and culinary demonstrations under Outputs 3.1 and 3.2 was to increase dietary diversity and intake during the program for the beneficiary mothers.¹³⁴ One of the conditions for getting rations was participation in some of the IR1-supported health services and the IR2 beneficiary group activities. Over the longer term, the program was expected to stimulate local demand for increased food intake and a more diversified diet using local foods through a series of activities under Output 3.3.

Although the short-term focus of the activities was on the Preventing Malnutrition in Children Under 2 Approach (PM2A) beneficiaries, the program was expected to have a population-based impact on dietary diversity in both provinces. Since most of the original PM2A beneficiaries have already graduated (Figure 4.1), this evaluation focuses on the activities under Output 3.3 and some of the cross-cutting lessons learned from Outputs 3.1-3.3 for PM2A programs that are hoping to have a population-based impact on household dietary diversity.

¹³⁴ **SOW Key Question 18:** With regards to the preventative model, what contribution will the PM2A be able to offer to the government?

Figure 4.1. Evolution of Tubaramure Beneficiaries Not Yet Graduated from the Program, 2009-2014¹³⁵



Source: Tubaramure M&E Office; August 2014.

1.1. The Original IR2 Strategy

To achieve Output 3.1, the Tubaramure Multi-Year Assistance Program (MYAP) Proposal outlined an efficient system for commodity distribution and targeting.

The activities under Output 3.2 focused on:

- Working through the Leader Mothers (LMs) to conduct community awareness campaigns to explain the program’s goals, eligibility criteria, duration for PM2A rations, and how these would be reinforced during home visits;
- Working through the Ministry of Health’s (MoH’s) commune-level personnel and community leaders to reinforce the rationale for rations; and
- Working through the Tubaramure Health Promoters to conduct spot checks of the household ration buckets to monitor the level of commodity utilization and verify awareness of who is targeted in the household.

The activities under Output 3.3 focused on increasing household consumption of nutritious food by getting fathers to serve the food to their children rather than selling it. The original MYAP sub-strategy for Output 3.3 focused on:

- Developing a strategy for promoting men’s involvement in maternal and child nutrition;
- Recipe demonstrations incorporating local foods (including animal products) appropriate for pregnant and lactating women and children under 2;

¹³⁵ The official total number of direct beneficiaries is listed as 49,650. These figures indicate the number of beneficiaries that have not yet graduated from the PM2A distribution.

- Identification of recipes by Tubaramure and MoH nutrition experts in consultation with LMs;
- Promotion of local foods;
- Raising farmers' awareness of increased demand for nutritious foods for pregnant and lactating women and children under 2;
- Pilot tests of food preparations that can be used by households once Title II has ended; and
- Promotion of seeds and small animals by Catholic Relief Services (CRS), "*under its cost share to a small population of the most highly vulnerable beneficiaries with extremely limited access to complementary foods.*"¹³⁶

2.0. Activities¹³⁷

2.1. Program Start Up to Mid-Term

2.1.1. Output 3.1: Food for Peace (FFP) Rations Distributed to Eligible Women and Children at Community Level. In keeping with the Tubaramure Program focus on preventing malnutrition, the program targeted all pregnant and lactating women and mothers of children under 2 regardless of nutritional status. To ensure that the local population understood the reasons this was being done, the program started with an intensive public awareness program that targeted all of the provincial, communal, and local-level chiefs. The fact that all of the Tubaramure Health Promoters were recruited from the local communes and continued to be based in the commune centers helped facilitate this communication process. The fact that all of the commune and provincial-level authorities were invited to the quarterly coordination meetings was another example of best practice (see Annex VI.A.5).

The strong, consistent implication of the local leaders in turn helped minimize commodity theft and illegal sales—often by the women's husbands—of the commodities. The same consistent pattern of communication with the local authorities helped minimize the inevitable social conflicts that resulted from only a portion of the households in a given *colline* being eligible for rations, and some *collines* being excluded from the program because they were the International Food Policy Research Institute/Food and Nutrition Technical Assistance Project (IFPRI/FANTA) test villages.

During the first two years of the program, the principal mechanism for executing the activities was through Tubaramure Health Promoters. The health promoters were the direct interface between the warehouses and mobile distribution points and the mothers. They were also responsible for monitoring the mothers' eligibility and making notes about any shifts in eligibility and rations, such as the child reaching 2 years of age. All of this was done by hand, time consuming, and easily susceptible to human error.¹³⁸

¹³⁶ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pg. 18.

¹³⁷ *SOW Specific Objective 1*: Are the health component activities being implemented according the Detailed Implementation Plan (DIP)? What are the obstacles and the delays observed? What recommendation can be done for future program?

¹³⁸ Most of the Tubaramure Health Workers estimated that this activity consumed the equivalent of about a week of each month during the first two years of food distribution (2010-2011).

A major turning point was the arrival of a new monitoring and evaluation (M&E) director at the end of the first year. Once he realized how labor intensive the system for documenting the households' eligibility was, he started working on a new database that would computerize the commodity targeting and reporting. This new system, launched in November 2011 just prior to the graduation of the first 8,000 beneficiaries, had a huge impact on the efficiency of the commodity system by making it possible to have real-time printouts for the warehouse and mobile distribution units, and reducing the amount of time that the Tubaramure Health Promoters needed to compile their reports from about a week to a few hours. This user-friendly—very simple to create and update—database system is an example of a best practice that other PM2A programs should emulate.

2.1.2. Output 3.2: Mothers and Children Use FFP Rations Appropriately. A great deal of effort was expended in the first year of the program explaining the rations, their purpose, who was eligible, what quantities were to be distributed to each category beneficiary, and what the conditions were for continued eligibility. To ensure that the corn-soy blend (CSB) and vegetable oil were correctly prepared, Tubaramure developed and disseminated recipes in both Kirundi and French, and periodically organized cooking demonstrations, sometimes including local foods in season along with the CSB and vegetable oil.¹³⁹ These culinary demonstrations followed the same cascade training model used under IR2, with the IR3 technical advisor training the Tubaramure Health Workers, who trained the LMs, who then trained the beneficiary groups.

To facilitate this process, the IR3 technical lead (CRS) developed a recipe book, which was approved by the MoH for use in the local communities. This cookbook included recipes for some of the nutritious dishes and weaning foods using the FFP rations, as well as foods that could be produced and/or purchased locally.

2.1.3. Output 3.3: Households Use Appropriate Local Foods in Addition to FFP Ration.

2.1.3.1. Culinary Demonstrations. From the start, culinary demonstrations emphasized the use of locally grown nutritious foods for family consumption and children's weaning broths. Based on the final evaluation focus group discussions, the culinary demonstrations had a major impact on the diets of both beneficiary and non-beneficiary (i.e. non-PM2A) recipients (Annexes IV and V). Many of the women interviewed emphasized that these dietary changes were encouraged by the enthusiastic scale up of the keyhole gardens, as well as increased income from the Savings and Internal Lending Communities (SILCs). One of the most frequently cited constraints to continuing these new dietary practices was the limited household access to improved seed.

2.1.3.2. Savings and Internal Lending Communities. Using its cost share, the CRS SILC specialist for the MYAP program in Kayanza, Kirundo, and Muyinga provinces trained all of the Tubaramure Health Promoters in the design and promotion of SILCs over a 16-month period between August 2010 and November 2011.¹⁴⁰ The concept of SILCs was new to both provinces,

¹³⁹ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 43.

¹⁴⁰ The original proposal anticipated the use of the cost-share funds to purchase livestock and seeds.

but built on the traditional concept of the saving tontine¹⁴¹ (Text Box 4.1), yet took off rapidly with no major problems. By 2011, the Tubaramure Program had created 61 SILCs; by the mid-term evaluation, there were 439.¹⁴² During this time, the principal participants in the SILCS were the LMs and PM2A beneficiaries although some non-beneficiary women were in the groups even from the start.

2.1.3.3. Initial Seed and Livestock Distributions. In early 2012, the program provided gardening seeds, fruit trees, and poultry to four *groupements* that had been organized by LMs (see Table 3.2 in Chapter 3). The principal justification of these distributions, which were not anticipated in the MYAP proposal, was to motivate these LMs to remain involved in the program after graduation. Although the distributions were appreciated, there were several cases in which these efforts were negatively influenced by the poor, sub-standard quality of the seed, plants, and poultry that was distributed, and poor timing of the distributions (due to the difficulty of accessing certified seed and the premature crop season) that decreased the effectiveness of this activity.¹⁴³ Most of these agricultural input issues were corrected after the mid-term evaluation when the program was able to conduct longer-term planning for these ‘new’ activities, which were not anticipated in the original MYAP proposal or program budget.

2.1.3.4. Keyhole Gardens. During the same time period, CRS facilitated some of the core Tubaramure staff attending a training workshop at a CRS program in Lesotho and made the first pilot tests in early 2012. The principal justification of this new activity (which was not anticipated in the MYAP proposal) was to help the beneficiary households develop an easy-to-access source of the vegetables needed to maintain a more diversified diet. By the end of April 2012, there were already 119 gardens—evidence that non-beneficiaries were replicating the gardens—and demand for the Tubaramure Health Providers to help people construct them.¹⁴⁴

¹⁴¹ A ‘tontine’ is a traditional form of rotating group savings that is widespread in many parts of Africa. A group is usually comprised of relatives or friends. The group agrees on a specific amount for each member to contribute and a specific day for the contribution, as well as the total number of participants in the scheme. On the agreed date, the members meet and pool the money together and one of them takes the total amount. The chosen member can be selected by lottery or the group can decide to allocate it to someone specific because of urgent matters affecting that person. No member can be selected twice in the same cycle. Before the entry of formal microfinance institutions, microlending existed through these tontines, as well as informal moneylenders and cooperative associations.

¹⁴² Tubaramure IR3 National Coordinator Regine Pacis Nohoreho; July 2014, based on reports by Tubaramure IR3 Coordinator (Ruyigi) Ezéchiél Kabwebwe and Tubaramure Provincial Coordinator (Cankuzo) Edmond Twagirayezu.

¹⁴³ Key informant interviews during the final evaluation and Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 44.

¹⁴⁴ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 45.

Text Box 4.1. The Concept of the Savings and Internal Learning Communities

CRS has a long and successful history of group-based rotating savings and credit associations, known as SILCs, where 15-30 people agree to first pool a set amount of money each week and, after one month, start distributing small credits to one/some members to use for up to three months at 10% interest until everyone has had a chance to borrow and reimburse until three months before the end of a maximum cycle length of 12 months. In these last three months, credit is not issued, the reimbursements are all collected, and each member gets a dividend proportional to their equity called a share out. After the payout, the group then starts another cycle, sometimes with slightly different rules based on consensus and lessons learned, and usually with a higher weekly contribution. All groups have two funds, one for productive loans (now with contributions about \$1/week) and one for personal emergencies (with contributions of about \$0.20/week). A few groups have a share out after eight or nine months to coincide with the season for peak cash need (August/September for school-related expenses).

Source: Ali Aamoum, Merella Mokbel Genequand, Bernard Crenn, and Mike Devries; 2012. *MYAP Final Evaluation Report*. Bujumbura: CRS. July 31, 2012. Pp. 45-35.

2.2. Principal Conclusions and Recommendations From the Program Mid-Term^{145 146}

2.2.1. *Output 3.1: FFP Rations Distributed to Eligible Women and Children at Community Level.* A thorough review of the Tubaramure Program's pipeline and the implemented system for ensuring the timely and effective distribution of Title II commodities was conducted during the program's mid-term evaluation (Text Box 4.2). For this reason, the approved scope of work (SOW) did not include any specific objectives or key questions focused on this element of the program.¹⁴⁷

¹⁴⁵ *SOW Specific Objective 8:* How the mid-term evaluation recommendations were taken into account for improving the program implementation?

¹⁴⁶ SOW Key Question 5: To what extent recommendations from the mid-term evaluation have been incorporated into the nutrition and health sector?

¹⁴⁷ During the first year of distribution (2010), the program had already reached 95% of the eligible women and child pairs, which represented 119% of its original target (see Annex II, Tubaramure Indicator Performance Tracking Table [IPTT]). This evaluation was effusive about the effectiveness and efficiency of the system (Text Box 4.2). The same IR3 food distribution system was lauded by the IFPRI/FANTA staff interviewed during the final evaluation for its effectiveness in getting the right rations to the right individuals in a timely manner. It is critical to underscore the huge complexity of this part of the program since the rations needed to be adjusted for whether the woman was pregnant or lactating, and include a protective ration that had to be adjusted to the size of the family. The principal recommendations for the mid-term were: 1) minor adjustments to the program (recommendations 1-8, 11-12); and 2) working with the community, the husbands, and other volunteers to construct shelters, latrines, and simple handwashing stations using the same principles as those taught to the women and households in the communities (recommendations 9 and 10).

Text Box 4.2. Mid-Term Evaluation Assessments of the Tubaramure Pipeline and Implemented Commodity System (IR 3, Output 3.1), June 2012

“The commodity management system for the Tubaramure Program has no threshold issues. It is evident that the key players in this component are very knowledgeable about Title II food commodities management principles and regulations. Some of the recommendations and suggestions in this report are already being carried out. With good coaching and closer monitoring of the warehouse managers and the field sites, CRS/Burundi (the technical lead for IR 3) will make its system a stellar model with good practices that others can replicate.”

“For Output 3.1, a smoothly functioning commodity supply chain ensures that eligible women and children are receiving the rations as planned. The combined efforts of local authorities, the LMs, and the Tubaramure staff—especially the Tubaramure Health Promoters—ensure that the Title II rations are being used appropriately.”

Source: Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pp. 45 and 69.

2.2.2. *Output 3.2. Mothers and Children Use FFP Rations Appropriately.* The mid-term evaluation report concluded that the program’s extensive investment in explaining the logic behind the rations had paid off in terms of high levels of beneficiary understanding, and that the program’s decision to execute a protective ration was justified and completely necessary.¹⁴⁸

2.2.3. *Output 3.3. Households Use Appropriate Local Foods in Addition to FFP Ration.* Based on the focus group discussions during the mid-term, the mid-term evaluation team concluded that, “everyone seemed to know well...the importance of a balanced diet. Beneficiaries and non-beneficiaries, men as well as women—all could list local products for the three main food categories; but whether the outcome—increased consumption of local food—will be achieved is another question.”^{149 150}

The original proposal anticipated that, “as part of the formative research, ...the project will look at the role of fathers in the feeding of children. Based on the findings the project will develop a strategy for promoting men’s involvement in maternal and children (sic) nutrition.”¹⁵¹ Another weakness observed at mid-term was the program never executed the formative research that was supposed to look at the role of fathers in feeding their children as a basis for promoting men’s involvement in maternal and child nutrition.^{152 153}

¹⁴⁸ The mid-term evaluation team concluded, “It is simply not acceptable or feasible for a mother not to share food with other family members. In this respect, the protection ration definitely contributes to the overall program goal of preventing malnutrition in children under 2.” (Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 44).

¹⁴⁹ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 47.

¹⁵⁰ *SOW Specific Objective 9:* To what extent program activities were financially supported, and how will they be sustained at the institution and the community levels after the program closure?

¹⁵¹ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pg. 17.

¹⁵² Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 44. The program did, however, develop a module on gender issues that it used to train staff and beneficiaries starting in June 2011 (Source: Feedback on the draft Tubaramure Final Evaluation, September 22, 2014).

¹⁵³ **SOW Key Question 12:** How effective is the nutrition and health sector at reaching fathers/men? What could be done in future programming to improve fathers’/men’s participation in such sectors?

The mid-term evaluation report made six recommendations to strengthen the achievements of the outcome indicators for Output 3.3:¹⁵⁴

- Continue to work on a gender action plan that would involve men more fully in promoting maternal and child nutrition;
- Determine the feasibility and potential effectiveness of adding activities to increase the availability and access to food in the program;
- Continue to explore the possibility of developing a substitute for CSB and vegetable oil;¹⁵⁵
- Continue to expand keyhole gardens and other agricultural and animal husbandry activities already initiated with the Ministry of Agriculture and Livestock (*Ministère d'Agriculture et d'Elevage* or MAE);
- Examine the current budget to see if cost centers (budget lines) can be adjusted to provide more resources for food production and/or SILC activities; and
- Complete the development of a plan to track women and children who have graduated from the ration-distribution component.

2.3. Impact of the Mid-Term Evaluation Recommendations on IR3 Strategies and Activities and Integration with the Program's IR2 Activities

The program's response to these recommendations focused on (Table 4.2):¹⁵⁶

- *Gender Strategy*: Developing a gender action plan to increase men's involvement in and support for the Tubaramure Program's activities
- *Income-Generating Activities (IGAs)*: Developing a series of activities for helping the LMs develop economic *groupements* (groups), keyhole gardens, and SILCs that they would need to sustain a more diversified diet.

¹⁵⁴ ¹⁵⁴ Kathy Tilford, Ange Tingbo, and Vera Bensmann; 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure. Pg. 49

¹⁵⁵ Unfortunately, the team did not gather very much information on the follow up to this recommendation about what worked and did not work, under PM2A.

¹⁵⁶ Leonie Niyonkuru; 2012. *Etude sur la Pérennisation des Care Groups et les Activités Genre dans le Programme Tubaramure*. Bujumbura: Tubaramure. (November 2012). Pp. 22-23.

Table 4.2. Link Between Mid-Term Evaluation Recommendations and Key Groups of Follow-Up Activities

Mid-Term Evaluation Recommendations	Gender Strategy and Training	Income-Generating Activities					
		Organization, Technical Training and Material Support to Develop <i>Groupements</i>	Seed and Livestock Distributions to <i>Groupements</i>	Expansion of the Number of SILCs	Develop Keyhole Gardens	Livestock Distributions to <i>Groupements</i>	Other
Continue to work on a gender action plan that would involve men more fully in promoting maternal and child nutrition	X						
Determine the feasibility and potential effectiveness of adding activities to increase the availability and access to food in the program		X		X	X		
Continue to explore the possibility of developing a substitute for CSB and vegetable oil ¹⁵⁷							Activities undertaken but not a focus of evaluation
Continue to expand keyhole gardens and other agricultural and animal husbandry activities already initiated with the MAE					X		
Examine the current budget to see if cost centers (budget lines) can be adjusted to provide more resources for food production and/or SILC activities	X	X	X	X	X	X	
Complete the development of a plan to track women and children who have graduated from the ration-distribution component							Not done

Source: Tubaramure Final Evaluation in response to a request from the United States Agency for International Development (USAID) reviewers; received October 10, 2014.

¹⁵⁷ Unfortunately, the team did not gather very much information on the follow-up to this recommendation about what worked and did not work, under PM2A.

Based on the recommendations from the mid-term evaluation findings for IR2 and IR3, the program supported two barrier-to-behavior-change studies in 2012, one of which focused on identifying a revised strategy for increasing men's involvement in the program and sustaining the Care Groups. This same study identified a strategy for helping the beneficiary groups develop the types of registered economic groups (*groupements*) needed to get more help from the MAE

2.3.1. Rapid Increase in the Number of Groupements Starting in 2012. The Tubaramure Program formulated its first formal *groupement* strategy in early 2013. By 2014, the program had facilitated the creation of 874 *groupements*.¹⁵⁸ Given the limited number of resources the program had to help the *groupements*, it tried to limit its direct assistance (seed, technical assistance, etc.) to two *groupements* per colline. As of August 2014, 434 of the *groupements* have been assisted, and an estimated 713 (82%) of all the *groupements* are registered.¹⁵⁹ Most groups are mixed, involving both beneficiary fathers as well as other men in the community.

2.3.2. Provision of Seeds and Livestock to the Groupements. To support the *groupements'* activities, the program helped them access seed and small livestock starting in 2012 (Chapter 3, Table 3.2). Certain *groupements* were also given goats in 2012, 2013, and 2014 (Chapter 3, Table 3.2). By 2014, all of the assisted *groupements* had received at least one pair of goats using a goat solidarity chain approach.¹⁶⁰ The initial beneficiaries in each *groupement* were expected to then 'rotate' a percentage of the offspring from this initial stock of animals to the other members in the *groupement*. Many of the *groupements* were also given soybean seeds to pilot test using a model developed by CRS/Rwanda (Chapter 3, Table 3.2). Based on the initial enthusiasm for the concept, the program distributed a full slate of equipment to promote soy production to the 434 assisted *groupements* in August 2014.¹⁶¹ Although some of the commune and provincial-level veterinarian specialists helped select the animals for distribution, this collaboration was not part of any formally negotiated collaboration with the MoH since this was not anticipated in the original program design.¹⁶²

2.3.3. Steady Expansion of the SILCs and Training of SILC Private Service Providers. The number of SILCs increased exponentially starting in 2012 (Figure 4.2).

¹⁵⁸ For more information on the evolution of the Tubaramure-supported *groupement* activities, see Chapter 2.

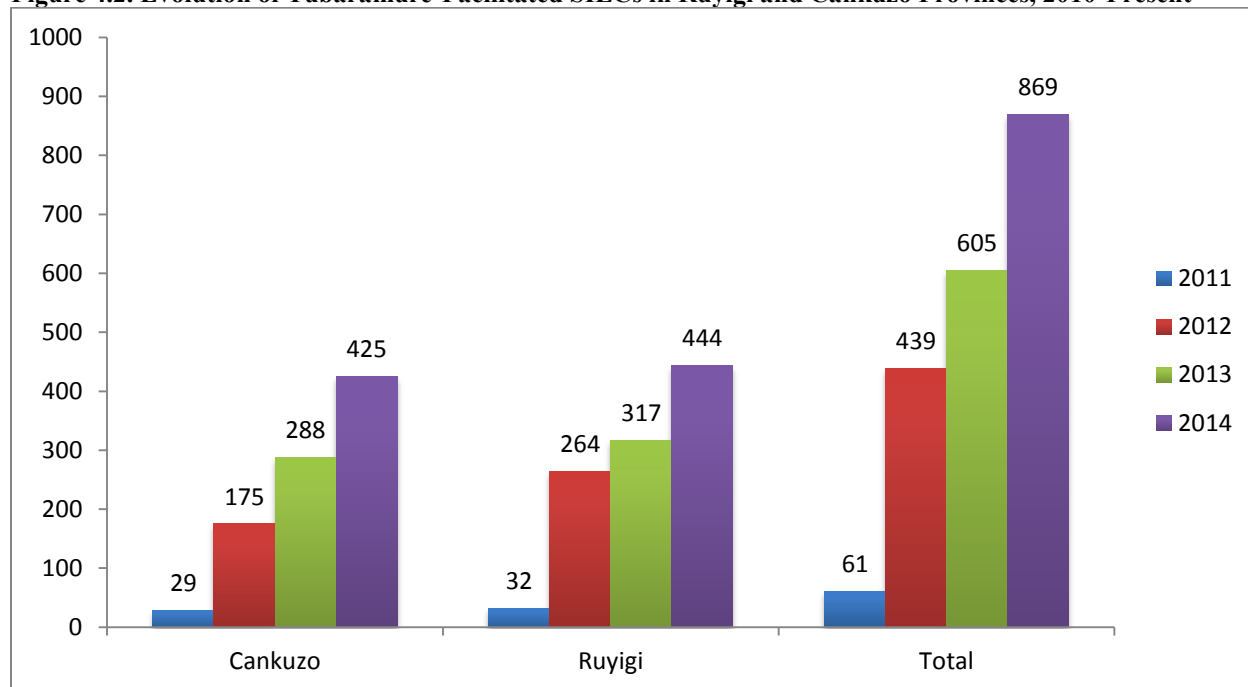
¹⁵⁹ Thaddee Niyonzima, Tubaramure M&E Office. August 28, 2014 from the program's *groupement* database.

¹⁶⁰ Only two of the many *groupements* created by the LMs in each *colline* were assisted by the program due to resource constraints. For more information, see Chapter 3.

¹⁶¹ *SOW Specific Objective 4:* Are provided equipments appropriate, well dispatched, and well used for reaching the expected results?

¹⁶² **SOW Key Question 4:** Is the nutrition and health sector fitting into the local government's strategy and priorities? What has been the level of coordination/collaboration with the Government of Burundi and other actors?

Figure 4.2. Evolution of Tubaramure-Facilitated SILCs in Ruyigi and Cankuzo Provinces, 2010-Present



Source: Tubaramure IR3 National Coordinator Regine Pacis Nohoreho, based on the field reports of IR3 Coordinator for Tubaramure (Ruyigi) Ezéchiel Kabwebwe and Tubaramure Provincial Coordinator (Cankuzo) Edmond Twagirayezu; July 2014. Updated September 22, 2014.

Given the high level of demand for SILCs, the program started working on various measures to make the SILCs more self-sustaining and to reduce the direct involvement of the already overworked Tubaramure Health Promoters (Chapter 3, Section 4.3.3; and Annex VI.B.5). This training was very rigorous: Out of the 96 persons who attended the SILC training-of-trainers workshop over three days, only 48 passed the test to become SILC Private Service Providers (PSPs), with the other 48 recruited as their assistants. Although the focus group discussions and key informant interviews suggest that some of the SILC PSPs are no longer working, many of them continue to train new groups and support existing ones.

In theory, the SILC PSPs receive a small honorarium and support for their transportation costs from the SILC groups they support. Two SILC PSPs interviewed said although they had never received a cash payment for their services,¹⁶³ they had benefitted from ongoing relationship with the SILC groups since they buy seed and other products from their other commercial enterprises.¹⁶⁴ The beneficiary and non-beneficiary women interviewed in the final evaluation focus group discussions cited a wide range of benefits accrued by their families from their participation in the SILCs, including loans that they could use to improve their agricultural activities, provide extra food, and pay their families' school and health fees (Text Box 4.3).

¹⁶³ The SILC PSPs stated that they sometimes received gasoline for their motorcycles. Both SILC PSPs indicated that this pattern was typical, but the evaluation team was unable to verify this.

¹⁶⁴ This was not a face-to-face interview, but based on case studies of specific PSPs that were conducted by the IR2 coordinator at Cankuzo.

The final quantitative survey estimated 32% of all women in the two provinces are currently involved with SILCs, and 11-13% of the households have a man involved in a SILC.¹⁶⁵

Text Box 4.3. Testimonials by Tubaramure SILC Members on Their Food Security, Income-Generating Activities, and Quality of Life

I'm Nsavyimana Gaspard; I'm 42 years old. I'm married with six children, three sons and three daughters.

Before the Tubaramure Program settled down in our community to teach us SILC activities, I was not saving, and I was the first in our community when it came to poorly managing the family resources. I often drank beer forgetting that I had to save money for the family's needs. I was unable to pay the school fees for my children. I did not have any livestock at all, not to mention clothes. I walked barefoot.

I approached the Tubaramure Health Promoter when I heard about some of the lessons that the program was teaching to the people of our community about SILC activities. I asked them if I could become a member of this group, and they accepted. They explained about all of the activities they do in the SILCs in addition to mutual help.

By joining a SILC, I followed their program. I made monthly contributions. I contracted a loan, which was intended to buy seeds and chemical fertilizers for my fields (a loan of BIF 20,000 that I paid back with BIF 22,000). My second loan was for BIF 50,000, to buy school materials for my children. I paid the loan back at BIF 55,000 within two months. After this, I continued to save until we shared dividends. My share of the dividend was used for the purchase of a rooster and a hen. Now I have six chicks. I am waiting for them to grow and lay eggs. I want to sell the eggs to earn more money for my family's needs.

I'm Josephine Ntahondereye, age 50. I spent two years in the SILC group.

Before I joined the SILC, I was in another association where I received very few benefits. The members of this association bickered/quarreled all the time, so I joined the SILC group. My husband is paralyzed. He cannot help me at all. I am only looking for what my family needs to survive.

When the new school year approaches, the SILC *groupement* lends me money and I pay for my children's school fees, their uniforms, and notebooks. Recently, my son was married, and my colleagues gave me the BIF 50,000 that he needed for the dowry.

I also asked for a loan from the SILC to buy chemical fertilizers for my field. If I had not had the loan, the harvest would have been bad. Prior to being in a SILC, I had a straw house. After the group shared the dividends, I bought corrugated sheets for my house. We are now safe from the rain. I also bought a goat. I currently have two goats and a pig.

Source: Annex V, Testimonials 10 and 12.

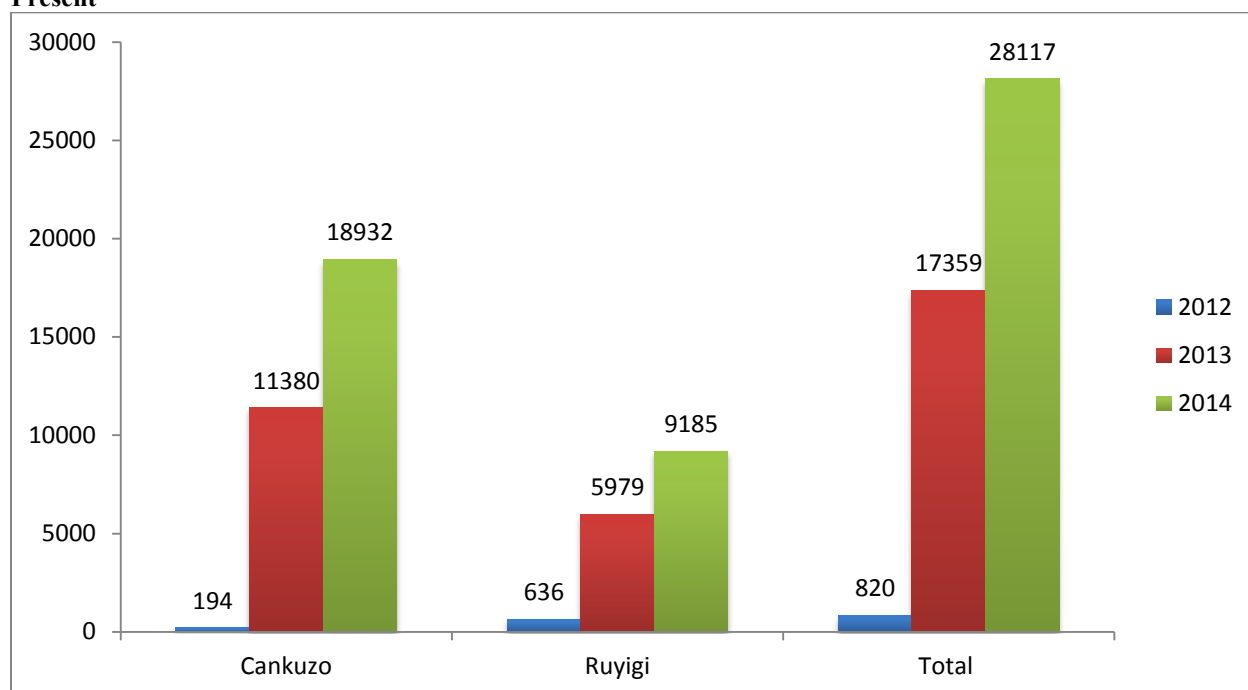
2.3.4. Rapid Increase in Keyhole Gardens and Nutrition Posters. In just three years (2012-2014) the program helped facilitate the creation of 28,117 keyhole gardens, especially in Cankuzo (Figure 4.3). The quantitative final survey reported that 44.2% of the households interviewed in the final quantitative survey reported having keyhole gardens—36.8% in Ruyigi and 56.6% in Cankuzo.¹⁶⁶

¹⁶⁵ Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU); 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU. Pp. 43-44.

¹⁶⁶ ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pg. 40.

During the same time period, the program distributed a large number of posters promoting some of the local vegetables that could be grown on the keyhole gardens to complement the Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) posters that were developed under IR2. The posters were distributed to all of the local authorities and given to both beneficiary and non-beneficiary families; they were also very prominently displayed at food distribution sites. 43.6% of the households reported that they still displayed one of the posters (50.1% in Cankuzo and 39.7% in Ruyigi). The posters were also prominently displayed in the offices of most of MoH and MAE personnel and local authorities that the team interviewed. This was a low-cost publicity bonanza that future programs might consider replicating.

Figure 4.3. Evolution of Tubaramure-Facilitated Keyhole Gardens in Ruyigi and Cankuzo Provinces, 2010-Present



Source: Tubaramure IR3 National Coordinator Regine Pacis Nohoreho, based on the routine reports of Tubaramure IR3 Coordinator (Ruyigi) Ezéchiél Kabwebwe and Tubaramure Provincial Coordinator (Cankuzo) Edmond Twagirayezu; July 2014. Updated September 22, 2014.

During the final evaluation focus group discussions with members of the *groupements* and LMs, beneficiaries cited the keyhole gardens as being one of the major program innovations that increased their household dietary diversity (Text Box 4.4; Annexes IV and V).

Text Box 4.4. Tubaramure Beneficiaries' Testimonials on the Impact of Keyhole Garden Plots on Their Household's Dietary Diversity

A non-PM2A beneficiary mother who adopted a keyhole garden: One day, I brought one of my sick children to the hospital for tests. The day after, I got the results, and the doctor told me that my child was suffering from malnutrition. I asked for their advice; they suggested I give him vegetables and eggs although I had no money. When the program came in our village, the Tubaramure Health Promoters began to educate us on growing vegetables, both during the dry season and the rainy season, as well as on digging garbage pits. Two months later, I saw a group of 20 people who cultivated vegetables during the dry season at home. I asked them if I could be part of their team, and they accepted. I then set up a vegetable garden around my house during the dry season. After just two months, I was able to make my child meals that contain vegetables, and his weight increased.

A PM2A direct-beneficiary mother who developed a keyhole garden: Since developing my garden, I eat vegetables every day, even in the dry season. I also learned something about soy production. I now know about the three food groups, including carbohydrates, lipids, and proteins. In preparing my meals, I care about the three food groups. I use whole meal flours to prepare our porridge. My family's hygiene has improved since we built a handwashing station.

Source: Annex V, Testimonials 7 and 24.

2.3.5. Culinary Demonstrations. Although the program continued to support the culinary distributions, most of them were conducted by the LMs and scheduled as part of the monthly plan developed with the Tubaramure Health Promoters. The demonstrations focused heavily on the use of local food for household consumption and weaning foods (Text Box 4.5). There was also a strong emphasis on the promotion of promising high-nutrient foods like soy and amaranth greens (and the seeds to grow these crops). During the final month (August 2014), the program distributed food-processing equipment to two *groupements* per *colline* to encourage the groups to develop IGAs—including restaurants—that could promote some of the new nutrient-rich foods such as soy. One opportunity that was discussed—but not fully promoted—was the idea of producing a high-value weaning food from local crops that the *groupements* could sell for income.

Text Box 4.5. Tubaramure Beneficiary Testimonial on the Impact of the Culinary Demonstrations on Their Household's Dietary Diversity

My name is Valerie Kadende. I'm 29. I live in Kirasira Village in Butezi commune in Ruyigi Province. As a housewife, I prepare food for my family. Before the Tubaramure Program, I prepared anything. I could not prepare them a balanced diet; that is to say, one that contains carbohydrates, lipids, and proteins. For instance, I prepared beans and cassava without vegetables, or rice with beans without sauce, and, when I was pregnant, I ate anything because I didn't know that when pregnant a mother needed a proper diet, such as porridge, vegetables, and fruits. I thought that I cultivated vegetables to sell them and earn money to purchase what I needed.

With Tubaramure Program, I learned a lot in the field of cooking, that is to say, the cooking demonstration. We learned how to prepare porridge with flour that we were given with vegetable oil, and how to prepare other local foods. Example:

To prepare porridge for the whole family, there is a measure to be followed:

Little flour + 3 tablespoons of oil + sugar or banana to replace sugar

To prepare porridge for children:

Little flour + ¼ tablespoon of oil + sugar or banana to replace sugar + vegetables prepared separately

When we don't have this flour, we use our own flour + peanut + sugar and we mix the two. To prepare other foods, Tubaramure Program taught us how to mix other foods for a balanced diet. Example:

Beans + sweet potatoes + vegetables

Rice + beans + meat

Milk + maize bread

Rice + potatoes + meat

Note that a lactating woman who drinks milk with maize bread will have her breast milk increased, and a pregnant woman who eats porridge for breakfast, and who eats rice together with potatoes and meat, will have her weight increased, and her baby's weight will increase at birth as well.

I thank Tubaramure Program for this demonstration that it taught us. I would ask the program to train us more in cooking demonstration if there are other recipes that we are ready to buy ingredients.

Source: Annex V, Testimonial 21.

3.0. Evidence of Results^{167 168}

3.1. Dietary Diversity^{169 170}

The final quantitative survey showed (Table 4.3):

- A highly significant increase in the average household dietary diversity; and
- A much smaller, but stable, percentage of children consuming at least four food groups during the 24 hours prior to the survey interview.

The disaggregated dietary diversity score was about the same for the two provinces, 8.5 in Cankuzo and 8.0 in Ruyigi.

¹⁶⁷ *SOW Specific Objective 3:* What interventions have been more or less successful in meeting targets?

¹⁶⁸ **SOW Key Question 8:** To what degree are behavior changes continued by graduated program beneficiaries, for example changes that improve the nutrition of children over the age of 2 and changes that impact subsequent births?

¹⁶⁹ **SOW Key Question 6:** With regards to food intake and diversity, are beneficiaries adopting desired practices or behaviors? Are there some secondary adopters?

¹⁷⁰ **SOW Key Question 10:** To what extent the use of local food has sustained a sufficient food intake and balanced diet at the household level after the distribution of Title II commodities?

Table 4.3. Eligible Women and Children Have Increased Intake of Diversified Foods

IR3 Key Program Indicators	Baseline 2010	Endline 2014	Statistical Significance	LOA Target
Indicator 3.1. Average household dietary diversity score	4.6	8.2	Significantly increased p=0.000	9.0
Indicator 3.5. Percentage of children 6-24 months reported as consumed at least four food groups during the last 24 hours	74.2	77.8	Baseline data was not suitable to perform a significant test	90.0

Source: Tubaramure IPTT and *Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)*; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014). Pp. 20.

The same final evaluation survey shows 97% of the households in the survey reported eating four or more food groups, which suggests that the vast majority of the population is eating a more diversified diet than at the program's baseline (Table 4.4). Since the final survey did not measure the months of adequate household food provisioning (it was measured during the baseline),¹⁷¹ there is no way of knowing if this could be attributed to aggregate increases in food access. Since there was very little external investment in agriculture or livestock in the area (by Tubaramure or any other agency) during the five years of the program—and since most of the PM2A graduates had already graduated by the time of the final survey—the most likely factors causing this shift are:^{172 173}

- A major change in both men's and women's understanding of and willingness to support household consumption (as opposed to sale) of the products they were already producing;
- Easier access to a more diversified group of vegetables from the keyhole gardens for about half the provinces' households; and
- Greater access to cash for purchasing food, especially during lean periods through SILCs or SILC-related investments (like on farm animal fattening), for about 30% of the households.

Table 4.4. Percentage of Households in the Final Quantitative Survey Eating Different Numbers of Food Groups

Province	Number of Food Groups Consumed by the Households				Number of Households
	0-3	4-6	7-8	9+	
Cankuzo	4.0	44.1	35.6	16.3	440 (100%)
Ruyigi	2.7	56.3	33.4	7.6	751 (100%)
Total	3.2	51.8	34.3	10.8	1,200 (100%)

Source: Tubaramure IPTT and ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014). Pg. 39.

¹⁷¹ This was measured during the baseline.

¹⁷² **SOW Key Question 1:** With regard to the program framework, which interventions have been critical and/or effective in achieving the nutrition and health-sector objectives and intermediate results? And why?

¹⁷³ **SOW Key Question 16:** How are graduated and current beneficiaries in the community coping with the end of food distribution?

3.2. Evidence of Impact on Local Institutional, Community, and Household Capacity¹⁷⁴

Six areas where the program has increased the local community's capacity to promote dietary diversity are:

- Training 4,920 LMs who continue to be strong advocates for dietary diversity;
- Facilitating the LMs and beneficiary groups organizing into *groupements*, 713 (82%) of which are registered
- Helping to plant the idea of keyhole gardens, which has had a host of secondary adopters;
- Building the capacity of two *groupements per colline* through technical support and training in (Text Box 4.6):
 - Basic principles of organization;
 - Some basic technical training in food processing, especially soy milk food processing; and
 - Promoting small livestock development through the distribution of seed herds to each of the *groupements* that the program is assisting;
- Facilitating the development of 711 SILC groups; and
- Creating a strong system of SILC PSPs, who continue to backstop both the existing and new SILCs being developed.

One unintended consequence of the SILC activities—which was noted by several of the LMs and beneficiary mothers during the focus group discussions—was to build social cohesion between the different groups living in the village (See Annexes IV and V).

¹⁷⁴ **SOW Key Question 13:** To what extent the implemented activities under IR2 and 3 have developed and strengthened the institutional, the community and the households' capacities?

Text Box 4.6. PM2A Beneficiary Testimonial on the Impact Joining a *Groupement* Had on Her Living Standard

My name is Goreth Nyandwi, I'm 25 years old. I live in Nyamasenga *Colline* in Nyabitsinda commune, which is in Ruyigi Province. I don't know how to describe Tubaramure. Honestly, this is a program that helped us a lot in our village. I do not know if you, yourself, have not heard of Tubaramure on the radio. Tubaramure fought against malnutrition for our children.

For instance, for me, when I was pregnant for the first time, I learned that I had to go for prenatal consultations at least four times, and after delivery, I had to go for postnatal consultations and for my baby's immunization. In addition, I had to eat for me and for my baby. The program has supported me by giving me porridge and everything I needed.

When my child reached the age of 2 years, the program guided, educated, and encouraged me to continue to raise my baby. It showed me the benefit of joining an association, and that it is easier to help a group than an individual. Tubaramure supported us by giving us two goats and seeds. We worked together, and we purchased another goat.

As far as seeds are concerned, if I do not have any, I request for a credit in the association, and I pay it back after harvest, whereas before I could leave some of my land in fallow because of lack of seeds.

Before, I was alone, but for the moment, I have many friends. My husband did not help me to work in the fields, but, when he joined our association, he has changed his behavior because, there, they give us advice. We purchase seeds in the association. When one is a member, if for example 1 kilogram costs BIF 1000, a member buys for BIF 500 per kilogram; it is an advantage of the association. At the end of the season, when we harvest, we share the surplus and we keep the rest as seed for the new season.

Source: Annex V, Testimonial VI.

4.0. Factors That Contributed to and Detracted from Program Relevance, Effectiveness, Efficiency, and Acceptability of Processes, Outputs, and Implementation

4.1. Relevance

The Tubaramure IR3 activities were highly relevant to the overall Tubaramure goal of preventing malnutrition in children under 2. Both provinces had, and continue to have, a high percentage of households classified as having high or limited food security—85% in Cankuzo and 65% in Ruyigi according to the 2014 *Institut de Statistiques et d'Etudes Economiques du Burundi* Standardized Monitoring and Assessment Relief and Transitions (ISTEEBU SMART) study (Table 4.5).

Table 4.5. Percentage of Households Classified as Having Different Levels of Household Food Security in Cankuzo and Ruyigi Provinces in the 2014 SMART Study¹⁷⁵

Zone	Highly Food Insecure (score <1.5)	Limited Food Security (1.5<score<2.5)	Moderate Food Security (2.5<score<3.5)	Severe Food Insecurity (3.5<score)
Cankuzo	47	38	12	4
Ruyigi	28	37	31	4
All Burundi	3	27	25	7

Source: ISTEEBU; 2014. *Analyse Global de la Sécurité Alimentaire, la Nutrition et la Vulnérabilité au Burundi, 2014: Résultats Préliminaires*. Bujumbura: ISTEEBU (22 May 2014). Pg. 21.

¹⁷⁵ The SMART study is described in greater detail in Chapter 5.

4.2. Effectiveness

The focus group discussions showed that the Tubaramure Program had increased the beneficiary mothers' understanding about the major food groups and the key components of a balanced diet (Annexes IV and V). This increased awareness concurs with the results of the final quantitative survey, which showed a substantial increase in the population-based dietary diversity score for both provinces.

The IR3 activities' effectiveness was decreased by:¹⁷⁶

- A substantial delay in the implementation of the MYAP's gender strategy, which was outlined in the original MYAP proposal;¹⁷⁷ and
- The original MYAP design not including a separate budget line item for investing in agriculture or livestock, nor could the cost centers for the program be adjusted to allow this as was recommended in the mid-term evaluation report. This diminished the amount of support that the commune and *colline*-level MAE staff was able to provide for the *groupements*' new crop and livestock activities both before and after the mid-term evaluation.¹⁷⁸

4.3. Efficiency and Acceptability of Processes and Program Outputs

In the short-term, the blanket distribution of PM2A rations did—as anticipated in the MYAP proposal—help jumpstart the beneficiaries' understanding of what constitutes a good diet and what types of local food would be needed to sustain it.

Although the Tubaramure Program did not invest heavily in either livestock or crop development, the program's behavior change communication (BCC) activities under IR2, and culinary demonstrations and home visits under IR3, have created a demand for increasing household food intake and diversity.

¹⁷⁶ **SOW Key Question 3:** Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?

¹⁷⁷ The original MYAP proposal anticipated that the initial formative research associated with the program would provide the basis for a, "*strategy for promoting men's involvement in maternal and children (sic) nutrition*" (Pg 17). The goal of this research was to help the program develop, "*community-level strategies for involving men in the program to help break through gender barriers/issues that unfairly burden the women*" (Source: CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS, Pg. 20).

¹⁷⁸ *SOW Specific Objective 2:* Is the health component well integrated in the government's strategy and priorities? Are there steps that could be taken to improve the integration?

4.4. Sustainability¹⁷⁹

Most of the 123 LMs interviewed during the final evaluation focus groups reported that they intend to continue promoting the concept of increased dietary diversity for both adults and children (Annexes IV and V). A recent Tubaramure survey reported that:¹⁸⁰

- 73% of the *groupements* in Ruyigi and 55% of the *groupements* in Cankuzo were continuing to discuss improved hygiene practices as recommended by the Tubaramure Health Promoters; and
- 63% of the *groupements* in Cankuzo and 54% in Ruyigi continue to discuss improved nutrition practices at their meetings.

Whether or not the Tubaramure *groupements* will continue to provide a forum for the promotion of increased dietary diversity will depend on whether or not this additional support is forthcoming. Most of the groups are young and require additional technical and organizational support. For the groups' activities to continue, they need additional support from the commune and *colline*-level MAE staff, as well as the new development programs scheduled to expand their activities in both provinces.

4.4.1. *Progress Toward the Implementation of the IR3 Exit Strategy.*

4.4.1.1. *Current Status.* One major weakness of the Tubaramure MYAP proposal described earlier in this chapter is that it did not include any provision for sustaining increased food intake and dietary diversity. It is important to emphasize that this was not the fault of CRS or the consortium members, all of who were well aware of this deficiency. When the Tubaramure Program was designed, United States Agency for International Development (USAID) was in the midst of executing the first MYAP ever implemented in Burundi in three northern provinces of Kayanza, Kurundo, and Muyinga (August 2008-August 2012). USAID's decision to fund a second MYAP in Burundi was conditional on that program being linked to a comparative assessment of the PM2A model for reducing malnutrition in Sub-Saharan Africa and Latin America. For this reason, the Tubaramure MYAP proposal section on IR3 includes 4.5-pages that focus almost entirely on the conditions for giving the PM2A rations and only a very limited discussion¹⁸¹ about how the anticipated impact on dietary diversity would be sustained once the program ended. There is also no mention of this issue in the MYAP's section on sustainability.

¹⁷⁹ **SOW Key Question 14:** Which outcomes are likely or unlikely to be sustainable and continue after the program ends? And why?

SOW Key Question 22: How has the topic of sustainability of program interventions been dealt with under the program, including: a) how sustainability was described/defined at the outset; b) whether there were flaws in the program design that would impact sustainability; c) what mid-course corrections were made, and what were missed, in enhancing program sustainability; and d) what lessons have been learned to improve the sustainability of future PM2A programming in Burundi and elsewhere.

SOW Key Question 23: Related to the sustainability topic is how long lasting are the interventions achieved under IRs 1 and 2? For example, do graduating families continue to apply the lessons they learned to children who have graduated or were born after the mothers graduated?

¹⁸⁰ *Equipe de Suivi-evaluation.* 2014. *Quelques resultats de travail sur les groupements (associations) de PM2A dans les provinces de Ruyigi et Cankuzo.* Bujumbura: CRS (Mars-Mai 2014). Pp. 4-5

¹⁸¹ CRS; 2014. *Tubaramure MYAP Proposal.* Bujumbura: CRS. Pp. 2 and 5.

As indicated earlier in this chapter (see Section 2.2), one of the key impacts of the mid-term evaluation was to bring this issue to the fore. Based on the mid-term evaluation report and the follow-up research study linked to it, the Tubaramure Program developed a low-cost strategy for strengthening household availability and access that focused on developing *groupements*, providing a select number of *groupements* (two per *colline*) with support, and scaling up the keyhole gardens. Since the mid-term, this new exit strategy has been carefully monitored by the consortium's IR3 coordinator. Activities are on track and the program is handing over the activities to the local communities and the MAE in September 2014.

4.4.1.2. Critical Next Steps. The recent completion of a new database summarizing all of the critical data on the *groupements* is a major resource that can facilitate the handover of the *groupements* to the Provincial Directorate for Agriculture and Livestock (*Direction Provinciale de l'Agriculture et de l'Elevage* or DPAAE) in both provinces and new programs moving in (See Annex VI.B.4). A handover workshop is scheduled to facilitate these types of linkages in September 2014.

4.4.2. Priority Issues for Follow Up the MoH and the DPAAE Are Likely to Face in Sustaining the Tubaramure Program's Results Under IR3. The MoH and the DPAAE are likely to face four priority issues for follow-up on the Tubaramure Program's IR3 activities in the coming year (Table 4.6).

Table 4.6. Priority Issues for Follow Up to Capitalize on the Results of the Tubaramure Program’s IR3 Activities

Priority Issues for Follow Up	For the MoH Over the Next Year	For the MAE Over the Next Year	For Other Donors Working in Health and Nutrition and Food Security in the Two Provinces
1. Facilitate the <i>groupements</i> ’ and individuals’ access to improved vegetable seed		Facilitate some of the area <i>groupements</i> producing certified vegetable seed that conforms to the MAE standards as is currently being done for rice in both regions	
2. Continue to support the expansion of the SILCs’ role in community-based development. Strengthen the LMs’ linkages to the MoH Community Health Workers and Public Health Technicians	Strengthen the MoH links with the DPAAE		
3. Continue to build the technical and organizational capacity of the Tubaramure-facilitated <i>groupements</i>			Encourage new programs to support the DPAAE efforts to work with the <i>groupements</i>
4. Build stronger links between the MoH and the DPAAE to promote increased dietary diversity and good nutrition	Consider ways that the five modules developed under IR2 and IR3, the nutrition and local foods posters, and cookbooks can help the DPAAE better understand the crops and nutrition themes that overlap with their activities in the local communities	Strengthen DPAAE (provincial, commune and <i>colline</i> -level) ability to capitalize on the existing knowledge and organization of the Tubaramure SILCs and <i>groupements</i>	

Source: Tubaramure Final Evaluation; July 2014.

One of the greatest short-term priority issues to sustaining the Tubaramure Program’s results under IR3 is improved seed.¹⁸² To date, the program has been the principal source of improved seed for all of the keyhole gardens and other crop-production activities by the *groupements*. Although the original MYAP proposal had anticipated the possibility of linking with, “seed...restocking programs to promote home gardens,” this did not occur.¹⁸³ When the program quit supplying vegetable seed in 2014 (Annex VI.C.1), many of the groups commissioned the staff to purchase seed for them in Bujumbura. Currently there is no reliable source of improved vegetable seed in the entire region. One short-term impact of this weak

¹⁸² **SOW Key Question 15:** Are there any factors (barriers/constraints) that limited community participation and engagement in the program implementation?

¹⁸³ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pg. 21.

access to improved seed is that many of the keyhole gardens are gradually reverting to monocultural production of the local green *lenga lenga* (amaranth greens).

The second priority issue—which is the same as for IR2—is to better link the Tubaramure-facilitated *groupements*' links to the government and non-governmental organization (NGO) programs they need to increase their food security and IGAs.¹⁸⁴ This might include handing over some of the training modules, cookbooks, and any pertinent posters developed under the program to a suitable office within the provincial MAE or MoH offices.¹⁸⁵ These materials—which were never validated at the national level for use in other provinces—could be of use in future donor and non-donor-funded programs. This second challenge is critical because it is directly linked to sustaining the program's global impact on malnutrition since:

- It affects food access and availability for the LMs and the PM2A graduates directly; and
- It affects the LMs' willingness and ability to continue carrying out the volunteer activities they were trained to execute through the Care Groups under IR2 and IR3.

The third priority issue is to continue to strengthen the capacity of the SILCs. Most of the SILCs need additional training in IGAs and food processing. A small but growing number of them are probably ready to expand into more risky, higher-earning IGAs. To do so, they will need to be better linked to the pre-existing base of microcredit institutions in both provinces. All of the SILCs encountered during the mid-term focus group discussions still need help in understanding their roles and responsibilities, and in developing links to existing MAE extension and NGO program-funded extension services in both provinces.

The fourth priority issue is for the MoH and the DPAAE to strengthen their collaboration and coordination on nutrition. While the Tubaramure Program was operating, it provided a mechanism for this to be achieved through the coordination groups and its routine debriefing of the commune and provincial-level leaders. There is strong evidence that the MoH and local NGOs will continue to support the regional coordination meetings. The program has also produced a large number of modules, posters, and cookbooks that the two agencies could use to promote the important areas of overlap between them.

In the next five years, both provinces are moving forward with the new food security component of the National Plan for Agricultural Investment. This initiative has, “*food security, nutrition and managing vulnerable groups*,” as one of its core sub-programs.¹⁸⁶ This sub-program includes a sub-group of activities focused on nutritional education and growth monitoring (GM). While the Tubaramure Program is closing out, this new government initiative, which aspires to strengthen the links between the MoH and the MAE, is starting up.

¹⁸⁴ **SOW Key Question 2:** What are the factors that hinder/assist the effective integration of the program components?

SOW Key Question 3: Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?

¹⁸⁵ *SOW Specific Objective 5:* Are the training modules appropriate and fitting with national protocol? How can they be improved in future program?

¹⁸⁶ *Ministère de l'Agriculture et de l'Élevage. Direction Provinciale de Cankuzo. Plan Provincial d'Investissement Agricole de Cankuzo (PPIA): 2013-2017. Bujumbura: Programme d'Appui Institutionnel et Opérationnel au Secteur Agricole (PAIOSA) (April 2013).*

5.0. Lessons Learned and Best Practice Checklist¹⁸⁷

Table 4.7. Tubaramure Program IR3 Lessons Learned and Best Practice Checklist

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ¹⁸⁸	Future Donor-Funded Activities	Future PM2A and Food Security Programs
IR3: Eligible women and children have increased intake of nutrient-rich diverse foods.			
Lesson 1. <i>Given the complexity of selecting and distributing rations to the target beneficiaries, programs need strong two-way communication with the local governments.</i>			
1. PM2A programs need to implement strong public awareness campaign at the beginning of the program to explain the activities to target audiences and local authorities before discussing the activities at the community level to help avoid misunderstandings about why the food is only given to some people and to help control illegal sales.			X
2. Strengthen existing coordination groups as a mechanism for staying in touch with local authorities in order to elicit their support in resolving conflicts, avoiding commodity theft, and promoting the program's community-level activities.		X	X
3. Produce attractive posters that promote key Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) themes, and distribute them through local authorities to health facilities, food distribution points, and households to help sustain community awareness of critical themes and behaviors.			X
Lesson 2. <i>Food distribution sites can offer a useful locale for building local government and wider community understanding of the new ENA and EHA themes being promoted by a program.</i>			
4. Consider innovative methodologies (e.g. posters, culinary demonstrations, skits) for promoting new ENA and EHA messages at the food distribution sites.			X
5. Anticipate the need for water, basic hygiene, and sun and rain protection at PM2A distribution sites.			X
Lesson 3. <i>Culinary distributions that promote local foods in conjunction with food rations proved a useful tool for on-the-ground nutrition training at the start of a program, which can then be scaled up to promote nutritious local foods.</i>			
6. Integrate information on local foods that can complement food rations from the start into all PM2A culinary demonstrations.			X
7. Consider ways that cookbooks can help build local authorities, MoH, MAE, and program staff's understanding of the culinary demonstrations and foods being promoted.			X
8. Encourage government agencies (like the district and provincial MoH and the commune and provincial offices of the MAE) to consider ways that cookbooks could be incorporated into and/or support their programs.			X

¹⁸⁷ *SOW Specific Objective 1:* Are the health component activities being implemented according the Detailed Implementation Plan (DIP)? What are the obstacles and the delays observed? What recommendation can be done for future program?

¹⁸⁸ This column refers to MoH activities that are critical to maintaining or sustaining the Tubaramure-supported activities once program funding ends. If there is no X in the column, it should be assumed that the MoH is already supporting this activity.

Lessons Learned, Best Practices, and Recommendations	Ruyigi and Cankuzo		Worldwide
	Government Institutions (MoH and MAE) ¹⁸⁸	Future Donor-Funded Activities	Future PM2A and Food Security Programs
9. Consider linking any culinary demonstrations and/or cookbooks developed under the program staff to any new or existing programs to promote community-based growth monitoring (GM) and <i>Foyer d'Apprentissage et de Réhabilitation Nutritionnelle</i> (FARNs or Positive Deviance [PD]/Hearth).			X
10. Network to identify promising high-nutrient foods like soy, soy processing, and amaranth that the local people may not be aware of for pilot testing.			X
11. Identify options for high-nutrient weaning foods made with local foods and nutrient-dense foods like soy, and promote them from the start both for children's health and as potential IGAs for program beneficiaries.			X
Lesson 4. <i>Keyhole gardens and SILCs are a useful, low-cost model for increasing household diversity, which can be quickly scaled up and sustained with minimum outside support for both PM2A beneficiaries and the wider community.</i>			
12. Before introducing keyhole gardens, identify examples of regional or national best practices and options for improved seed in order to make sure that the package is appropriate to the target area.		X	X
13. Once an appropriate keyhole garden model and package of seeds has been identified, encourage staff to work through the local MAE staff to adapt the program to the local microenvironments in each area.		X	X
14. Consider ways that the pre-existing technical resources in the area (like the MAE or existing agricultural development programs) can help support the pilot testing and scale up of keyhole gardens to avoid overburdening the program extension agents and strengthening the program's links to the MAE.		X	X
15. Identify an experienced SILC expert to train staff on basic principles and models.		X	X
15. Identify different models for creating new or building the capacity of SILC Private Service Providers (PSPs) in the program area as a way of reducing the burden that SILC activities might place on the program extension agents and/or local MoH staff.		X	X
16. Anticipate the need to help the most successful SILCs to identify IGAs and access IGA loans from the existing microfinance institutions in the program intervention zone.		X	X

Source: Tubaramure Final Evaluation; July-August, 2014. Revised based on feedback to the first draft, September 25-October 5, 2014.

Chapter 5: Principal Program Results and Their Likelihood of Being Sustained

This final evaluation of Preventing Malnutrition in Children Under 2 Approach (PM2A) intended to assess the impact of the Tubaramure Program's focus on preventing malnutrition in children under two in two food-insecure provinces of Burundi, Cankuzo and Ruyigi. The evaluation also focused on the identification of good practices and lessons learned that will be useful in improving future interventions.

Each of the previous chapters describes the major program outputs that contributed to the achievement of these outcomes. This chapter is divided into three sections, which focus on measuring the actual outcomes of the program in relation to the program's goals for having a population-based impact on malnutrition:

- **Section 1.0** provides a brief overview of the principal population-based results of the program in relation to the original targets and the baseline measures for the activities or outcomes;
- **Section 2.0** describes the links between these outcomes and the achievement of the program's major objectives based on the population-based achievements on the program's principal program-level indicators for malnutrition; and
- **Section 3.0** concludes with an analysis of which outputs and activities appear to have had the greatest impact on the achievement of these outcomes and what types of sustainable support is needed once program funding ends.

The principal source of data for the analysis is the quantitative baseline and final household surveys:

- **Baseline Quantitative Survey:** The baseline quantitative survey involved 1,255 households from 26 randomly selected *collines* (communities) in the program intervention areas in the Cankuzo and Ruyigi provinces.¹⁸⁹
- **Final Quantitative Survey:** The final survey involved a random sample of 1,200 households selected from random clusters in 40 *collines* with a total of 1,784 children under 5 years who participated in anthropometric measurements. Of the 1,200 households surveyed, 450 households (37.5%) were Tubaramure Program indirect beneficiaries (who had not been enrolled in the program).¹⁹⁰

Both surveys were conducted by the same research institution using the same methodology, including anthropometric data analysis and the same version of the Emergency Nutrition Assessment 2011 software.¹⁹¹ Unfortunately, there was a slight variation in the timing of the two

¹⁸⁹ Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU); 2010. *Enquête de Base du Programme Tubaramure. Rapport Final*. Bujumbura: ISTEEBU (July 2010).

¹⁹⁰ ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014).

¹⁹¹ "The purpose of Emergency Nutrition Assessment (ENA) software for Standardized Monitoring and Assessment Relief and Transitions (SMART) is to make nutrition assessments and mortality rate calculations in emergency situations as easy and reliable as possible. To achieve this, it focuses on the most important indicators (anthropometric and mortality data), checks the plausibility of the entered data, and gives out an automatic report. Since the software can not explain why children are malnourished or mortality rates are high, the results of the survey have to be complemented with other information (e.g. from the Food Security part of ENA or discussions

surveys. The baseline data was collected in *March 2010*, corresponding to the leanest period in Burundi. The final survey was conducted in *June 2014*, which corresponded to a period of relative food security, so the timing differences can be expected to have a major impact on indicators like the Household Dietary Diversity Score (HDDS), which are extremely sensitive to seasonal abundance and food shortages.

1.0. Evidence of Results Based on the Program’s Principle Outcome Indicators

1.1. IR1: Women and Children Under 5 Access Quality Nutrition and Health Services^{192 193}

Overall, the Tubaramure Program’s IR1 activities were successful in breaking down some of the barriers that impeded local people’s willingness and ability to access the health and nutrition services both during and after the period of peak PM2A distributions.¹⁹⁴

1.1.1. Increased Quality of Diagnostic and Treatment Services for the Major Childhood Illnesses in All Health Centers. This included a statistically significant increase in the number of nurses that are now better able to diagnose and treat children under 5 (120% of target) (Table 5.1).

1.1.2. Increase in the Percentage of Women Accessing Prenatal Services. There has also been a statistically significant increase in the number of mothers completing the recommended number of prenatal visits, from 28.9% at baseline (2010) to 50.3% in 2014 (Table 5.1).

with key informants, collection of this additional information on the household level is usually not very helpful and has a high risk to reduce the quality of the anthropometric and mortality data.” ENA for SMART. 2011. Software for Emergency Nutrition Assessment. (<http://nutrisurvey.net/ena2011>).

¹⁹² *SOW Specific Objective 1* (IR1): Evaluate the effectiveness and the outcomes of the behavior change communication (BCC) strategy and messaging, as implemented (Essential Nutrition Actions [ENA], the Essential Hygiene Actions [EHA], and food diversification);

SOW Specific Objective 2 (IR1): Assess the effectiveness of key behaviors as adopted by beneficiaries, with regards to the ENA, the EHA, the IMCI practices and the food diversification as well as the use of Title II commodities and local food; and

SOW Specific Objective 7 (IR1): Evaluate how graduated beneficiaries continue to incorporate behavior changes in the parenting of their children after graduation and of new children born after the mother graduated from PM2A.

¹⁹³ *SOW Specific Objective 6* (IR2/IR3): Are trained staffs over health centers making difference with non-trained agents?

¹⁹⁴ **SOW Key Question 1** (IR2/IR3): With regard to the program framework, which interventions have been critical and/or effective in achieving the nutrition and health sector objectives and intermediate results? And why?

Table 5.1. Women and Children Under 5 Access Quality Nutrition and Health Services

Key Indicators Used to Track IRI Outcomes	Baseline 2010 (March)	Endline 2014 (June)	Statistical Significance	LOA Target
Outcome Indicators				
1.1. <i>Original Indicator:</i> Percentage of women completing the package of four prenatal visits	28.9	50.3	Significantly increased p = 0.000 ¹⁹⁵	98.0
1.1. <i>Mid-Term Revision of Indicator:</i> Percentage of women completing the package of three prenatal visits (*)	NA	83.4	NA	98.0
1.2. <i>Original Indicator:</i> Percentage of women completing the package of three postnatal visits	5.0	3.1	Baseline data was not suitable to perform a significant test*	75.0
1.2. <i>Mid-Term Revision of Indicator:</i> Percentage of women completing the package of two postnatal visits (*)	N/A	11.1	N/A	75.0
1.3. Percentage of children 0-59 months attending GM visits at least once in a two-month period (as recorded on card)	16.0	57.3	Significantly increased p = 0.000	90.0
1.4. <i>Mid-Term Revision of Indicator:</i> ¹⁹⁶ Percentage of nurses accurately diagnosing and teaching children under 5 *	0.0	100.0	NA	80.0
Other Indicators				
Percentage of children born in health centers	45.8	77.3		
Percentage of women giving birth with the assistance of a qualified health professional	53.4	78.6		

* The baseline information was collected by a complementary baseline study so the sample was not comparable with the final survey sample.

Acronym: LOA=Life of activity

Source: Indicator Performance Tracking Table (IPTT) (Annex II) and *Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)*. 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEEBU (August 2014).

1.1.3. Increase in the Percentage of Children Who Participated in Growth Monitoring. The same study showed there was a statistically significant increase in the percentage of children who participated in growth monitoring (GM) programs, from 16% at baseline to 57.3% in 2014 (Table 5.1). However, this figure is substantially below the original target of 90% for this indicator. It is important to emphasize that because one of the key assumptions (i.e. the Government of Burundi [GoB] finalizing the national protocol on community-based GM) did not hold, this original target was unrealistic.

¹⁹⁵ The smaller the p value, the less likely the difference between the current status of the indicator and the baseline can be explained by chance alone.

¹⁹⁶ The original indicator, “% of health providers (facilities/ Community Health Workers) accurately assessing a child using Integrated Management of Childhood Illness (IMCI) protocols,” was slightly modified at mid-term for greater clarity. There was no difference in the baseline measurement.

The quantitative data from the final household survey is supported by focus group discussions, which suggest that:

- The PM2A women graduates are motivated to continue attending the prenatal consultations and clinics based at the health centers for new pregnancies even after graduation;¹⁹⁷ and
- The non-beneficiary mothers have increased their attendance at prenatal consultation services as well.

In general, however, the rates of at least three prenatal consultations were much higher for the PM2A women graduates than for the non-beneficiary mothers—89.2% vs. 74.4%.¹⁹⁸

1.1.4. Less Successful Increase in Postnatal Consultations. Despite the concerted efforts of the Tubaramure Program's IR1 and IR2 activities to promote postnatal consultations, the rate of PM2A mothers accessing these services was never higher than 8.4-19.1% during the program, and the total reported rate of mothers accessing the service in the two provinces only increased from 5% to 11%, which is well below the program target of 75% (Table 5.1). Some of the key factors affecting this were the strong cultural pressure against well-woman programs and the pressure on short-staffed health centers and Leader Mothers (LMs) to give priority to prenatal and curative care over well-woman care (See Chapter 2, Section 3.1.3.4).¹⁹⁹ The low rate of postnatal care is a national problem in Burundi that few programs have been able to address without offering mothers some sort of concrete return (for example combining the postnatal visit with some other health service like infant vaccinations or distribution of iron supplements) that justifies their coming in for the well-woman visits. Far more likely to be successful (as described in Chapter 2) will be a new strategy that tries to link the postnatal well-woman visits to the mother's dealing with other issues like vaccination, setting up a special protocol for having a female health provider see the women privately, and building more support from local authorities and the community (grandmothers, husbands) for reducing some of the cultural barriers to this new behavior.

1.2. IR2: Households Practice Appropriate Household and Nutrition Behaviors

1.2.1. Increase in the Percentage of Mothers Able to Identify Childhood Diseases. The final quantitative survey found a substantial population-based increase in the percentage of mothers who can diagnose and treat childhood diseases (Table 5.2). The mothers interviewed in the focus groups attributed this result to the IR2 behavior change communication (BCC) programs, as well as the LMs and Community Health Workers' awareness of health activities.

1.2.2. Increase in the Percentage of Mothers Breastfeeding. Exclusive breastfeeding, which was already a common practice, increased significantly—from 69.4% of the population to 87.9% (Table 5.2). Most mothers in the focus group discussions attributed this to LMs' promotion of

¹⁹⁷ The final survey did not have a disaggregated analysis of prenatal and postnatal visits.

¹⁹⁸ This calculation did not include a test for significance. It is based on a reanalysis of data from the final survey annex (Pg. 104) by Dr. Sidibe Sidikiba. Source: ISTEEBU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014).

¹⁹⁹ Tubaramure; 2012. *Étude sur les Obstacles à l'Adoption des Bonnes Pratiques en Matière de Santé, Nutrition et Hygiène, dans les Provinces de Ruyigi et Cankuzo. Rapport Final.* Bujumbura: Tubaramure M&E Office.

exclusive breast feeding through their BCC activities, as well as the MoH Community Health Workers' promotion of exclusive breastfeeding during prenatal counseling and right after giving birth in the health centers (Annexes IV and V).

Table 5.2. Households Practice Appropriate Health and Nutrition Behaviors

Key Indicators Used to Track IR2 Outcomes	Baseline 2009	Endline 2014	Statistical Significance	LOA Target
Outcome Indicators				
2.1. Percentage of babies < 6 months exclusively breast-fed in the last 24 hours	69.4	87.9	Significantly increased p=0.000	90.0
2.3. Percentage of children 0-59 months reported with diarrhea (3 or more days of loose stools) within the past two weeks	14.1	6.5	Significantly decreased p=0.001	5.0
Other Indicators				
2.6. Percentage of mothers with children under 2 who can state at least four of the six danger signs for childhood illness	Data was not collected during the baseline *	24.4	N/A	45.0
Percentage of children < 5 years of age who were reported being sick during the last three months		70.0		
• Percentage with malaria		49.0		
• Percentage with diarrhea		11.4		
• Percentage with <i>Infection respiratoire aiguë</i> (IRA)		11.3		

* The baseline information was collected by a complementary baseline study, so the sample was not comparable with the final survey sample.

Source: Tubaramure IPTT and ISTEERU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEERU (August 2014).

1.2.3. Decreased Incidence of Diarrhea. There was a very significant decrease in the proportion of children who suffered from diarrhea over the two weeks preceding the survey (from 14.1% to 6.5%) (Table 5.2). During the key informant discussions, most staff attributed this decrease to the Tubaramure-related improvements in hygiene and sanitation through adopting basic hygiene practices such as conserving drinking water in a container with a cover, having a place to wash hands, and using latrines (See Chapter 3, Table 3.3; Annexes IV and V). Many beneficiary and non-beneficiary mothers that were interviewed in the focus group discussions made the same connection (Annexes IV and V).

1.2.4. Increased Adoption of Basic Nutrition and Hygiene Practices. Overall, the endline survey findings show a substantial population-based increase in the adoption of some of the most important Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) practices that were being adopted by the program (Table 5.3).

In a few cases, the statistics for health and hygiene behaviors were slightly better at Cankuzo than at Ruyigi, although it is impossible to see if any of these were statistically significant since this was not tested during the survey. For example (Table 5.3):

- 72.9% of the children under 5 reported being sick in the last three months at Ruyigi vs. 64.4% at Cankuzo; and

- For adoption of latrines (72.8% vs. 52.1%), hand washing (49.0% vs. 28.2%), dishwashing racks (59% vs. 42.2%), and mosquito net use (58.4% vs. 42.7%).

Table 5.3. Percentage of Households Practicing the Main ENA and EHA Practices Promoted by the Tubaramure Program in Ruyigi and Cankuzo Provinces

Actions	Baseline	Final (n=1,200)		
	N=1,255	N=1,200	Cankuzo N=449	Ruyigi N=751
Output Indicator 2.4. <i>Percentage of households observed carrying out four or more ENA actions at time of household visit (observed or reported)</i>	N/A	68.8%	72.2%	68.4%
EBF: Percent of babies < 6 months exclusively breast-fed in last 24 hours	69.4	87.9	89.8	86.8
Four Food Groups: Consumption of at least four food groups by Children	74.2	77.8	80.0	76.4
IBF: Immediate breastfeeding after birth	88.1	90.2	90.2	90.1
Iodized Salt: Consumption of iodized salt		58.4	58.8	58.2
GM: Child weighed and measured during the last four months	16.0	57.3	59.2	56.1
Pregnancy Diet: Increased food consumption by mother during pregnancy	N/A	32.0	29.4	33.6
Output Indicator 2.5. <i>Percentage of households observed carrying out four or more EHA actions at time of household visit (observed or reported)</i>	N/A	58.5%	69.0%	52.2%
Hand Washing	N/A	36.0	49.0	28.2
Latrine	18.4	59.8	72.8	52.1
Clean Yard	N/A	95.8	95.5	96.0
Pit: Existence of a compost pit	N/A	64.2	67.3	62.3
Platform: Existence of a drying rack for washed plates	9.0	48.5	59.0	42.2
Water Purification: Practices water purification	10.6	47.1	47.0	47.1
Insecticide-Treated Net	61.3	48.6	58.4	42.7

Source: Tubaramure IPTT and ISTEERU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEERU (August 2014). Pp. 38-39.

1.3. IR3: Eligible Women and Children Have Increased Intake of Nutrient-Rich, Diverse Foods²⁰⁰

1.3.1. Average Household Dietary Diversity Score. Compared to the baseline, there is a significant increase in the average dietary diversity score. The average score increased from 4.6 in 2010 to 8.2 in 2014, giving a significant increase of 3.6 points (78.3% achievement of the target), which is statistically significant ($p = 0.000$) (Table 5.4). This performance is very close to the expected target (life of activity [LOA] average dietary diversity score= 9). Over 95% of households consumed at least three food groups, and over 40% use at least seven groups. The dietary diversity score was higher in Cankuzo than Ruyigi.

²⁰⁰ **SOW Key Question 10 (IR2/IR3):** To what extent the use local food has sustained a sufficient food intake and balanced diet at the household level after the distribution of Title II commodities?

Table 5.4. Eligible Women and Children have Increased Intake of Diversified Foods

IR3 Key Program Indicators	Baseline 2010	Endline 2014	Statistical Significance	LOA Target
Average household dietary diversity score	4.6	8.2	Significantly increased p=0.000	9.0
Percentage of children 6-24 months reported as having consumed at least four food groups during the last 24 hours	74.2	77.8	Baseline data was not suitable to perform a significant test*	90.0

* The baseline information was collected by a complementary baseline study so the sample was not comparable with the final survey sample.

Source: Tubaramure IPTT and ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014).

At mid-term, the dietary diversity score was only 5.8 for the PM2A beneficiaries (see Annex II). The dramatic increase in the dietary score between the mid-term (June 2012) and the final population-based survey (June 2014) is linked to the program’s concerted efforts to promote keyhole gardens under IR3. Since 2012, the number of keyhole vegetable gardens has increased from:

- 820 to 25,984;²⁰¹ and
- 44.2% of the households interviewed in the final quantitative survey (56.6% in Cankuzo and 36.8% in Ruyigi) reported having keyhole gardens.²⁰²

Other interventions that contributed to this population-based impact after the mid-term were the post mid-term distribution of nutritional and ENA posters—43.6% of the households interviewed in the final quantitative survey reported having posters (50.1% in Cankuzo vs. 39.7% in Ruyigi).²⁰³

1.3.2. Percentage of Children 6-24 Months Reported as Consuming at Least Four Food Groups During the Last 24 Hours. The final survey showed mothers’ practices regarding child dietary diversity improved. Although baseline data was not suitable to perform a significance test, a larger proportion of women reported that their children aged 6-24 months consumed at least four foods groups during the last 24 hours—77.8% in 2014 compared to 74.2% in 2010 (Table 5.4), with 76.1% in Cankuzo vs. 70.8% in Ruyigi. Compared to the LOA target of 90%, achievement was 86.4%. In conclusion, the beneficiary communities have adhered to the principle of food diversification for their children. During focus group discussions with mothers, the evaluation team noted that women are very knowledgeable about the different food groups and the importance of food diversification for children over 6 months. Some mothers also stated that breastfeeding alone is no longer sufficient to cover a child’s food needs after 6 months. Most were able to name three major food groups available locally.

²⁰¹ Tubaramure IR3 National Coordinator Regine Pacis Nohoreho; July 2014.

²⁰² ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pg. 40.

²⁰³ ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014). Pg. 40.

2.0. Evidence of Results Based on the Program's Impact Indicators

The goal of the PM2A program was to prevent malnutrition among children under 2 years in the provinces of Cankuzo and Ruyigi. This impact was tracked by four program-level impact indicators that were measured during the quantitative baseline and endline surveys (Table 5.5).

Table 5.5. Nutritional Status of Children Under 5 Years of Age in the Provinces of Cankuzo and Ruyigi at the Tubaramure Program Baseline (2010) and Endline (2014)

Indicator	Baseline 2010	Endline 2014	Target	Statistical Significance
<i>Indicator 1.</i> Chronic Malnutrition (Stunting, height/age ≤ -2 SD): Percentage of children 0-59 months of age with height for age Zscore < -2 SD	51.8% (N=1,442)	50.5% (N=1,608)	42%	Not significant p=0.236
<i>Indicator 2.</i> Acute Malnutrition (Wasting, weight/height ≤ -2 SD): Percentage of children 0-59 months of age with weight for age Zscore < -2 SD	8.2% (N=1,442)	4.8% (N=1,603)	(-25%)	Significant decrease p=0.000
<i>Indicator 3.</i> Underweight (weight for age ≤ -2 SD): Percentage of children 0-59 months of age with weight for height Zscore < -2 SD	43.2% (N=1,449)	22.0% (N=1,774)	No target	Significant decrease p=0.000
<i>Indicator 4.</i> Percentage of newborn weight < 2500 g	7.2%	5.4%	2%	Significant decrease p=0.0005

Source: Tubaramure IPTT and ISTEERU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEERU (August 2014).

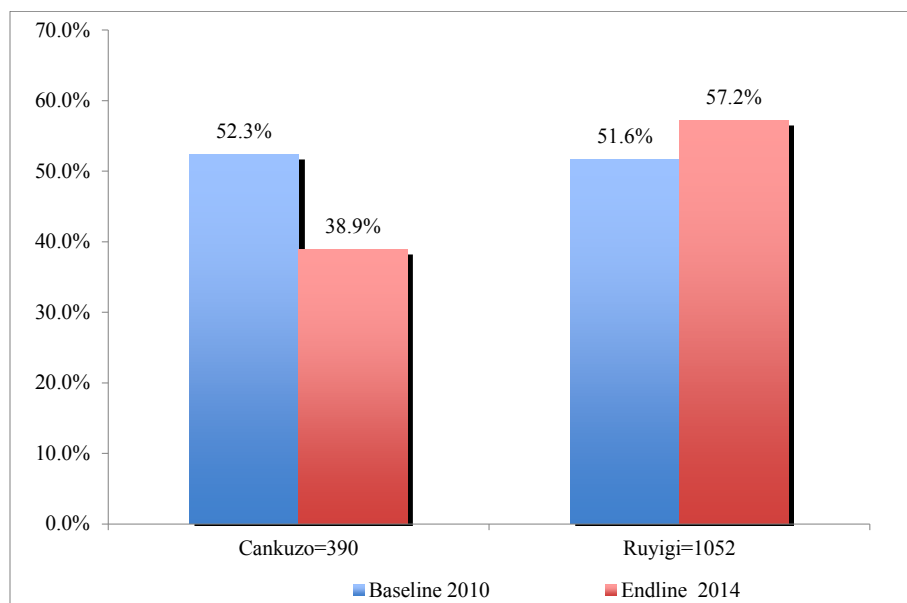
2.1. Chronic Malnutrition (Stunting, height / age ≤ -2 SD): Percentage of Children 0-59 Months of Age With Height-for-Age Zscore < -2 SD

2.1.1. Both Provinces. Stunting, or chronic malnutrition resulting in low height-for-age, is usually the result of improper diet and/or infectious diseases occurring repeatedly or over a relatively long period of time. Height-for-age is indicative of the quality of the environment and, in general, the level of socio-economic development of a population. The index height-for-age, which reflects the size of a child in relation to his age, is a measure of long-term effects of malnutrition and changes very little with the season during which the children were measured. This indicator generally reflects the long-term cumulative effects of inadequate food intake, poor hygiene, and recurrent diseases.

The comparison of endline to baseline data shows a small insignificant decrease in the overall prevalence of stunting, from 52.3% in 2010 to 50.5% in 2014, giving a difference of 1.8 points, non-statistically significant ($p = 0.236$) (Table 5.5). The LOA target for stunting was 42% for both provinces. If, however, the endline result (recoded by the final quantitative survey) is compared with the baseline 2010 data that was collected by the *Enquête Démographique et de Santé de Burundi* (National Demographic and Health Survey of Burundi or EDSB) in 2010 for both provinces (61.5%), the decrease in stunting is 9.2 points as opposed to 1.8 points.

2.1.2. Ruyigi. A disaggregated analysis by province shows that Ruyigi had a higher level of stunting (57.2%) than Cankuzo (38.9%) (Figure 5.1).

Figure 5.1. Percentage of Children Classified as Having Chronic Malnutrition (Stunting, Height/Age ≤ -2 SD)



Source: Tubaramure IPTT and ISTEERU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEERU (August 2014). Pg. 18.

2.1.3. Cankuzo. In contrast, the Tubaramure final household survey showed a remarkable 13-point decrease in the prevalence of stunting—from 52.3% in 2010 to 38.9% in 2014—that was statistically significant ($p=0.000$) (Figure 5.1).

2.1.4. Analysis. The evaluators would like to attribute the Tubaramure final survey's evidence for lower rates of stunting in Cankuzo to the higher percentage of households classified as 'food secure' in Cankuzo than in Ruyigi (Table 5.6). However, the Tubaramure final survey's results do not agree with the World Food Program-sponsored Standardized Monitoring and Assessment Relief and Transitions (SMART)²⁰⁴ study's provisional results for Cankuzo (the survey has not yet produced its final report)—indeed they contradict it. This discrepancy highlights the

²⁰⁴ "SMART is an inter-agency initiative launched in 2002 by a network of organizations and humanitarian practitioners. SMART advocates a multi-partner, systematized approach to provide critical, reliable information for decision-making, and to establish shared systems and resources for host government partners and humanitarian organizations. The SMART methodology is an improved survey method that balances simplicity (for rapid assessment of acute emergencies) and technical soundness. It draws from the core elements of several methodologies with continuous upgrading informed by research and current best practices. The SMART survey methodology is based on the two most vital and basic public health indicators for the assessment of the magnitude and severity of a humanitarian crisis:

- Nutritional status of children under 5.
- Mortality rate of the population.

These indicators are useful for prioritizing resources as well as for monitoring the extent to which the relief system is meeting the needs of the population, and therefore the overall impact of relief response. The SMART Methodology looks to reform and harmonize assessments of and responses to emergencies and for surveillance (if used at equal time intervals). It ensures that policy and programming decisions are based on reliable, standardized data and that humanitarian aid is provided to those most in need." UNICEF Website, Accessed August 26, 2014.

difficulty of measuring and analyzing the data needed to measure stunting. Stunting is a development indicator—one that typically requires change over a much longer period of time than five years. It is also hard to measure.

Table 5.6. Percentage of Households Classified as Having Different Levels of Household Food Security in Cankuzo and Ruyigi Provinces in the 2014 SMART Study

Zone	Food Secure (score <1.5)	Limited Food Security (1.5<score<2.5)	Moderate Food Security (2.5<score<3.5)	Severe Food Insecurity (3.5<score)
Cankuzo	47	38	12	4
Ruyigi	28	37	31	4
All Burundi	3	27	25	7

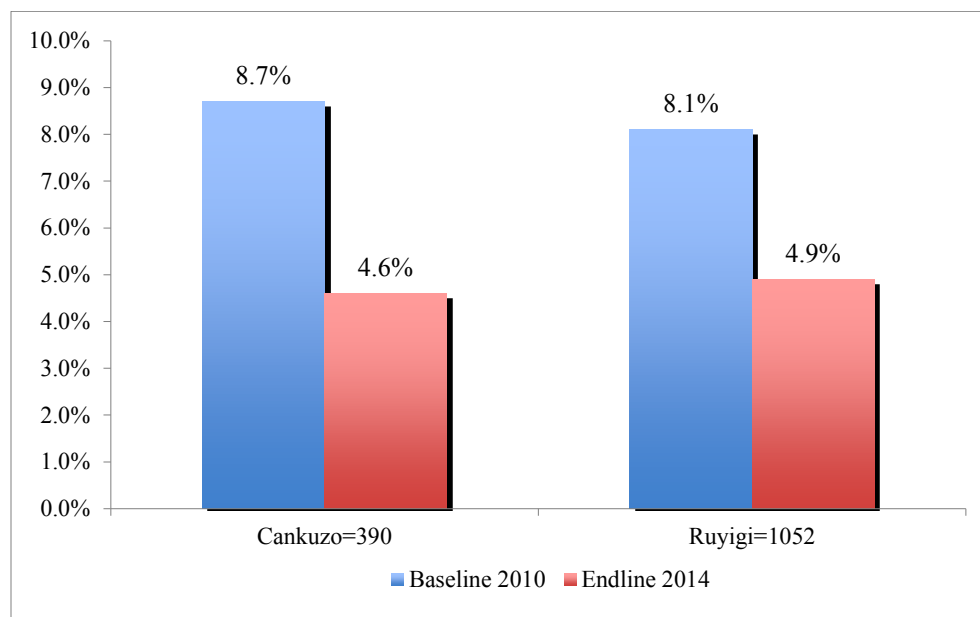
Source: ISTEEBU; 2014. *Analyse Globale de la Sécurité Alimentaire, la Nutrition et la Vulnérabilité au Burundi*, 2014: Résultats Préliminaires. Bujumbura: ISTEEBU (22 May 2014). Pg. 21.

2.2. Acute Malnutrition (Wasting, Weight / Height \leq -2 SD): Percentage of Children 0-59 Months of Age With Weight-for-Height Zscore $<$ - 2 SD

2.2.1. *Both Provinces.* The final quantitative Tubaramure survey showed a statistically significant 3.6-point ($p = 0.000$) decrease in acute malnutrition, from 8.2% in 2010 to 4.8% in 2014 (Table 5.5).

2.2.2. *Disaggregated Analysis by Province.* The disaggregated analysis showed that there was no major difference between Ruyigi and Cankuzo in terms of the percentage decrease in wasting (Figure 5.2).

Figure 5.2. Percentage of Children Classified as Having Acute Malnutrition (Wasting, Weight/Height \leq -2 SD)



Source: ISTEEBU; 2014. *Enquête Ménage pour l'Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014).

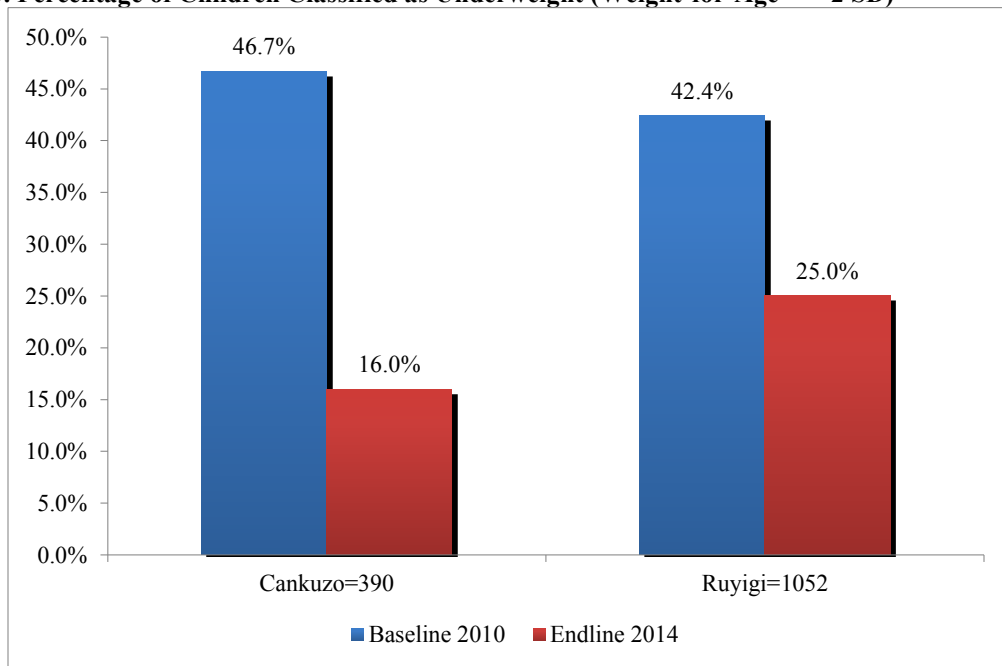
2.3. Underweight (Weight-for-Age \leq -2 SD): Percentage of Children 0-59 Months of Age With Weight-for-Age Zscore $<$ - 2 SD

2.3.1. Both Provinces. This weight-for-age indicator is usually used for GM programs. It is a simple index that can be used to monitor the prevalence of all types of malnutrition mixed together. It is a combined indicator in the sense that the child's underweight status could be provoked by either wasting or stunting. Thus, it is an indicator that does not distinguish between long-term food deficits (stunting) and more recent food deficits (wasting).

The Tubaramure final household survey showed a significant decrease in the prevalence of underweight children under 5 from 43.2% in 2010 to 22.0% in 2014 (Table 5.5). This represents a very significant difference of 21.2 points (a net decrease of 49%) that is statistically significant ($p=0.000$).

2.3.2. Disaggregated Analysis by Province. The disaggregated data shows that the decrease of underweight prevalence was more pronounced in Cankuzo than Ruyigi (Figure 5.3).

Figure 5.3. Percentage of Children Classified as Underweight (Weight-for-Age ≤ -2 SD)

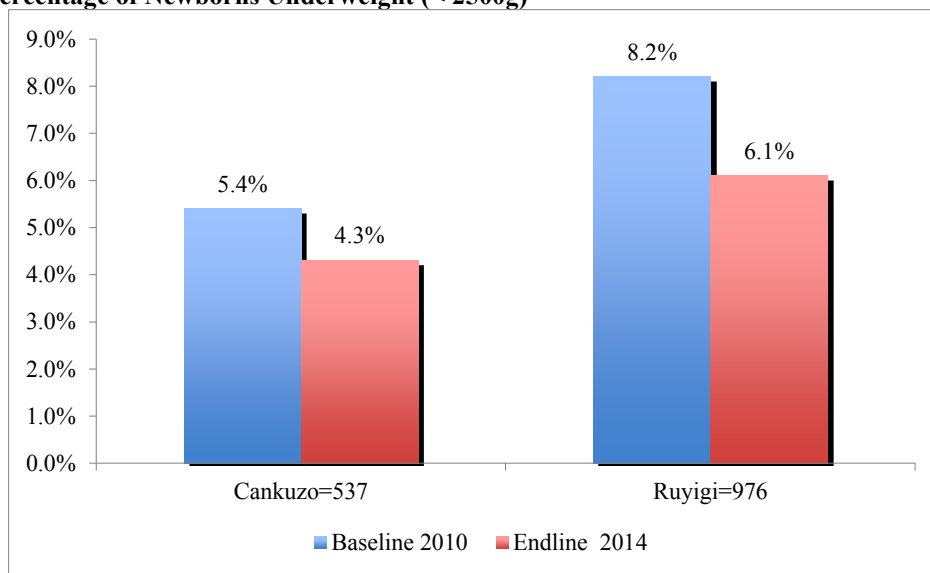


Source: Tubaramure IPTT and ISTEEBU; 2014. *Enquête Ménage pour l’Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final.* Bujumbura: ISTEEBU (August 2014).

2.4. Percentage of Newborns Under Weight (< 2500g)

Regarding the prevalence of low birth weight (less than 2,500 grams), the final Tubaramure survey showed a major decrease in the prevalence of low-birth-weight children (<than 2,500 grams) from 7.2% in 2010 to 5.4% in 2014, a difference of 25% that was statistically significant ($p = 0.0005$) (Table 5.5). The percent of underweight babies was lower at Cankuzo than Ruyigi (Figure 5.4).

Figure 5.4. Percentage of Newborns Underweight (< 2500g)



Source: Tubaramure IPTT and ISTEERU; 2014. *Enquête Ménage pour l’Evaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEERU (August 2014).

This information concurred with the focus group and key informant feedback from health personnel and women, which argued that there has been a significant improvement in the weight of children at birth that they attributed to the PM2A rations and the IR2 BCC activities: “*Before the project, the rate of low birth weight was very high in our health facility, but now we are seeing a marked improvement since the weight of children at birth for many women followed during pregnancy increased from 2.5 kg to 3.5 kg or 3.*”²⁰⁵ During the focus groups, the evaluators noted that most of the women being interviewed had a good understanding about how they should be eating to maintain their good health both prior to and during pregnancy, and the role of the family’s keyhole garden in helping them improve these feeding practices.

2.5. Conclusion

The significant reduction in the rates of acute malnutrition and underweight newborns found in the quantitative survey corroborates the qualitative data that the evaluation obtained during focus group discussions and interviews with key people. Based on the quantitative data, the overall objective of the program for the prevention of malnutrition has been largely achieved. These impacts on reducing the rate of malnutrition in children suggest that women/mothers continued the good nutrition and hygiene practices learned in the program. In the *collines* visited by the team, the women/mothers, health workers, and authorities all reported that the nutritional and health status of the local children had been greatly improved thanks to the Tubaramure Program. They also reported that in addition to food, women learned how to prepare healthy meals through cooking demonstrations with local foods, to follow improved hygiene practices, and to continue these new practices with children born after their graduation from the program.

²⁰⁵ Key information interview from one of the health personnel at the *Nyagutoha* health center.

These are results that can be documented based on the quantitative data from the final survey and the focus group discussions.

3.0. Activities Producing Good Outcomes and Their Prospects for Being Sustained Once the Program Ends²⁰⁶

This final section:

- Summarizes the earlier discussions of the different outcomes produced by Tubaramure and the key activities that have produced these outcomes; and
- Classifies these activities according to three levels of impact being achieved and the likelihood that the activities and impacts can be sustained at their current level. These different levels are described Table 5.7 below:
 - Some activities—as shown in the first column of Table 5.7—have produced very positive outcomes and are likely to be sustained beyond the life of the program;
 - Other activities—as those in the second column in Table 5.7—produced some very important outcomes that are likely to diminish over time unless they receive some additional support from follow-on governmental or non-governmental organization (NGO) programs; and
 - A third category of Tubaramure activities that have had less of an outcome—either because they were new or because they were affected by a number of constraints that were outside the control of the program—and are unlikely to continue once the program ends.

Table 5.7. Major Outcomes Being Generated in the Tubaramure Program and Options for Sustaining the Impact Once the Program Ends

Activities Producing Good Outcomes That are Likely to Be Sustainable	Activities Producing Good Outcomes That Need Additional Support	Activities That Needs Additional Support to Have Measurable Outcomes
IR1: Women and children under 5 access quality nutrition and health services		
IR1.1-1.3. Training clinical-level workers	IR1.1-1.3. Training MoH Community Health Workers and their Public Health Technician supervisors	
IR1. Material and equipment for health centers	IR1. Material and equipment for the MoH Community Health Workers	
IR1. Formative supervision (clinical level)	IR1. Formative supervision of the MoH Community Health Workers	
IR1. Joint supervision meetings (clinical level)		
	IR1. MoH coordination meetings (all 3 levels)	
IR1.1. Clinical-level prenatal consultations		IR1.2. Clinical-level postnatal consultations
IR1.2. Clinical-level Integrated Management Of Childhood Illness (IMCI)	IR1.2 and IR2.2. MoH community-level IMCI activities	
IR 1.3. Clinical-level GM	IR1.3. Pilot test of community-based	

²⁰⁶ *SOW Specific Objective 6* (IR1): Assess the issues of sustainability both at the institutional, the community and the households' levels.

Activities Producing Good Outcomes That are Likely to Be Sustainable	Activities Producing Good Outcomes That Need Additional Support	Activities That Needs Additional Support to Have Measurable Outcomes
	growth monitoring (high level of community interest but needs outside support for scale up)	
	IR1.4. Severe acute malnutrition (SAM) referral and clinical treatment of children identified as severely malnourished and treatment of children	IR1.4. Community Management of Acute Malnutrition (CMAM) children are being referred but not treated at either the clinical or community level
IR 2: Households practice appropriate health and nutrition behavior		
IR2.1. ENA & EHA (low cost)	IR2/2.2. EHA-Latrines (need additional support & access to potable drinking water)	
IR2. LMs	IR2. Care Group training model (if the MoH makes it a priority and integrates with other activities like GM and Hearth)	IR2. Care Group training module (if the MoH does not make it a priority and does not integrate it with other activities like GM and Hearth)
	IR2. Five BCC modules	
IR3. Eligible women and children have increased food intake and diversity		
	IR3/3.1-3.2. PM2A rations increased food access for eligible children (but sustainable)	
IR3.3. Households consume and want to consume a more diversified diet	IR 3.3: Keyholes (seed constraint) (not well integrated with <i>Direction Provinciale de l'Agriculture et de l'Elevage</i> [DPAE])	
IR3.3. Savings and Internal Lending Communities (SILCs)		
	IR 2. <i>Groupements</i> (added to encourage the MLs and beneficiaries to stay in Care Groups)	Goat distributions (too few, too late; not well integrated with DPAE)
	Soy bean production and processing (not yet well integrated with the DPAE)	

Source: Tubaramure final evaluation team classification of activities; August 2015, which was discussed, reviewed, and amended with various program stakeholders during the final three debriefings.

3.1. IR1: Women and Children Under 5 Access Quality Nutrition and Health Services

3.1.1. *Activities Producing Good Outcomes That Are Likely to Be Sustainable.*

3.1.1.1. *Training, Equipment, and Supervision Support for the MoH's Clinical-Based Activities to Prevent Malnutrition.* Clinical-level trainings of MoH staff under IR1 had a huge impact on the quality of the MoH staff and the health and nutrition services in the health centers. These high-quality services—combined with the BCC training under IR2—are the drivers of the key program outcomes under IR1 described at the top of this chapter, including:²⁰⁷

²⁰⁷ *SOW Specific Objective 4* (IR1): Assess how the program fitted and contributed in a sustainable way, to the achievement and the overall objectives of the Ministry of Health.

- The increased number of women who are following the recommended package of prenatal consultations;
- The increased number of children attending GM visits; and
- The increased percentage of MoH nurses who are able to accurately diagnose and treat children under 5.

The training needed to sustain these activities is likely to be continued because it is built on existing ministry protocols, modules, and trainings. There was extensive investment over four years in training and routine supervision to ensure that the trainees, as well as their co-workers, understood the new protocols and tools they would need to execute them effectively. The distribution of equipment to the new and existing centers was an additional support that increased service quality. To facilitate handover, the Tubaramure Program is buying new equipment to replace the earlier equipment that they gave the centers in the first year just prior to shutting down in August 2014. The key to sustainability will be for the health centers to anticipate the need for further renewals through their core budgets and/or future donor-funded projects; for the MoH to continue funding the basic training of the new provincial level staff; and for the MoH to continue executing its supervisions with the same level of rigor that it had attained by the end of the program. Since most of these activities are already planned as part of the routine provincial-level ministry activities, there is a good chance that these activities will continue to support the outcomes attained.

3.1.2. Activities Producing Good Outcomes That Need Additional Support.

3.1.2.1. MoH Coordination Meetings. One Tubaramure activity that contributed to the positive population-based outcomes of the program was its logistical and technical support for three levels of coordination meetings: 1) a provincial-level coordination meeting focused on health and nutrition; 2) a partner meeting focused on community-based health initiatives; and 3) a series of commune-level coordination meetings. For these meetings to be sustained, they need additional support from area donors. To date, only one NGO donor, World Vision, is providing partial support for one of the three meetings.

3.1.2.2. MoH-Supported Community-Based Growth Monitoring. Given the high level of interest in GM—even after graduation—it is highly likely that the provincial offices of the MoH will be able to maintain the current levels of clinic-based GM, which covers about half the eligible children. For this figure to go any higher—like the 90% target that the Tubaramure Program had targeted originally—the MoH would need to expand the number of communities with community-based GM run by the MoH Community Health Workers under the supervision of the Public Health Technicians with support from the 4,920 Tubaramure LMs, who are all trained in community-based GM. To date, Tubaramure has supported the development of community-based GM in only 12 sites in Ruyigi and Cankuzo, and World Vision has supported in eight sites in Cankuzo.

3.1.2.3. Community-Based Referrals to Clinical-Based Services to Treat SAM. One major output of the Tubaramure support was to increase the ability of beneficiary and non-beneficiary mothers, Community Health Workers, and LMs to identify malnourished children and understand the process needed to ensure malnourished children are referred to a hospital-based

center for recuperation. These United Nations Children’s Fund (UNICEF)-funded centers are useful and good. There is a need to continue to train and supervise the Community Health Workers in these processes.

3.1.2.4. Training, Equipment, and Supervision Support for the MoH’s Community-Based Activities to Prevent Malnutrition. To date, however, the IR1 activities have had their greatest impact at the clinical level. Most (not all) of the current slate of Public Health Technicians have been trained in the new protocols that are important for preventing and treating malnutrition for children under 5. They have also been trained in the MoH’s integrated manual, which they have used to train the Community Health Workers. Although the short-term impact of this training—in combination with the BCC public awareness training under IR2—has been very positive, it is just starting. A high percentage of the Community Health Workers were recruited in 2013 and many of their trainings are quite recent. To be effective, these Community Health Workers will need additional training, retraining, and consistent, well-managed supervision by their MoH supervisors and technical staff that backstops the Community Health Workers on particular protocols. They will also need appropriate community-level equipment to execute their current and projected functions.²⁰⁸ Since the MoH Community Health Workers are volunteers, there is a need to find new ways to compensate them, for example, by linking them to the types of income-generating activities (IGAs) that they can execute in conjunction with their health activities.

Public Health Technicians will need transportation support, like motorcycles, to supervise the Community Health Workers and their activities. In addition, both the Public Health Technicians and Community Health Workers will need a certain amount of basic equipment, training, and retraining. Given the critical importance of these activities in sustaining the very positive outcomes that started under Tubaramure, this type of support is a high priority for the provincial-level MoH offices and one that merits support from future NGO and bilateral programs moving into the two provinces.

3.1.3. Activities that Need Additional Support to Have Their Desired Outcomes.

3.1.3.1. Postnatal Consultation. Despite a huge investment of time and energy under both IR1 and IR2, the Tubaramure Program was unsuccessful in facilitating a significant increase in the percentage of women who came in for the recommended number of postnatal visits within 45 days of giving birth (first and second postnatal). In the current context, this is not a top priority for either the local health center-based personnel or the local mothers. Changing this will require a series of investments in making the health center-based services more user-friendly to the mothers that was beyond the scope of Tubaramure to change.

3.1.3.2. Identifying and Treating Moderate Malnutrition in the Local Communities. A second very pressing issue of public policy concern is strengthening the local communities’ capacity to identify and treat children identified as moderately malnourished using clinics, community-based GM programs, and/or SAM referrals. One of the best methodologies for addressing this issue that is recognized by the GoB is through the creation of *Foyer d’Apprentissage et de Réhabilitation Nutritionnelle* (FARN or Hearth-model rehabilitation programs).

²⁰⁸ *SOW Specific Objective 4 (IR1):* Are provided equipments appropriate, well dispatched and well used for reaching the expected results?

The issue of identifying and treating the children who are only moderately or severely malnourished (without complications)—as opposed to being acutely malnourished and eligible for referral to hospital-based programs—was (in the case of these two provinces) and is likely to continue to be (in other geographical regions of Burundi) a problem both during and after PM2A distributions. Specifically:

- Although the distribution of the PM2A rations decreased the number of children being referred for SAM rehabilitation during the program, the GM programs still continued to identify a relatively large number of cases of moderate malnutrition; and
- Their number will likely increase in the post-PM2A context of both provinces.

Ignoring this issue is likely to discourage mothers from referring their children to the health centers (for fear they might not be accepted) until their malnutrition has reached the point that it is very severe and far more expensive to treat.

3.2. IR 2: Households Practice Appropriate Health and Nutrition Behavior

3.2.1. *Activities Producing Good Outcomes That Are Likely to Be Sustainable.*

3.2.1.1. ENA and EHA Behaviors. The same analysis provides clear evidence that the Tubaramure BCC practices were catalyzing some important behavior changes both in beneficiary and non-beneficiary mothers. Another very important impact of these BCC programs is that these BCC messages stimulated the demand for the stronger MoH health and nutrition services under IR1.

3.2.1.2. LMs. There is clear evidence from the final evaluation focus group discussions and key informant interviews that the LMs have been trained and that these women constitute a major resource for health and nutrition development in both provinces. The major challenge will be to better connect them to the MoH community intervention structures, which are the Community Health Workers and their supervisors, the Public Health Technicians.

3.2.2. *Activities Producing Good Outcomes That Need Additional Support.*

3.2.2.1. ENA and EHA Behaviors. In the short-term, one of the most immediate problems will be for the MoH to work with its new and existing partners moving into both provinces to increase access to potable water. The lack of potable water is a critical constraint in about 48% of the communities in Ruyigi and 55% percent in Cankuzo.²⁰⁹

Although the rate of latrine creation and use has increased, this is an area that needs additional support both for public awareness building and for the provision of basic materials like the cement platforms (*dals*).

3.2.2.2. Care Groups. Two important assumptions on the program's original sustainability strategy were the Care Groups would remain functional in the Tubaramure Program areas and

²⁰⁹ These estimates are based on the initial qualitative classification of the *collines* that was conducted as a basis for choosing the *collines* for the interviews.

that they would be taken to scale throughout Burundi.²¹⁰ It was also assumed that the Care Groups would be the principal mechanism for maintaining the positive ENA and EHA changes that were created by the program.

It is increasingly clear from the focus group discussions and key informant interviews with Tubaramure staff during the final evaluation that none of the Care Groups are likely to continue to meet in their current form once the Tubaramure staff are no longer available to facilitate them unless there is a major shift in the national MoH support for the Care Group concept.²¹¹ Although many of MoH Public Health Technicians interviewed during the final evaluation saw the Care Groups as a very useful model, they simply do not have the time or energy to support this activity in addition to their other duties. The issue of supporting the Care Groups is further complicated by the fact that the concept of the Care Groups was never taken to scale nor validated by the MoH.

If there is a major shift in the national MoH support for the Care Group concept—which is being supported by a large group of international NGOs—then the concept of the Care Group might become more viable. For the concept to become more viable, it would also need to be accompanied by an increase in the number of MoH Public Health Technicians, since the current number are already overstretched to cover the existing base of Community Health Workers.

*3.2.2.3. The Five BCC Modules Developed Under IR2.*²¹² One very important output of IR2 was the creation of five BCC training modules that were well adapted to the educational level of the LMs, most of whom were illiterate or only marginally literate. The five BCC training modules were approved by the ministry for use in the two provinces. Although they were approved, they were never officially validated, which means that they do not constitute a group of training modules that will be used at the national level. The modules exist; they were carefully crafted and pilot tested; and, based on the LMs' feedback during the final evaluation focus group discussions, they were effective in building understanding of basic health and nutrition issues. These IR2 modules—like those developed under IR3—represent an important capital that the MoH and other donor-funded programs can use in other programs. The key challenge for the MoH, both in the provinces and nationally, will be to link the modules developed by Tubaramure to the official MoH modules like the integrated Community Health Worker training modules that are validated for all official training programs. Since the Community Health Worker-integrated module is official, any new modules have to be linked to that module, not vice versa. The large number of modules developed by Tubaramure under IR2 (five) and IR3 (three) has complicated this linking process.

3.3. IR3: Eligible Women and Children Have Increased Food Intake and Diversity

3.3.1. Activities Producing Good Outcomes That Are Likely to Be Sustainable.

²¹⁰ CRS; 2009. *Tubaramure MYAP Proposal*. Bujumbura: CRS. Pg. 22.

²¹¹ *SOW Specific Objective 7 (IR2/IR3)*: How is at all levels, the collaboration between the program and the Ministry of Health. What can be done to improve the collaboration?

²¹² *SOW Specific Objective 5 (IR2/IR3)*: Are the training modules appropriate and fitting with national protocol? How can they be improved in future program?

3.3.1.1. *Increased Dietary Diversity*. The quantitative survey shows that the program was highly successful in increasing dietary diversity of the beneficiary households through a series of culinary demonstrations, supervision visits, posters, keyhole gardens, and IGAs through the Savings and Internal Lending Communities (SILCs) and economic *groupements*. Especially important is the fact that this increased dietary diversity appears to have been population based even after the PM2A rations stopped. The key challenge will be for the MoH to strengthen its communication with various non-health actors—like the Ministry of Agriculture and Livestock (*Ministère d'Agriculture et d'Élevage* or MAE) as well as the existing and projected base of donor-funded livestock and crop development programs—to continue to build food availability and access.²¹³

3.3.1.2. *SILCs*. The Tubaramure Program introduced SILCs with CRS' cost share funds. There was a great deal of qualitative evidence from the focus groups that the SILCs have had a major impact on the local beneficiaries' food access by providing them with cash funds for extra food as well as small-scale investments that they needed to increase food availability and access, as was anticipated in the original MYAP proposal. The SILCs built on and reinforced the traditional system for rotating group credit or *tontines*.

3.3.2. *Activities Producing Good Outcomes That Need Additional Support*.

3.3.2.1. *Groupements*. The Tubaramure Program's decision to promote the development of legally recognized economic *groupements* after the mid-term was made as a way of trying to keep the Care Groups meeting even after graduation. The short-term impact of these activities was to increase the number of *groupements* in both areas, and the number of women involved in *groupements*. While this development is very positive, it is just beginning. A high percentage of the groups are only a year old, and many of them are still very weak in terms of technical and organizational skills since the program was only able to assist two *groupements* per *colline*. Thus, one of the most pressing handover tasks already underway is to increase the local MAE office's awareness of where these *groupements* are located, what they do, and how they can be accessed by new programs moving into both provinces. Over the long-term, the SILCs and the *groupements* offer one of the best prospects for helping households gain access to the IGAs necessary to have the food that they need to maintain a more diversified diet.

3.3.2.2. *Keyhole Gardens*. The keyhole gardens are another activity that was started after the mid-term to help the households maintain a more diversified diet once the PM2A rations stopped. The uptake of the new technology was a success—from 820 gardens in 2012 to 25,984 in 2014. Today—less than three years after the concept of the keyhole gardens was first pilot tested by the Tubaramure Program—more than 44.2% of the households in the final survey reported having a keyhole garden (56.6% in Cankuzo and 36.8% in Ruyigi).²¹⁴ This is an activity that has had a widespread, very important population-based impact. The most pressing short-term constraint to additional scale up and/or maintaining the very positive impact of the keyhole

²¹³ **SOW Key Question 3** (IR2/IR3): Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?

²¹⁴ ISTEERU; 2014. *Enquête Ménage pour l'Évaluation Quantitative Finale du Programme PM2A—Tubaramure (Provinces Cankuzo et Ruyigi). Rapport Final*. Bujumbura: ISTEERU (August 2014). Pg. 40.

gardens on household nutrition is ensuring that the households have access to vegetable seeds. Tubaramure provided these seeds during the program. Currently, a large number of keyhole gardens are reverting to the local vegetables that they can grow with local seeds, mostly *lenga lenga* (amaranth greens). This increased demand for improved seed is a good opportunity for the new and existing agricultural development programs in both provinces to promote community-based seed production.

3.3.2.3. Soy Production and Processing. The program's efforts to introduce soybean production as a strategy for increasing dietary diversity have generated a great deal of interest among the MAE staff, as well as local farmers. By the end of the program, at least two groups per *colline* will have been trained in the basic techniques for producing soy and will have the basic equipment that they need to process soy for sale in various value-added products. To date, however, there is no secure source of soy seed outside of Bujumbura. One of the most pressing challenges for any additional scale up of soy is likely to be seed supply. This activity is an attractive option for new agricultural programs moving into the area.

3.3.3. Activities That Need Additional Support to Have Their Desired Outcomes. The program's efforts to promote small livestock production through the *groupements* were well intended and have generated a great deal of interest. To date, however, these activities have not generated the same level of outcome as the keyhole gardens or the SILCs. They are also more complicated than the keyhole gardens, the SILCs, or soy production because they require more intensive training of the *groupements* in livestock production and building these groups' connections to the existing public (MAE) and private (input suppliers)-sector supports that the groups will need to be successful. This is an area that will require a great deal of more intensive support to be successful. It is a promising area, however, which needs to be encouraged by the MAE, as well as any existing or new agricultural and livestock programs moving into both provinces.

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Annex I.A.
Summary List of Specific Questions and Key Questions in the Consultant SOWs

IR1
Specific Objectives:
1. Evaluate the effectiveness and the outcomes of the behavior change communication (BCC) strategy and messaging, as implemented (Essential Nutrition Actions (ENA), the Essential Hygiene Actions (EHA), and food diversification;
2. Assess the effectiveness of key behaviors as adopted by beneficiaries, with regards to the ENA, the EHA, the IMCI practices and the food diversification as well as the use of Title II commodities and local food;
3. Identify possible constraints and barriers that impacted on the adoption and the ownership of program proposed behaviors by the community as well as by households;
4. Assess how the program fitted and contributed in a sustainable way, to the achievement and the overall objectives of the Ministry of Health
5. Document lessons learned and provide recommendations for future programming, including for USAID.
6. Assess the issues of sustainability both at the institutional, the community and the households' levels.
7. Evaluate how graduated beneficiaries continue to incorporate behavior changes in the parenting of their children after graduation and of new children born after the mother graduated from PM2A
Key Questions
1. Are the health component activities being implemented according the DIP (Detailed Implementing plan)? What are the obstacles and the delays observed? What recommendation can be done for future program?
2. Is the health component well integrated in the government's strategy and priorities? Are there steps that could be taken to improve the integration?
3. What interventions have been more or less successful in meeting targets?
4. Are provided equipments appropriate, well dispatched and well used for reaching the expected results?
5. Are the training modules appropriate and fitting with national protocol? How can they be improved in future program?
6. Are trained staffs over health centers making difference with non-trained agents?
7. How is at all levels, the collaboration between the program and the Ministry of health. What can be done to improve the collaboration?
8. How the mid-term evaluation recommendations were taken into account for improving the program implementation?
9. To what extend project activities were financially supported and how will they be sustained at the institution and the community levels, after the project closure?
10. How could the program impact on national policies related to nutrition and health been improved?
11. How the project implementation dealt with the research component including the integrity of the control group?

IR2 and IR3
Specific Objectives
1. Are the health component activities being implemented according the DIP (Detailed Implementing plan)? What are the obstacles and the delays observed? What recommendation can be done for future program?
2. Is the health component well integrated in the government's strategy and priorities? Are there steps that could be taken to improve the integration?
3. What interventions have been more or less successful in meeting targets?
4. Are provided equipments appropriate, well dispatched and well used for reaching the expected results?
5. Are the training modules appropriate and fitting with national protocol? How can they be improved in future program?
6. Are trained staffs over health centers making difference with non-trained agents?
7. How is at all levels, the collaboration between the program and the Ministry of health. What can be done to improve the collaboration?
8. How the mid-term evaluation recommendations were taken into account for improving the program implementation?
9. To what extend project activities were financially supported and how will they be sustained at the institution and the community levels, after the project closure?
10. How could the program impact on national policies related to nutrition and health been improved?
11. How the project implementation dealt with the research component including the integrity of the control group?
Key Questions
1. With regard to the program framework, which interventions have been critical and/or effective in achieving the nutrition and health sector objectives and intermediate results? And why?
2. What are the factors that hinder/assist the effective integration of the program components?
3. Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?
4. Is the nutrition and health sector fitting into the local government's strategy and priorities? What has been the level of coordination/collaboration with Government of Burundi and other actors?
5. To what extent recommendations from the mid-term evaluation have been incorporated into the nutrition and health sector?
6. With regards to the ENA, EHA, IMCI and the food intake and diversity, are beneficiaries adopting desired practices or behaviors? Are there some secondary adopters?
7. Are there certain groups within the population with lower rates of adoption and why?
8. To what degree are behavior changes continued by graduated program beneficiaries, for example changes that improve the nutrition of children over the age of two and changes that impact subsequent births?
9. Have the pipeline and the implemented system helped for the timely and effective distribution of Title II commodities to all eligible beneficiaries?

10. To what extent the use local food has sustained a sufficient food intake and balance diet at the household level after the distribution of Title II commodities?
11. To what extent the project cost-effectiveness was reasonable over programming IR 2&3, as well as per beneficiary?
12. How effective is the nutrition and health sector at reaching fathers/men? What could be done in future programming to improve father/men's participation in such sectors?
13. To what extent the implemented activities under IR2 and 3 have developed and strengthened the institutional, the community and the households' capacities?
14. Which outcomes are likely or unlikely to be sustainable and continue after the project ends? and why?
15. Are there any factors (barriers/constraints) that limited community participation and engagement in the program implementation?
16. How are graduated and current beneficiaries in the community coping with the end of food distribution?
17. What national policy topics were affected, or could have been affected, by PM2A program actors, interventions, and lessons learned? How could the program have had more of an impact on national policies related to nutrition and health?
18. With regards to the preventative model, what contribution will the PM2A be able to offer to the Government?
19. Looking at all three IRs, from a cost effectiveness standpoint, how well were program resources allocated to the different IRs and how could they have been better allocated to a) achieve program objectives and b) enhance the sustainability of the program?
20. What was the cost per beneficiary of each IR, and which activities under the different IRs are deemed to be a) more cost efficient, and b) more cost effective in preventing malnutrition?
21. How was the impact of having a separately-designed and managed research component (under IFPRI) on the implementation of the CRS-led consortium program
22. How has the topic of "sustainability" of program interventions been dealt with under the program, including a) how sustainability was described/defined at the outset, b) whether there were flaws in the program design that would impact sustainability, c) what mid-course corrections were made, and what were missed, in enhancing program sustainability, and d) what lessons have been learned to improve the sustainability of future PM2A programming in Burundi and elsewhere.
23. Related to the sustainability topic is how long-lasting are the interventions achieved under IRs 1 and 2? For example, do graduating families continue to apply the lessons they learned to children who a) have graduated, or b) were born after the mothers graduated? Another example, are health center personnel properly implementing the Ministry protocols that were reinforced under IR 1 and that impact the nutrition of mothers and young children?
24. PM2A took a modular approach to BCC at the household and community level, and a curriculum was developed for improving health services, particularly at local health clinics. Please include a request for team observations on the relative impact of each of the three IRs on preventing malnutrition.
25. For example, during the BCC module on dietary diversity, what introduced foods

and new recipes were better received by beneficiaries than others? Why? Which potentially had a greater impact on meeting the nutrition deficits of the beneficiary population? Is exclusive breast-feeding during the first six months a larger (or smaller) concern than dietary diversity from 6 - 23 months? Why? Etc.

Annex I.B.
Scope of Work for the Team Leader and Evaluator Specialist

Final Evaluation: 05 July to 07 August 2014

I. Introduction/Background information

The Tubaramure consortium is recruiting a team of independent consultants for the final evaluation of the program, tentatively scheduled for July/August 2014. Further information on the objectives and methodology as well as the required consultant team and the expected deliverables are provided below.

Since 2009, Catholic Relief Services/Burundi is implementing a Multi-Year Assistance Program (MYAP), entitled *Tubaramure-PM2A* (“Let’s help them grow”, in Kirundi). This five years program is funded by USAID-Food for Peace (FFP); the overall objective of the program is to “prevent malnutrition in children under the age of two” using the Prevention of Malnutrition in children under 2 Years of Age (PM2A) approach, in two food- insecure provinces of Burundi (Cankuzo and Ruyigi). Approximately 49,650 mother-child pairs have been targeted over the five years (July 2009 to October 2014) of the life of this 43.134 millions USD grant. *Tubaramure* is a community based program including three components or intermediate results (IR) focusing on: (1) increased access to quality health and nutrition services; (2) improved health and nutrition behaviors; and (3) increased intake of nutrient-rich, diverse foods.

Key program components include behavior change communication (health, nutrition and hygiene), as well as the distribution of Title II rations and the promotion of local foods. It uses a preventative approach to empower the most affected populations so that they can influence their own food security. Since prevention of malnutrition begins with the mother, *Tubaramure* aims at targeting the mother and child as a unit with the provision of a package of targeted interventions that commence during the mothers’ pregnancy and end when the child reaches his/her second birthday. With CRS as lead, the program is implemented by a consortium of international and national NGO (International Medical Corps –IMC-, Food for the Hungry – FH-, and Caritas Burundi).

The program is the subject of a separate research study being conducted by the International Food Policy Research Institute (IFPRI) in partnership with Food and Nutrition Technical Assistance 2 (FANTA 2), to further assess and improve the preventive model.

Intermediate results # 1	1: Women and Children 0-59 months access quality nutrition and health services	1.1: Pregnant and lactating women access pre and postnatal care services
		1.2: Implementation of National IMCI plan is supported
		1.3: Health Facility Growth Monitoring (GM) services comply with national protocols
		1.4: SAM is detected and referred for treatment
Intermediate results #2	2: Households practice	2.1: Households adopt Essential Nutrition Actions (ENA)
		2.2: Households adopt Essential Hygiene Actions (EHA)

	<i>appropriate health and nutrition behaviors</i>	2.3: Households adopt prevention and management behaviors for maternal and childhood illnesses
Intermediate results #3	3: Eligible women and children have increased intake of diverse foods	3.1: FFP rations distributed to eligible women and children
		3.2: Mothers and children use FFP rations appropriately
		3.3: HHs use appropriate local foods in addition to FFP ration

II The objectives of the final evaluation

The objectives of the final evaluation is to assess the program’s achievements at the level of strategic objective and intermediate results, as well as the achievement in all indicators as stated in the approved proposal (available upon arrival).

Per Food For Peace requirements, the emphases of this final evaluation will be to determine:

- ✓ the relevance, the effectiveness, the efficiency, and the acceptability of processes and outputs;
- ✓ the factors affecting the implementation
- ✓ the degree of adherence to terms of agreement
- ✓ what and why results (outcomes/impacts) have/have not been achieved,
- ✓ the sustainability of results.

It is important to remind that besides this proposed final evaluation, there is also a US funded and separated research conducted by the International Food Policy Research Institute (IFPRI) in partnership with Food and Nutrition Technical Assistance 2 (FANTA 2), that aims to better understand/document the impact, cost, and cost-effectiveness of PM2A programs and to generate “learning” about how PM2A programs should be designed and implemented to maximize their impact and cost-effectiveness (see FANTA/IFPRI protocol of research). Examples of questions include how much food is needed (individual vs. household ration), what type of food/products is best? Should micronutrient supplements be used in place of individual food rations? What is the best timing and duration of exposure to a PM2A program), etc.

III. Team Composition (Roles and responsibilities of consultants)

The evaluation team will be composed of two external hired and independent consultants.

- ✓ One international consultant with Primary Health Care and Integrated Management of Childhood Illnesses expertise to evaluate Tubaramure IR1. S/he will work under the supervision of the team leader and will write and submit to him/her the report related to IR1.
- ✓ One international consultant with Health & Nutrition expertise to evaluate IR2 & 3 of the program. S/he will serve as the Team leader and assure the quality of the work throughout the evaluation process. S/he will give due attention during the phases of development of data collection tools, data analysis, report writing and other relevant deliverables. S/he will be the responsible for the consolidated and overall report.

Local experts from the Ministry of Health as well as delegates from the country SUN Focal point will be appointed for closely working with the team. If needed, the Consultants will be also allowed to hire local enumerators, Kirundi-translators as well as local statisticians.

IV. **Specific objectives for the Health and Nutrition Expert**

Taking account of the midterm evaluation report, specific objectives of the Health and Nutrition expert, who will also serve as team leader for the final evaluation, includes the following (IR2 and IR 3):

- ✓ Evaluate the effectiveness and the outcomes of the behavior change communication (BCC) strategy and messaging, as implemented (Essential Nutrition Actions (ENA), the Essential Hygiene Actions (EHA), and food diversification;
- ✓ Assess the effectiveness of key behaviors as adopted by beneficiaries, with regards to the ENA, the EHA, the IMCI practices and the food diversification as well as the use of Title II commodities and local food;
- ✓ Identify possible constraints and barriers that impacted on the adoption and the ownership of program proposed behaviors by the community as well as by households;
- ✓ Assess how the program fitted and contributed in a sustainable way, to the achievement and the overall objectives of the Ministry of Health
- ✓ Document lessons learned and provide recommendations for future programming, including for USAID.
- ✓ Assess the issues of sustainability both at the institutional, the community and the households' levels.
- ✓ Evaluate how graduated beneficiaries continue to incorporate behavior changes in the parenting of their children after graduation and of new children born after the mother graduated from PM2A

V. **Evaluation Questions**

The Team Leader and Health and Nutrition Specialist expert will work with Tubaramure team and finalize the questions to be answered. With regards to the previous specific objectives and tasks, as well as to the IPTT, anticipated and not limited questions are the following:

- ✓ With regard to the program framework, which interventions have been critical and/or effective in achieving the nutrition and health sector objectives and intermediate results? And why?
- ✓ What are the factors that hinder/assist the effective integration of the program components?
- ✓ Are there steps that could have been taken to improve integration as well as food security impacts through greater integration?
- ✓ Is the nutrition and health sector fitting into the local government's strategy and priorities? What has been the level of coordination/collaboration with Government of Burundi and other actors?
- ✓ To what extent recommendations from the mid-term evaluation have been incorporated into the nutrition and health sector?
- ✓ With regards to the ENA, EHA, IMCI and the food intake and diversity, are beneficiaries adopting desired practices or behaviors? Are there some secondary adopters?

- ✓ Are there certain groups within the population with lower rates of adoption and why?
- ✓ To what degree are behavior changes continued by graduated program beneficiaries, for example changes that improve the nutrition of children over the age of two and changes that impact subsequent births?
- ✓ Have the pipeline and the implemented system helped for the timely and effective distribution of Title II commodities to all eligible beneficiaries?
- ✓ To what extent the use local food has sustained a sufficient food intake and balance diet at the household level after the distribution of Title II commodities?
- ✓ To what extent the project cost-effectiveness was reasonable over programming IR 2&3, as well as per beneficiary?
- ✓ How effective is the nutrition and health sector at reaching fathers/men? What could be done in future programming to improve father/men's participation in such sectors?
- ✓ To what extent the implemented activities under IR2 and 3 have developed and strengthened the institutional, the community and the households' capacities?
- ✓ Which outcomes are likely or unlikely to be sustainable and continue after the project ends? and why?
- ✓ Are there any factors (barriers/constraints) that limited community participation and engagement in the program implementation?
- ✓ How are graduated and current beneficiaries in the community coping with the end of food distribution?
- ✓ What national policy topics were affected, or could have been affected, by PM2A program actors, interventions, and lessons learned? How could the program have had more of an impact on national policies related to nutrition and health?
- ✓ With regards to the preventative model, what contribution will the PM2A be able to offer to the Government?
- ✓ Looking at all three IRs, from a cost effectiveness standpoint, how well were program resources allocated to the different IRs and how could they have been better allocated to a) achieve program objectives and b) enhance the sustainability of the program?
- ✓ What was the cost per beneficiary of each IR, and which activities under the different IRs are deemed to be a) more cost efficient, and b) more cost effective in preventing malnutrition?
- ✓ How was the impact of having a separately-designed and managed research component (under IFPRI) on the implementation of the CRS-led consortium program
- ✓ How has the topic of "sustainability" of program interventions been dealt with under the program, including a) how sustainability was described/defined at the outset, b) whether there were flaws in the program design that would impact sustainability, c) what mid-course corrections were made, and what were missed, in enhancing program sustainability, and d) what lessons have been learned to improve the sustainability of future PM2A programming in Burundi and elsewhere.
- ✓ Related to the sustainability topic is how long-lasting are the interventions achieved under IRs 1 and 2? For example, do graduating families continue to apply the lessons they learned to children who a) have graduated, or b) were born after the mothers graduated? Another example, are health center personnel properly implementing the Ministry protocols that were reinforced under IR 1 and that impact the nutrition of mothers and young children?

- ✓ PM2A took a modular approach to BCC at the household and community level, and a curriculum was developed for improving health services, particularly at local health clinics. Please include a request for team observations on the relative impact of each of the three IRs on preventing malnutrition.
- ✓ For example, during the BCC module on dietary diversity, what introduced foods and new recipes were better received by beneficiaries than others? Why? Which potentially had a greater impact on meeting the nutrition deficits of the beneficiary population? Is exclusive breast-feeding during the first six months a larger (or smaller) concern than dietary diversity from 6 - 23 months? Why? Etc.

VI. Methodology

The evaluation will combine documentary review as well as the collection of qualitative and quantitative data (already available) to compare project achievements against targets and determine areas of success or failure and highlights lessons learned. The review and analysis of existing routine data will be combined with data collected.

The methodology, as determined, may include the following elements:

- ✓ Review of projects key documents: narrative, baseline, midterm evaluation reports, performance tracking table (IPTT), field trips reports and annual progress reports;
- ✓ Meetings and interviews with key informant: project managers, technical and field staff, partners, local authorities, USAID officials;
- ✓ Activities records, groups and households interviews;
- ✓ Direct Observations and measurement;
- ✓ Household and community surveys;
- ✓ Review of data collected during the 4 years of implementation as well as the Indicator
- ✓ Interviews and focus group discussions with beneficiaries and community members;
- ✓ Process and analysis of data and information collected;
- ✓ Analysis of information gathered through the process;
- ✓ Debriefings in Bujumbura.

VII. Illustrative list of Reference documents

- ✓ Burundi TUBARAMURE-PM2A narrative Proposal and relevant Appendices (Performance Monitoring plan, and Detailed implementation plan)
- ✓ IPTT (Indicator Performance Tracking Table)
- ✓ PMP (Performance Management Plan)
- ✓ Baseline study assessments/reports
- ✓ Annual Result reports (FY10, FY11, FY12 FY13)
- ✓ Mid-term evaluation report
- ✓ Quarterly reports (from CRS, IMC and FH)
- ✓ M&E reports
- ✓ DQA reports
- ✓ Field trip reports

VIII. Work to be accomplished:

- ✓ Prior to the arrival in country, familiarize with the Burundi context and TUBARAMURE-PM2A program activities through review of key documents and email exchange with staff;

- ✓ Develop and submit a draft of the preliminary work plan, logistics request, schedule and report outline;
- ✓ Meet with TUBARAMURE-PM2A staff and with USAID officials to review work plans;
- ✓ Finalize proposed methodology, tools and work plan with the Team;
- ✓ Lead data collection and data analysis with team;
- ✓ Lead workshop to present/discuss preliminary findings ;
- ✓ Draft final Evaluation report (including findings, conclusions, and recommendations) and submit for review/feedback
- ✓ Submit electronic version of all raw data and tables drawn from the data (on a CD)
- ✓ Submit final evaluation report that incorporates or addresses comments from the Burundi TUBARAMURE-PM2A and USAID officials.
- ✓ The team leader is the responsible of the overall study report. The team members will provide him the report of their section and also any other input requested by the team leader

IX. Deliverables

The following items constitute the deliverables of the Final Evaluation:

- ✓ Interview Guides
- ✓ Tools for data collection
- ✓ Report outline, highlighting major sections and themes to be covered, specifically addressing all the objectives cited above
- ✓ Draft evaluation report, including the methodology used, pertinent tables and graphs, quantitative and qualitative information, lessons learned and recommendations
- ✓ Final version of the Evaluation report, after the review of the consortium and of USAID

All deliverables should be submitted in both hard copy and electronic copy, using Microsoft Word/Excel

The Primary Health and IMCI expert will work closely with the team leader to provide the above deliverable, by providing his sector report and any other information requested by the team leader.

The reporting process will include: an in-country de-briefing, submission of the draft of the report and presentation, feedback from stakeholders, statement of differences (if applicable), finalization of Report, report dissemination, submission to the development evaluation, etc

X. Schedule:

The proposed period for the final Evaluation will run from **July 05 August 07, 2014** in the provinces covered by the program. The proposed schedule required for the successful completion of this SOW is as follows (adjustments can be made by the team, depending on the field context at the evaluation time):

2.0.Draft Schedule (Revised June 10 in Bujumbura)

Phase	Activities
Phase I: Preplanning	
May 20 to June 30, 2014	-Work on contracts and travel arrangements -Finalize SOW -Review initial key informant lists
	-Initial discussions of methodology with CRS/Burundi -Develop draft questionnaires -Initial document review
July 5-6	Consultants arrive
Phase II: Field Work and Key Informant Interviews	
July 7	-Clarify expectations for the report with the different partners in the consortium through individual protocol visits with the Country Directors ²¹⁵ -Work with CRS to verify and review the list of suggested key informants in each partners -Initial discussions of the methodology, draft table of contents, and list of key informants with CRS, FH, and other program partners - Set up key informant interviews for each IR and province (Cankuzo and Ruyigi)\ -Meet Dr. Evelyn Ngomirakiza;
July 8	-Initial partner introductions (FH, IMC, Caritas, USAID) -Preparation of detailed field plan and logistics -Choice of enqueteurs and translators -Formulation of process to be used to choose villages -Revise SOW and interview forms
July 9	-Prepare a draft presentation for partner meeting -Draft table of contents and discuss
	-Finalize SOW and develop a detailed list of interviews and program
July 10	-Group meeting with consortium members (Bujumbura) -Meet with Tubarmure project coordinators (from Ruyigi and Cancuzo) to rank all 269 communities in terms of their level of performance as a basis for the choice of 20 <i>collines</i> for field visits
	-Organize additional individual and group meetings with key informants (Bujumbura) -Finalize logistics and interview schedule
July 11	Additional Key Informant Interviews (Bujumbura)
July 12	-Meet with Sara Borger and Cyprien Tuyizere, FH (9:00 am) -Preparation
July 13	7/13 (noon). Travel to Ruyigi
July 14-15	Enumerator training and finalization of the forms (Ruyigi) under the leadership of Dr. Sidibe and Dr. Ngomirakiza
July 14-23	Key informant interviews (Ruyigi) under the leadership of Dr. McMillan
July 16-23	-Fieldwork under the leadership of (Ruyigi) under the leadership of Dr. Sidibe and Dr. Ngomirakiza
July 23	<i>Debriefing of local partners (Ruyigi)</i>
July 24-July 29	-Fieldwork (Cankuzo) under the leadership of Dr. Sidibe and Dr. Ngomirakiza -Key informant interviews and initial write up of the results of the quantitative survey and interviews (Cankuzo) under the leadership of Dr. McMillan
July 29	<i>Debriefing of local partners(Cankuzo)</i>
July 30 (Wednesday)	Cars leave 8:00 am
July 30-Aug 3	Initial analysis and write up

²¹⁵ Since no forms are available from the mid-term as models, this phase will be critical to developing well thought out forms.

Phase	Activities
August 4-5	Initial Partner Debriefings (8/4-8/5) (tentative)
August 6	USAID debriefing (8/6) (tentative)
August 7	Consultants leave
Phase III: Finalization of Report	
August 6-15	Draft document for internal review
August 22	External comments requests for revision
August 22-30	Finalization of document/editing and formatting
August 3-30	Final editing and formatting to incorporate comments from the field and USAID (of multiple versions)—including annexes and photo essay—in USAID required formats

XI. Key Working Relationships:

Internal: TUBARAMURE-PM2A program staff: CRS, IMC, FH and Caritas staff; CRS Burundi Commodity and Monetization manager, CRS Burundi M&E Coordinator, and other relevant staff.

External: Community beneficiaries, key, field staff, Burundi Agriculture/Health provincial authorities, locally elected authorities, USAID mission staff.

XII. Place of performance:

The primary place of performance will be in Burundi, in Burundi; including Bujumbura and the two provinces of Ruyigi and Cankuzo.

XIII. Required Qualification for the Team Leader, Evaluator Specialist specialist

The consultant should have the following background:

- ✓ PhD or Master's degree in evaluation or social study (e.g., anthropology, community development, rural development, etc.)
- ✓ Minimum of five years of experience evaluating programs using a combination of quantitative and qualitative methods
- ✓ Skilled user of SPSS multi-variables analysis routines (computer provided by CRS)
- ✓ Experience in the evaluation of behavior change communications and community related services, and maternal and child nutrition preferred
- ✓ Experience evaluating Title II development programs preferred
- ✓ Ability to motivate and lead a multi-national team
- ✓ Fluent in English, bilingual English-French a plus ((the evaluation report will be written in English with a summary in French);
- ✓ Ability to work in a multicultural team
- ✓ Excellent communication skills
- ✓ Willingness to travel to remote areas
- ✓ Ability to working under pressure.
- ✓ This consultant will serve as the Team Leader, in charge of the final and consolidate report.

Key responsibilities for the Team Leader include and not limited to the following tasks:

- ✓ Lead the evaluation plan design
- ✓ Assure a thorough review/analysis of available secondary data; rational sampling of targeted communities, activities and outputs in primary data collection; and adequate triangulation and validation of findings.
- ✓ Examine Burundian policy relevant to health and nutrition services in the target areas

- ✓ Review the initial analysis of quantitative survey and further analyze the data to support and complement the qualitative investigation
- ✓ Monitor and assure the quality of qualitative data collection and analysis methods
- ✓ Evaluate the quality of the program's commodity management
- ✓ Evaluate the program's M&E system and identify additional data to support the evaluation
- ✓ Evaluate program efforts to improve gender equity and outcomes
- ✓ Lead the team in a comparison of qualitative and quantitative results to integrate the findings
- ✓ Assure timely submission of a final report presentation that is logical and clearly separates findings, conclusions, and recommendations, and in which all conclusions and recommendations are based on evidence presented in the report.

XIV. Expressions of interest:

Consultants interested in this assignment should send the following information to CRS Burundi by 6:00 PM local time, on **February 28, 2014 or later if applicable** Brief cover letter highlighting relevant experience and skills, as well as confirming availability from **July 05 to August 07, 2014** time frame;

- ✓ An up to date Curriculum Vitae;
- ✓ Written proposal (in English) of at least two pages and not more than 5 pages describing the methodology and actions for the completion of the final term review;
- ✓ A writing sample from a previous and similar consultancy;
- ✓ Three professional references with phone numbers and/or email addresses;
- ✓ One page budget indicating daily fee and other related consultancy costs.
- ✓ One up to date medical and evacuation insurance.

Annex I.C.
Scope of Work for the Primary Health Care and Integrated Management of Childhood Illnesses

Final Evaluation: 05 July to 07 August 2014

I. Introduction/Background information

The Tubaramure consortium is recruiting a team of independent consultants for the final evaluation of the program, tentatively scheduled for April/May 2014. Further information on the objectives and methodology as well as the required consultant team and the expected deliverables are provided below.

Since 2009, Catholic Relief Services/Burundi is implementing a Multi-Year Assistance Program (MYAP), entitled *Tubaramure-PM2A* (“Let’s help them grow”, in Kirundi). This five years program is funded by USAID-Food for Peace (FFP); the overall objective of the program is to “prevent malnutrition in children under the age of two” using the Prevention of Malnutrition in children under 2 Years of Age (PM2A) approach, in two food- insecure provinces of Burundi (Cankuzo and Ruyigi). Approximately 49,650 mother-child pairs have been targeted over the five years (July 2009 to October 2014) of the life of this 43.134 millions USD grant. *Tubaramure* is a community based program including three components or intermediate results (IR) focusing on: (1) increased access to quality health and nutrition services; (2) improved health and nutrition behaviors; and (3) increased intake of nutrient-rich, diverse foods.

Key program components include behavior change communication (health, nutrition and hygiene), as well as the distribution of Title II rations and the promotion of local foods. It uses a preventative approach to empower the most affected populations so that they can influence their own food security. Since prevention of malnutrition begins with the mother, *Tubaramure* aims at targeting the mother and child as a unit with the provision of a package of targeted interventions that commence during the mothers’ pregnancy and end when the child reaches his/her second birthday. With CRS as lead, the program is implemented by a consortium of international and national NGO (International Medical Corps –IMC-, Food for the Hungry – FH-, and Caritas Burundi).

The program is the subject of a separate research study being conducted by the International Food Policy Research Institute (IFPRI) in partnership with Food and Nutrition Technical Assistance 2 (FANTA 2), to further assess and improve the preventive model.

Intermediate results # 1	1: Women and Children 0-59 months access quality nutrition and health services	1.1: Pregnant and lactating women access pre and postnatal care services
		1.2: Implementation of National IMCI plan is supported
		1.3: Health Facility Growth Monitoring (GM) services comply with national protocols
		1.4: SAM is detected and referred for treatment
Intermediate	2: Households	2.1: Households adopt Essential Nutrition Actions (ENA)

results #2	<i>practice appropriate health and nutrition behaviors</i>	2.2: Households adopt Essential Hygiene Actions (EHA)
		2.3: Households adopt prevention and management behaviors for maternal and childhood illnesses
Intermediate results #3	3: Eligible women and children have increased intake of diverse foods	3.1: FFP rations distributed to eligible women and children
		3.2: Mothers and children use FFP rations appropriately
		3.3: HHs use appropriate local foods in addition to FFP ration

II. The objectives of the final evaluation

The objectives of the final evaluation is to assess the program’s achievements at the level of strategic objective and intermediate results, as well as the achievement in all indicators as stated in the approved proposal (available upon arrival).

Per Food For Peace requirements, the emphases of this final evaluation will be to determine:

- ✓ the relevance, the effectiveness, the efficiency, and the acceptability of processes and outputs;
- ✓ the factors affecting the implementation
- ✓ the degree of adherence to terms of agreement
- ✓ what and why results (outcomes/impacts) have/have not been achieved,
- ✓ the sustainability of results.

It is important to remind that besides this proposed final evaluation, there is also a US funded and separated research conducted by the International Food Policy Research Institute (IFPRI) in partnership with Food and Nutrition Technical Assistance 2 (FANTA 2), that aims to better understand/document the impact, cost, and cost-effectiveness of PM2A programs and to generate “learning” about how PM2A programs should be designed and implemented to maximize their impact and cost-effectiveness (see FANTA/IFPRI protocol of research). Examples of questions include how much food is needed (individual vs. household ration), what type of food/products is best? Should micronutrient supplements be used in place of individual food rations? What is the best timing and duration of exposure to a PM2A program), etc.

VI. Team Composition (Roles and responsibilities of consultants)

The evaluation team will be composed of two external hired and independent consultants.

- ✓ One international consultant with Primary Health Care and Integrated Management of Childhood Illnesses expertise to evaluate Tubaramure IR1. S/he will work under the supervision of the team leader and will write and submit to him/her the report related to IR1.
- ✓ One international consultant with Health & Nutrition expertise to evaluate IR2 & 3 of the program. S/he will serve as the team leader and assure the quality of the work throughout the evaluation process. S/he will give due attention during the phases of development of data collection tools, data analysis, report writing and other relevant deliverables. S/he will be the responsible for the consolidated and overall report.

Local experts from the Ministry of Health as well as delegates from the country SUN Focal point will be appointed for closely working with the team. If needed, the Consultants will be also allowed to hire local enumerators, Kirundi-translators as well as local statisticians .

VII. **Specific objectives for the Primary Health care Expert specialized in IMCI**

Taking account of the midterm evaluation report, specific objectives of the Primary Health Care health expert are as follows below:

- ✓ Assess the overall achievements of the health component of the program (IR 1);
- ✓ Evaluate the relevance, effectiveness and efficiency of health equipment provided by the program to the target health centers;
- ✓ Assess the effectiveness and the relevance of trainings and materials provided by the program with regards to the national IMCI protocol.

- ✓ Identify constraints in the implementation of the health component activities;
- ✓ Assess the relevance and the performance of existing and operating prenatal and postnatal services;
- ✓ Evaluate the relevance, the effectiveness and the performance of the implemented growth monitoring system , with regards to the national protocol;
- ✓ Assess the effectiveness and the performance of the detection and referral of SAM' cases.
- ✓ Assess how the program fitted and contributed in a sustainable way, to the achievement and the overall objectives of the Ministry of Health
- ✓ Document lessons learned and provide recommendations for future programming, including for USAID.
- ✓ Assess the issues of sustainability both at the institutional, the community and the households' levels.

VIII. **Evaluation Questions**

With regards to the project objectives and the IPTT, the Primary health care and IMCI expert will use comments from USAID/FFP and work with the team Leader and Tubaramure staff, for finalizing the questions to be answered. Anticipated and not limited questions are the following:

- ✓ Are the health component activities being implemented according the DIP (Detailed Implementing plan)? What are the obstacles and the delays observed? What recommendation can be done for future program?
- ✓ Is the health component well integrated in the government's strategy and priorities? Are there steps that could be taken to improve the integration?
- ✓ What interventions have been more or less successful in meeting targets?
- ✓ Are provided equipments appropriate, well dispatched and well used for reaching the expected results?
- ✓ Are the training modules appropriate and fitting with national protocol? How can they be improved in future program?
- ✓ Are trained staffs over health centers making difference with non-trained agents?
- ✓ How is at all levels, the collaboration between the program and the Ministry of health. What can be done to improve the collaboration?

- ✓ How the mid-term evaluation recommendations were taken into account for improving the program implementation?
- ✓ To what extent project activities were financially supported and how will they be sustained at the institution and the community levels, after the project closure?
- ✓ How could the program impact on national policies related to nutrition and health been improved?
- ✓ How the project implementation dealt with the research component including the integrity of the control group?

VI. Methodology

The evaluation will combine documentary review as well as the collection of qualitative and quantitative data (already available) to compare project achievements against targets and determine areas of success or failure and highlights lessons learned. The review and analysis of existing routine data will be combined with data collected.

The methodology, as determined, may include the following elements:

- ✓ Review of projects key documents: narrative, baseline, midterm evaluation reports, performance tracking table (IPTT), field trips reports and annual progress reports;
- ✓ Meetings and interviews with key informant: project managers, technical and field staff, partners, local authorities, USAID officials;
- ✓ Activities records, groups and households interviews;
- ✓ Direct Observations and measurement;
- ✓ Household and community surveys;
- ✓ Review of data collected during the 4 years of implementation as well as the Indicator
- ✓ Interviews and focus group discussions with beneficiaries and community members;
- ✓ Process and analysis of data and information collected;
- ✓ Analysis of information gathered through the process;
- ✓ Debriefings in Bujumbura.

VII. Illustrative list of Reference documents

- ✓ Burundi TUBARAMURE-PM2A narrative Proposal and relevant Appendices (Performance Monitoring plan, and Detailed implementation plan)
- ✓ IPTT (Indicator Performance Tracking Table)
- ✓ PMP (Performance Management Plan)
- ✓ Baseline study assessments/reports
- ✓ Annual Result reports (FY10, FY11, FY12 FY13)
- ✓ Mid-term evaluation report
- ✓ Quarterly reports (from CRS, IMC and FH)
- ✓ M&E reports
- ✓ DQA reports
- ✓ Field trip reports

VIII. Work to be accomplished:

- ✓ Prior to the arrival in country, familiarize with the Burundi context and TUBARAMURE-PM2A program activities through review of key documents and email exchange with staff;

- ✓ Develop and submit a draft of the preliminary work plan, logistics request, schedule and report outline;
- ✓ Meet with TUBARAMURE-PM2A staff and with USAID officials to review work plans;
- ✓ Finalize proposed methodology, tools and work plan with the Team;
- ✓ Lead data collection and data analysis with team;
- ✓ Lead workshop to present/discuss preliminary findings ;
- ✓ Draft final Evaluation report (including findings, conclusions, and recommendations) and submit for review/feedback
- ✓ Submit electronic version of all raw data and tables drawn from the data (on a CD)
- ✓ Submit final evaluation report that incorporates or addresses comments from the Burundi TUBARAMURE-PM2A and USAID officials.
- ✓ The team leader is the responsible of the overall study report. The team members will provide him the report of their section and also any other input requested by the team leader

IX. Deliverables

The following items constitute the deliverables of the Final Evaluation:

- ✓ Interview Guides
 - ✓ Tools for data collection
 - ✓ Report outline, highlighting major sections and themes to be covered, specifically addressing all the objectives cited above
 - ✓ Draft evaluation report, including the methodology used, pertinent tables and graphs, quantitative and qualitative information, lessons learned and recommendations
 - ✓ Final version of the Evaluation report, after the review of the consortium and of USAID
- All deliverables should be submitted in both hard copy and electronic copy, using Microsoft Word/Excel

The Primary Health and IMCI expert will work closely with the team leader to provide the above deliverable, by providing his sector report and any other information requested by the team leader.

The reporting process will include: an in-country de-briefing, submission of the draft of the report and presentation, feedback from stakeholders, statement of differences (if applicable), finalization of Report, report dissemination, submission to the development evaluation, etc

X. Schedule:

The proposed period for the final Evaluation will run from **05 July to 07 August 2014**

in the provinces covered by the program. The proposed schedule required for the successful completion of this SOW is as follows (adjustments can be made by the team, depending on the field context at the evaluation time.

Phase	Activities (Revised July 10, 2014 in Bujumbura)
Phase I: Preplanning	
May 20 to June 30, 2014	-Work on contracts and travel arrangements -Finalize SOW -Review initial key informant lists
	-Initial discussions of methodology with CRS/Burundi -Develop draft questionnaires -Initial document review

Phase	Activities (Revised July 10, 2014 in Bujumbura)
July 5-6	Consultants arrive
Phase II: Field Work and Key Informant Interviews	
July 7	-Clarify expectations for the report with the different partners in the consortium through individual protocol visits with the Country Directors ²¹⁶ -Work with CRS to verify and review the list of suggested key informants in each partners -Initial discussions of the methodology, draft table of contents, and list of key informants with CRS, FH, and other program partners - Set up key informant interviews for each IR and province (Cankuzo and Ruyigi)\ -Meet Dr. Evelyn Ngomirakiza;
July 8	-Initial partner introductions (FH, IMC, Caritas, USAID) -Preparation of detailed field plan and logistics -Choice of enqueteurs and translators -Formulation of process to be used to choose villages -Revise SOW and interview forms
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July 12	-Meet with Sara Borger and Cyprien Tuyizere, FH (9:00 am) -Preparation
July 13	7/13 (noon). Travel to Ruyigi
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July 24-July 29	-Fieldwork (Cankuzo) under the leadership of Dr. Sidibe and Dr. Ngomirakiza -Key informant interviews and initial write up of the results of the quantitative survey and interviews (Cankuzo) under the leadership of Dr. McMillan
July 29	<i>Debriefing of local partners(Cankuzo)</i>
July 30 (Wednesday)	Cars leave 8:00 am
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August 6	USAID debriefing (8/6) (tentative)
August 7	Consultants leave
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August 6-15	Draft document for internal review
August 22	External comments requests for revision
August 22-30	Finalization of document/editing and formatting
August 3-30	Final editing and formatting to incorporate comments from the field and USAID (of multiple versions)—including annexes and photo essay—in USAID required formats

²¹⁶ Since no forms are available from the mid-term as models, this phase will be critical to developing well thought out forms.

XI. Key Working Relationships:

Internal: TUBARAMURE-PM2A program staff: CRS, IMC, FH and Caritas staff; CRS Burundi Commodity and Monetization manager, CRS Burundi M&E Coordinator, and other relevant staff.

External: Community beneficiaries, key, field staff, Burundi Agriculture/Health provincial authorities, locally elected authorities, USAID mission staff.

XII. Place of performance:

The primary place of performance will be in Burundi, in Burundi; including Bujumbura and the two provinces of Ruyigi and Cankuzo.

XIII. Minimum Qualification required for the health specialist

The consultant should have the following background:

- ✓ PhD or Medical doctor degree, with a strong experience in Primary Health Care and Integrated Management of Childhood Illnesses (IMCI).
- ✓ Minimum of ten years of experience evaluating programs.
- ✓ Demonstrate significant program evaluation experiences with a strong preference for evaluating health services.
- ✓ Bilingual English- French (the evaluation report will be written in English, with a summary in French)
- ✓ Ability to work in a multicultural team
- ✓ Excellent communication skills
- ✓ Willingness to travel to remote areas
- ✓ Ability to working under pressure;

XIV. Expressions of interest:

Consultants interested in this assignment should send the following information to CRS Burundi by 6:00 PM local time, on **February 28, 2014**. Application should include:

- ✓ Brief cover letter highlighting relevant experience and skills, as well as confirming availability from 05 July to 07 August 2014
 - ✓ An up to date Curriculum Vitae;
 - ✓ Written proposal (in English) of at least two pages and not more than 5 pages describing the methodology and actions for the completion of the final term review;
 - ✓ A writing sample from a previous and similar consultancy;
 - ✓ Three professional references with phone numbers and/or email addresses;
 - ✓ One page budget indicating daily fee and other related consultancy costs.
 - ✓ One up to date medical and evacuation insurance.

The above materials should be sent by email to: BI_RMC@global.crs.org

Tubaramure Final Evaluation. Annex II. Tubaramure PM2A Program IPTT (Including revised indicators proposed by the MTE, September 8, 2014) October 22, 2014. Final.

Indicator	Desired direction of change (+) or (-)	Baseline	FY 10			FY 11			FY 12			FY 13			FY 14			LOA	
			Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved
ind 1. % of children 0-59 months of age with height for age Zscore < - 2 S.D.(Stunting) disaggregated by U 2 and 24-59 months	(-)	51.5%	N/A			NA			NA			NA			42%	50.5%*		42%	50.5%*
ind 2. % of children 0-59 months of age with weight for age Zscore < - 2 S.D. (Disaggregated by 0-11, 11to 24 an 25-59)	(-)	43.2%	N/A			NA			NA			NA			18%	22.0%*	(-42.9)	(-25%)	(42.9)%*
ind 3. % of children 0-59 months of age with weight for height Zscore < - 2 S.D.Disaggregated by 0-11, 11to 24 an 25-59)	(-)	8.2%	NA			NA			NA			NA				4.8%*			4.8%*
Ind 4. % of newborn weight < 2500g	(-)	7.2%	N/A			NA			NA			NA			2%	5.4%*		2%	5.4%*
Intermediate Result 1: Women and children under 5 access quality nutrition and health services.																			
1.1. % of pregnant women completing package of (4) prenatal visits	(+)	28.9%	98%	39%	40%	98%	61.4%	63%	98%	64.1%	65%	98%	70.2%	72%	98%	50.2%*		98%	50.2%*
1.1. (revised): % of pregnant women completing (at least) 3 prenatal visits	(+)	28.9%	98%	39%	40%	98%	61.4%	63%	98%	94%	96%	98%	94.8%	97%	98%	83.4%*		98%	83.4%*
1.2. % of mothers completing package of postnatal visits	(+)	5%	40%	0.5%	1%	50%	8.4%	17%	55%	19.1%	35%	70%	8.1%	12%	75%	3.1%*		75%	3.1%*
1.2. (revised): % of mothers completing (at least) 2 postnatal visits	(+)	5%	40%	0.5%	1%	50%	8.4%	17%	55%	33.2%	60%	70%	23.4%	33%	75%	11.1%*		75%	11.1%*
1.3. % of children 0-59 months attending growth monitoring at least once in a two-month period (as recorded on card)	(+)	16%	30%	54.7	182%	65%	61.4%	94%	75%	66%	88%	85%	16.5%	19%	90%	57.3%*		90%	57.3%*
1.3. (revised): % of children 0-36 months attending growth monitoring at least once in a two-month period (as recorded on card)	(+)	16%	30%	54.7	182%	65%	61.4%	94%	75%	66%	88%	85%	16.5%	19%	90%	57.3%*		90%	57.3%*
1.4. % of health providers (facilities/ CHW) accurately assessing a child using IMCI protocols	(+)	0%	30%	69.9%	233%	40%	88%	220%	50%	55%	110%	60%	83%	138%	80%	48%	60%	80%	48%
1.4. (revised) % of nurses accurately diagnosing and treating children under five	(+)	0%	30%	69.9%	233%	40%	88%	220%	50%	Nav	Nav	60%	100%	167%	80%	100%	125%	80%	100%
Output 1.1: Pregnant and lactating women access pre and postnatal services																			
1.5. % increase of women registered for prenatal services by the sixth month of pregnancy	(+)	80.1%	85%	87.5%	102%	95%	94%	99%	95%	NA	NA	95%	NA	NA	95%	95.1%*			95%
1.5. (revised) % of women registered for prenatal services by the sixth month of pregnancy	(+)	80.1%	85%	87.5%	102%	95%	94%	99%	95%	97.6%	103%	95%	97.4%	103%	95%	95.1%*			95%
1.6. % of health facilities with 2 or more staff who completed in-service training in pre-post natal services	(+)	0%	25%	32%	128%	40%	42%	105%	60%	46%	77%	70%	100%	143%	75%	57%	77%		75%
Output 1.2: Implementation of National IMCI plan is supported																			
1.7. % of health facilities with two staff members trained in IMCI protocol through MOH's IMCI office	(+)	15%	30%	100%	333%	70%	48%	69%	100%	46%	46%	100%	96.9%	97%	100%	72%	72%		100%

Tubaramure Final Evaluation. Annex II. Tubaramure PM2A Program IPTT (Including revised indicators proposed by the MTE, September 8, 2014) October 22, 2014. Final.

1.8. % of trained CHW in IMCI in target areas through MOH's IMCI office	(+)	0%	30%	0%	0%	40%	99%	247%	50%	100%	200%	60%	NA	NA	70%	100%	143%	70%	
Indicator	Desired direction of change (+) or (-)	Baseline	FY 10			FY 11			FY 12			FY 13			FY 14			LOA	
			Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved
1.8. (revised) % of collines with 2 or more CHWs trained in IMCI in target areas through MOH's IMCI office	(+)	0%	30%	0%	0%	40%	99%	247%	50%	Nav	Nav	60%	NA	NA	70%	100%	143%	70%	
Output 1.3: Health facilities supported in providing GM.																			
1.9. Number of communes with at least one functioning community based growth monitoring center after year 3	(+)	0	N/A			NA			5	6	120%	12	12	100%	(+12)	12	100%	(+12)	12
1.10. % of health facilities with upgraded growth monitoring equipment.	(+)	0%	30%	0%	0%	40%	100%	250%	60%	100%	167%	75%	80%	107%	75%	56%	74.1%	75%	56%
Output 1.4: SAM is detected and referred for treatment																			
1.11. % children referred to CMAM actually admitted for treatment	(+)	72.7%	85%	89%	105%	85%	96%	113%	85%	92%	108%	85%	81%	95%	85%	32%	38%	85%	32%
1.11. (revised) % children with malnutrition referred from the community who are enrolled in nutrition services	(+)	72.7%	85%	89%	105%	85%	96%	113%	85%	Nav	Nav	85%	100%	118%	85%	32%	38%	85%	32%
1.12. % of children recovered from acute malnutrition being followed by the CHWs or LM.	(+)	7.1%	40%	0%	0%	60%	0%	0%	70%	75%	107%	80%	50%	63%	90%	25.16%	28%	90%	25.16%
1.12. (revised) % of children recovered from acute malnutrition visited at home by the CHWs at least twice a month for three months.	(+)	7.1%	40%	0%	0%	60%	0%	0%	70%	Nav	Nav	80%	75%	94%	90%	25%	28%	90%	25%
Intermediate Result 2: HHH practice appropriate health and nutrition behaviors																			
2.1. % of babies 0 to 5 months of age exclusively breast-fed in last 24 hours	(+)	69.4%	80%	75.3%	94%	85%	92.6%	109%	90%	81.5%	91%	95%	NA	NA	95%	87.9%*		95%	87.9%*
2.2. % of babies 6- 12 months of age receiving complementary foods (according to IYCF guidelines) plus breastmilk in last 24 hours	(+)	86.5%	90%	N/A		95%	N/A	N/A	95%	NA	NA	95%	NA	NA	95%			95%	
2.3. % of children 0-24 months reported with diahreha (3 or days of loose stools) within past two-weeks	(-)	14.1%	10%	20%	50%	5%	9.6%	52%	5%	16.6%	30%	5%	15.9%	31%	5%	6.5%*		5%	6.5%
Output 2.1: HHHs adopt Essential Nutrition Actions																			
2.4. % of households observed carrying out four or more ENA actions at time of household visit.	(+)	N/Av	60%	N/A		75%	87.1%	116%	80%	89.5%	112%	85%	69.6%	82%	90%	69.8%*		90%	58.5%
Output 2.2: HHHs adopt Essential Hygiene Actions																			
2.5. % of households observed carrying out four or more EHA (essential hygiene actions) actions at time of household visit.	(+)	N/Av	45%	N/A		50%	57.5%	115%	75%	74.3%	99%	75%	70.1%	93%	75%	58.5%*		75%	69.8%*
Output 2.3: HHHs adopt Prevention and management behaviors for maternal and childhood diseases																			

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2.6. % of households with children under 2 with a reserved package of ORS at time of household visit	(+)	4.6%	20%	N/A		30%	N/A	N/A	35%	NA	NA	40%	NA	NA	45%			45%	
------------------------------------------------------------------------------------------------------	-----	------	-----	-----	--	-----	-----	-----	-----	----	----	-----	----	----	-----	--	--	-----	--

Indicator	Desired direction of change (+) or (-)	Baseline	FY 10			FY 11			FY 12			FY 13			FY 14			LOA	
			Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved	% Target met	Target	Achieved
% of mothers with children under two who can state at least and at least two of the four danger signs for pregnant women		5%	20%	N/A		30%	N/A	N/A	35%	NA	NA	40%	NA	NA	45%	71.3%		45%	71.3%
2.6. (revised): % of mothers with children under two who can state at least four of the six danger signs for childhood illness and at least two of the four danger signs for pregnant women	(+)	4.6%	20%	N/A		30%	N/A	N/A	35%	19%	54%	40%	20.5%	51%	45%	24.4%*		45%	24.4%*
Intermediate Result 3 (Food utilization): Eligible women and children have increased food intake and diversity.																			
3.1. Average Household dietary diversity score	(+)	4.6		N/A		N/A			8	5.8	73%	NA	NA	NA	9	8.2*		9	8.2*
Output 3.1: TII rations distributed to eligible women and children at community level																			
3.2. % of mother/child unit qualifying for food rations according to eligibility criteria of project.	(+)	0%	80%	95%	119%	85%	54.7%	64%	90%	82%	91%	90%	86%	96%	90%			90%	
Output 3.2: Mothers and children consume TII rations destined to them																			
3.3. % of mother/child unit recalling consumption of CSB/Oil within last 24 hours	(+)	6.1%	70%	87.5%	125%	90%	89.9%	100%	95%	86.2%	91%	100%	89.6%	90%	100%			100%	
3.4. % of hh demonstrating remain supply of CSB/Oil based in accordance to expected CSB usage per month.	(+)	0%	70%	50%	71%	80%	75.6	95%	90%	85.5%	95%	95%	57.2%	60%	95%			95%	
Output 3.3: HHs use appropriate local foods in addition to FFP ration																			
3.5. % of children 6 to 24 months consuming at least 4 food groups within last 24 hours	(+)	74.2%	80%	50%	63%	85%	82.8%	97%	90%	85.6%	95%	95%	93.1%	98%	95%	72.7%*		95%	72.7%*
F Indicators																			
F1. Number of people trained in child health and nutrition through USG supported health area programs			18,554	17998	97%	27,899	26,949	97%	38,343	49,868	130%	47,588	26,859	56%	56,722	8,423	15%	56,722	8,423
F2. # of antenatal (ANC) (pre-natal) visits by skilled providers from USG-assisted facilities (yearly)			14,684	N/Av		23,819	107,714	452%	32,953	40,176	122%	42,088	36,788	87%	51,222	27,930	55%	51,222	27,930
F3. # of postpartum newborn visits within 3 days of birth in USG programs			14,684	N/Av		23,819	4,172	18%	32,953	21,023	64%	42,088	23,007	55%	51,222	12,620	24.6%	51,222	12,620
F4: # of children reached by USG supported nutrition programs			11,000	8498	77%	22,549	30,614	136%	34,098	48,364	142%	45,646	26,722	59%	57,195	7,090	12.4%	57,195	7,090

Annex III.
Guides d'Entretiens

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Annex III.A.

GUIDE D’ENTRETIEN: Key Informants (general)

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l’évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Apres de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d’avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l’amélioration de l’état nutritionnel des enfants moins de cinq ans dans les zones d’intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L’interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d’informations et en toute sincérité.

(Essayez de mettre le groupe à l’aise et d’encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification :

	Date de collecte _____
Nom et prénom de l’agent de collecte	_____
_____	COMMUNE _____
_____	_____
Types de key Informant	
Nom du partenaire :	

1. Pouvez- vous me parlez quel était le niveau de collaboration du programme avec les structures sanitaires dans la mise en œuvre des activités.
2. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
3. Selon vous, quels ont été les points forts du projet Tubaramure?
4. Quels ont été les points faibles du projet Tubaramure?
5. Quels sont les changements qui sont survenus au niveau de la mise en œuvre des activités après l'évaluation mi-parcours
6. Quels sont les résultats peu susceptible d'être durable et continuer après le retrait du projet? et dites pourquoi?
7. Quels sont les défis actuels dans les villages du projet Tubaramure?
8. Quelles suggestions ou recommandations avez-vous afin de renforcer les acquis du projet dans les différentes zones ?
9. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire

Annex III.B1.

GUIDE D’ENTRETIEN: Key Informants IR1

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l’évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Apres de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d’avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l’amélioration de l’état nutritionnel des enfants moins de cinq ans dans les zones d’intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L’interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d’informations et en toute sincérité.

(Essayez de mettre le groupe à l’aise et d’encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification :

	Date de collecte _____
Nom et prénom de l’agent de collecte	_____
_____	COMMUNE _____
_____	_____
Types de key Informant	
Nom du partenaire :	

I. Questions Générales

1. Pouvez-vous me parler de votre collaboration avec CRS à travers son partenaire d'exécution dans la lutte contre la malnutrition dans votre aire de santé.
2. Comment était organisée prévention/ la prise en charge de la malnutrition au niveau communautaire et au niveau du Centre de Santé ? (*référence et contre référence, disponibilité des intrants, etc*)
3. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
4. Selon vous, quels ont été les points forts du projet Tubaramure?
5. Quels ont été les points faibles du projet Tubaramure?
6. Quels sont les changements qui sont survenus au niveau de la mise en œuvre des activités après l'évaluation mi-parcours ?
10. Quels sont les défis actuels dans les villages du projet Tubaramure?
11. Quelles suggestions ou recommandations avez-vous afin de renforcer les acquis du projet dans les différentes zones ?
12. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire

II. Questions Spécifiques :

1. Les activités de la composante santé ont été elles mises en œuvre selon le proposal (document de base du projet)? Quels sont les obstacles et les retards observés? Quelles recommandations pourraient être faites pour le futur programme?
2. Est-ce que la composante santé a été bien intégrée dans la stratégie et les priorités du gouvernement en matière de lutte contre la malnutrition ? Y a-t-il des mesures qui pourraient être prises pour améliorer cette intégration?
3. Quelles ont été les interventions qui ont de plus ou moins réussies pour atteindre les objectifs du programme?
4. Les équipements fournis sont-ils appropriés, ont-ils été bien expédiés et ont-ils été bien utilisés pour atteindre les résultats escomptés?
5. Les modules de formation sont-ils appropriés et en accord avec le protocole national? Comment peuvent-ils être améliorés dans le futur programme?
6. Y a-t-il une différence entre le personnel des centres de santé formés et non formés?
7. Comment est la collaboration entre le programme et le ministère de la santé. Que peut-on faire pour améliorer cette collaboration?
8. Comment les recommandations de l'évaluation à mi-parcours ont été prises en compte pour améliorer la mise en œuvre du programme?
9. Dans quelle mesure les activités du projet ont été soutenues financièrement les activités et comment vont-elles être maintenues au niveau de la communauté et institution, après le retrait du projet?
10. Comment l'impact du programme sur les politiques nationales en matière de nutrition et de la santé pourrait être amélioré?
11. Quelles ont été les leçons apprises et donnez des exemples

12. Comment a été la mise en œuvre des activités du projet portant sur le volet de la recherche, y compris le groupe de contrôle?
13. Est ce que les interventions du projet ont été efficaces et / ou efficaces dans l'atteinte des objectifs de la nutrition et du secteur de la santé? Et dites comment?
14. Quels sont les facteurs qui ont entravés / facilités l'intégration efficace des différentes composantes du programme?
15. Dans quelle mesure les recommandations de l'évaluation à mi-parcours ont été intégrées dans la mise en œuvre des activités de la nutrition et de la santé?
16. Quels sont les résultats peu susceptibles d'être durables et continuer après le retrait du projet? et dites pourquoi?
17. Dans quelle mesure les activités mises en œuvre ont pu renforcer le cadre institutionnel, la capacité des communautés et des ménages bénéficiaires dans la prévention de la malnutrition?
18. Y a-t-il des facteurs (obstacles / contraintes) ayant limité la participation de la communauté et leur engagement dans la mise en œuvre du programme?
19. Par rapport à la durabilité des interventions du programme: a) Il y a-t-il eu des failles dans la conception du programme qui pourraient avoir un impact durable, c) ces corrections ont-elles été prises en compte pendant l'évaluation à mi-parcours pour l'amélioration de la durabilité du programme, et d) quelles leçons ont été tirées pour améliorer la viabilité de la future programmation PM2A au Burundi et ailleurs.

Annex III.B2.

GUIDE D'ENTRETIEN: Key Informants IR3

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Apres de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification :

		Date de collecte _____
Nom et prénom de l'agent de collecte		_____
_____		COMMUNE _____
_____		_____
Types de key Informant		
Nom du partenaire :		

I. Questions Générales

1. Pouvez- vous me parlez de votre collaboration avec CRS à travers son partenaire d'exécution dans le cadre de la mise en œuvre du programme Tubaramure.
2. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
3. Selon vous, quels ont été les points forts du projet Tubaramure?
4. Quels ont été les points faibles du projet Tubaramure?
5. Quels sont les changements qui sont survenus au niveau de la mise en œuvre des activités après l'évaluation mi-parcours ?
6. Quels sont les défis actuels dans les villages du projet Tubaramure?
7. Quelles suggestions ou recommandations avez-vous afin de renforcer les acquis du projet dans les différentes zones ?
8. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire

II. Questions Spécifiques

1. Selon vous, quels sont les facteurs qui ont entravés / facilités l'intégration efficace des différentes composantes du programme?
2. Y a t-il des mesures qui auraient pu être prises pour une meilleure intégration des composantes pour améliorer la sécurité alimentaire de la population bénéficiaire?
3. Dans quelle mesure les recommandations de l'évaluation à mi-parcours ont été intégrées dans la mise en œuvre des activités de la nutrition et de la santé?
4. Quelles ont été les stratégies mises œuvres pour assurer une distribution rapide et efficace des vivres du titre II aux différents bénéficiaires?
5. Comment la distribution des vivres du titre II ont ils améliorés le niveau de sécurité alimentaire et l'utilisation des produits locaux au niveau des ménages après la distribution des vivres?
6. Quelle stratégie de la composante a permis d'atteindre les hommes/pères ? Que faut-il faire pour les programmes futures pour améliorer la participation père /hommes dans les activités de Sante nutrition.
7. Dans quelle mesure les activités mises en œuvre ont pu renforcer le cadre institutionnel, la capacité des communautés et des ménages bénéficiaires dans la prévention de la malnutrition?
8. Quels sont les résultats peu susceptible d'être durable et continuer après le retrait du projet? et dites pourquoi?
9. Y a t-il des facteurs (obstacles / contraintes) ayant limité la participation de la communauté et leur engagement dans la mise en œuvre du programme?
10. Comment les bénéficiaires ont été gradués et comment les bénéficiaires ont été préparés pour l'arrêt de la distribution la distribution alimentaire?
11. Par rapport a la durabilité» des interventions du programme: a) Il y a avait il des failles dans la conception du programme qui pouvait avoir un impact durable, c) ces corrections ont elles été prises en compte pendant l'évaluation à mi-parcours pour l'amélioration de la durabilité du programme, et d) quelles leçons ont été tirées pour améliorer la viabilité de la future programmation PM2A au Burundi et ailleurs.

Annex III.B3.

GUIDE D'ENTRETIEN: Key Informants IR2

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification :

		Date de collecte _____
Nom et prénom de l'agent de collecte	_____	
_____	COMMUNE _____	
_____	_____	
Types de key Informant		
Nom du partenaire :		

I. Questions Générales

1. Pouvez- vous me parlez de votre collaboration avec CRS á travers son partenaire d'exécution dans le cadre de la mise en œuvre du programme Tubaramure.
2. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
3. Selon vous, quels ont été les points forts du projet Tubaramure?
4. Quels ont été les points faibles du projet Tubaramure?
5. Quels sont les changements qui sont survenus au niveau de la mise en œuvre des activités après l'évaluation mi-parcours ?
6. Quels sont les défis actuels dans les villages du projet Tubaramure?
7. Quelles suggestions ou recommandations avez-vous afin de renforcer les acquis du projet dans les différentes zones ?
8. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire

II. Questions Spécifiques

1. Est ce que les interventions du projet ont été efficaces et / ou efficace dans l'atteinte des objectifs de la nutrition et du secteur de la santé? Et dites comment?
2. Quels sont les facteurs qui ont entravés / facilités l'intégration efficace des différentes composantes du programme?
3. Y a t-il des mesures qui auraient pu être prises pour une meilleure intégration des composantes pour améliorer la sécurité alimentaire de la population bénéficiaire?
4. Est ce que la composante nutrition et santé étaient mises en œuvre conformément à la stratégie et les priorités du gouvernement au niveau local? Quel a été le niveau de coordination / collaboration avec les autres partenaires et avec le gouvernement du Burundi?
5. Dans quelle mesure les recommandations de l'évaluation à mi-parcours ont été intégrées dans la mise en œuvre des activités de la nutrition et de la santé?
6. Les bénéficiaires ont ils adoptés les meilleures pratiques ou comportements souhaités en matière des actions essentielles en nutrition, en Hygiène, la PCIME et la diversité alimentaire?
7. Y a t-il des groupes de la population ou bénéficiaires avec de faible taux d'adoption des meilleures pratiques et dites pourquoi?
8. Dans quelle mesure les changements de comportement ont ils été progressifs au niveau des bénéficiaires, par exemple des changements qui ont améliorés la nutrition des enfants de plus de deux ans et qui ont un impact sur les futures naissances ?
9. Quelles ont été les stratégies mises en œuvre pour assurer une distribution rapide et efficace des vivres du titre II aux différents bénéficiaires?
10. Comment la distribution des vivres du titre II ont ils améliorés le niveau de sécurité alimentaire et l'utilisation des produits locaux au niveau des ménages après la distribution des vivres?
11. Dans quelle mesure le projet a été bénéfique pour bénéficiaire et l'atteinte des objectifs de IR 2 et 3?
12. Quelle stratégie de la composante a permis d'atteindre les hommes/pères ? Que faut-il faire pour les programmes futures pour améliorer la participation père /hommes dans les activités de Santé nutrition.
13. Dans quelle mesure les activités mises en œuvre ont pu renforcer le cadre institutionnel, la capacité des communautés et des ménages bénéficiaires dans la prévention de la malnutrition?
14. Quels sont les résultats peu susceptible d'être durable et continuer après le retrait du projet? et dites pourquoi?

15. Y a t-il des facteurs (obstacles / contraintes) ayant limité la participation de la communauté et leur engagement dans la mise en œuvre du programme?
16. Comment les bénéficiaires ont été gradués et comment ont été préparés pour l'arrêt de la distribution la distribution alimentaire?
17. Quelles sont les leçons apprises? Comment le programme pourrait avoir plus d'impact sur la politique nationale en matière de nutrition et de la santé?
18. Quelle a été la contribution du programme PM2A pour le renforcement de la politique nationale du gouvernement en matière de la lutte contre la malnutrition ?
19. Par rapport au Coût-efficacité comment les ressources du programme allouées aux différents RI ont été mieux ont permis a) à atteindre les objectifs du programme et b) améliorer la durabilité du programme?
20. Quel a été le coût par bénéficiaire de chaque IR, les activités dans les différents RI ont ils été rentables dans la prévention de la malnutrition?
21. Quel a été l'impact d'avoir un volet de recherche séparément conçu (sous la gestion de IFPRI) pour la mise en œuvre du programme du consortium CRS
22. Par rapport a la durabilité» des interventions du programme: a) Il y a avait il des failles dans la conception du programme qui pouvait avoir un impact durable, c) ces corrections ont elles été prises en compte pendant l'évaluation à mi-parcours pour l'amélioration de la durabilité du programme, et d) quelles leçons ont été tirées pour améliorer la viabilité de la future programmation PM2A au Burundi et ailleurs.
23. Par rapport a la Durabilité comment les interventions réalisées sous RI 1 et 2? Par exemple, les familles graduées continuent elles a appliquer les leçons et pratiques apprises dans l'alimentation des enfants ou b) poursuite des pratiques apprises pour les futures naissances? Un autre exemple, le personnel des centres de santé a t-il mis en œuvre correctement les protocoles du ministère de la santé pour renforcer les activités sous IR 1 et pour renforcer l'impact de la nutrition des mères et des jeunes enfants?
24. Quels sont des impacts du programme PM2A sur l'adoption de l'approche modulaire de BCC au niveau des ménages et de la communauté, et l'élaboration d'un programme pour améliorer les services de santé, en particulier dans les centres de santé locaux sur la prévention de la malnutrition.
25. Par exemple, les messages BCC sur la diversité alimentaire pour l'introduction des aliments et de nouvelles recettes ont ils été bien reçu par les bénéficiaires? Dites Pourquoi? Quels sont les messages qui ont eu un impact plus important sur la prévention des déficits nutritionnels de la population bénéficiaire?

Annex III.C.

GUIDE D’ENTRETIEN: Community Health Workers, Mother Leaders, and Care Groups

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l’évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d’avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l’amélioration de l’état nutritionnel des enfants moins de cinq ans dans les zones d’intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L’interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d’informations et en toute sincérité.

(Essayez de mettre le groupe à l’aise et d’encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification

		Date de collecte : _____
Nom et prénom de l’agent de collecte	_____	
: _____	COMMUNE	
VILLAGE : _____		
		Nombre de relais du village Présents : T / _____ / H :

	/ ____ / F : / ____ /
--	-----------------------

1. Quelles sont les activités que vous avez menées dans le village dans le cadre du projet Tubaramure-PM2A? (*noter toutes les activités citées par les participants.*)
2. Quelles activités faites-vous dans vtre localite ? (Quel est votre rôle en tant que Care group/ML ?)
3. Selon vous, quels changements/différences avez-vous constaté dans l'état nutritionnel des enfants de moins 5 ans? (les effets observés sur les enfants. Noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a, Cherchez des exemples individuels à exploiter en profondeur]
4. Quels changements/différences avez-vous constaté dans la situation sanitaire et nutritionnelle des femmes enceintes et allaitantes ayant bénéficié les interventions du programme? (noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a, Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas]
5. Selon vous, quels ont été les points forts des activités ? (changement survenus : pratiques alimentaires, amélioration de l'état sanitaire des enfants)
6. Quels ont été les points faibles du programme (choses que vous n'appréciez pas pendant le programme)?
7. Quelles dispositions avez-vous mise en place pour pouvoir continuer les activités dans votre après le retrait du projet? (noter toutes les dispositions)
8. Quelles suggestions ou recommandations avez-vous afin de mieux renforcer les acquis du projet dans les différentes zones d'intervention (pour améliorer la lutte et la prévention de la malnutrition dans votre village)?
9. Lecons apprises/ Temoignage/ proverbes. (Note : preter attention aux recits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Distribution des vivres

1. Que pensez-vous de l'effet de l'assistance (distribution des vivres) sur la Santé des bénéficiaires (enfants femmes enceintes et enfants de moins de 5 ans malnutris)?
2. Quelles étaient les principales difficultés rencontrées?
3. Quels sont les principaux défis liés à la prise en charge des enfants malnutris au niveau de votre village?
4. Lecons apprises/ Temoignage/ proverbes. (Note : preter attention aux recits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Activités SILC

1. Menez vous des activités SILC
 1. Oui
 2. Non
2. Combien d'entre vous font partie du groupement SILC ? / _____ /

3. Depuis que les activités SILC ont commencé, quels changements/différences constatez-vous dans votre travail? (Noter les changements évoqués par les participants, demander des exemples concrets pour soutenir les propos)
4. Quelles dispositions avez-vous prises pour continuer les activités de SILC après le retrait du projet ? (noter les dispositions évoquées par les participants à l'entretien)
5. Si pas de disposition, pourquoi? (*noter toutes les raisons évoquées par les participants à l'entretien*)
6. Quelles suggestions ou recommandations faites-vous dans le cadre du suivi et renforcement des de vos activités SILC ? (noter toutes les suggestions évoquées par les participants à l'entretien)
7. Leçons apprises/ Temoignage/ proverbes sur les activités SILC. (Note : preter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Annex III.D.

GUIDE D'ENTRETIEN: Graduated Mothers

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet en ce qui concerne la situation sanitaire et nutritionnelle des femmes. Les questions s'adresseront aux femmes bénéficiaires du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Nom des membres de l'équipe :

Identification :

	Date de collecte
Nom et prénom de l'agent de collecte	_____
: _____	
:	Nombre de participantes: H / ____ / F : / ____ /

1. Selon vous, quelles ont été les principales interventions du programme pendant les 5 ans dernières années dans votre localité en ce qui concerne les femmes enceintes et allaitantes?

2. Quelles sont les actions d'hygiène que vous avez apprises avec l'intervention du projet dans votre localité ? Citer les avantages
 3. Quelles sont les meilleures pratiques d'alimentation que vous avez apprises avec l'intervention du projet dans votre localité ? (Citer les avantages)
 4. Selon vous quels ont été les avantages de votre participation au programme ? [*On voudrait savoir quels bénéfices vous avez tirés, amélioration du poids de l'enfant a la naissance ?*]
 5. Quels changements/différences avez-vous constaté au niveau votre état sanitaire et nutritionnel suite à votre participation au programme du projet ? (noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a, *Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas*)
-
6. Citez quelques exemples de bonnes pratiques sanitaires et nutritionnelles que vous appliquez actuellement
 7. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Distribution des vivres

8. Quel type d'assistance avez-vous reçu quand vous étiez enceinte de votre dernier enfant? (distribution des vivres ?)
9. Selon vous, quels étaient les critères définis pour recevoir assistance
10. Quels changements/différences avez-vous constaté au niveau l'état sanitaire et nutritionnel des femmes ayant bénéficié de distribution des vivres pendant la grossesse?
11. Quelles suggestions faites-vous afin de mieux renforcer les acquis dans le cadre de l'amélioration de l'état sanitaire et nutritionnel des femmes pendant la grossesse ?
12. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Activités SILC

13. Menez vous des activités SILC /membre du groupement
 1. Oui
 2. Non
14. Combien d'entre vous font partis du groupement SILC
15. Depuis que les activités SILC ont commencé, quels changements/différences constatez-vous dans votre vie ? (Noter les changements évoqués par les participants, demander des exemples concrets pour soutenir les propos)

16. Quelles suggestions faites-vous dans le cadre du suivi et renforcement des de vos activités SILC ? (noter toutes les suggestions évoquées par les participants à l'entretien)
17. Lecons apprises/ Temoignage/ proverbes sur les activités SILC. (Note : preter attention aux recits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Remercier les femmes participantes

Annex III.E.

GUIDE D'ENTRETIEN: Indirect Beneficiaries (mothers of children less than five years of age who were not PM2A beneficiaries)

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet en ce qui concerne la situation sanitaire et nutritionnelle des enfants. Les questions s'adresseront aux mères d'enfants.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Nom des membres de l'équipe :

Identification :

	Date de collecte
Nom et prénom de l'agent de collecte	_____

:	_____
:	Nombre de participantes: H / _____ / F : / _____ /
Nombre de mères d'enfants ayant participé au programme de Tubaramure	
Nombre faisant parti d'un groupement	
Nombre faisant parti du SILC	

1. Je voudrais que nous parlions de la situation sanitaire et nutritionnelle des enfants avant l'arrivée du programme Tubaramure dans votre localité ? (*quelles étaient les maladies les plus fréquentes? Quels sont les signes de la malnutrition que vous connaissez? Comment était organisée la prise en charge?*)
2. Selon vous, quelles ont été les principales interventions du programme pendant les 5 ans dernières années dans votre localité en ce qui concerne les femmes enceintes et allaitantes?
3. Quelles sont les actions d'hygiène que vous avez apprises avec l'intervention du projet dans votre localité ? Citer les avantages et comment les avez vous apprises ?
4. Quelles sont les meilleures pratiques d'alimentation que vous avez apprises avec l'intervention du projet dans votre localité ? Citer les avantages et comment les avez vous apprises ?
5. Quels changements/différences avez-vous constaté au niveau de l'état nutritionnel des enfants suite à l'intervention du projet ? (noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a, *Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas*]
6. Quels changements/différences avez-vous constaté au niveau votre chez les femmes suite à votre participation au programme du projet ? (noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a, *Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas*]
7. Citez quelques exemples de bonnes pratiques nutritionnelles que vous appliquez actuellement pour l'alimentation de votre enfant
8. Quelles dispositions/initiatives que avez vous mises en place pour continuer les bonnes pratiques apprises après le retrait du projet dans votre localité
9. Quelles suggestions ou recommandations avez-vous afin de mieux renforcer les acquis du projet dans les différentes zones d'intervention (pour améliorer la lutte et la prévention de la malnutrition dans votre village)?
10. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Annex III.F.

GUIDE D'ENTRETIEN: Local Authorities

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification :

	Date de collecte _____
Nom et prénom de l'agent de collecte	_____
_____	COMMUNE _____
_____	_____
Types de key Informant	
Nom du partenaire :	

1. Que savez des activités du programme Tubaramura dans votre localité ?.
2. Quel a été votre niveau d'implémentation dans les activités de ce programme
3. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
4. Quels changements/différences avez-vous constaté chez des enfants suite à l'intervention du projet ?
(noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a,
Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas)
5. Quels changements/différences avez-vous constaté chez suite femmes à l'intervention du projet ?
(noter toutes les réponses, demander aux participants d'illustrer, de citer des exemples s'il y a,
Cherchez des exemples individuels à exploiter en profondeur, noter l'amélioration ou pas)
6. Selon vous, quels ont été les points forts du projet Tubaramure?
7. Quels ont été les points faibles du projet Tubaramure?
8. Quels sont les défis actuels dans les villages du projet Tubaramure?
9. Quelles suggestions ou recommandations avez-vous afin de renforcer les acquis du projet dans les différentes zones ?
10. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire

Annex III.G.

GUIDE D'ENTRETIEN: Groupement Members

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification

	Date de collecte : _____
Nom et prénom de l'agent de collecte	_____
: _____	COMMUNE
VILLAGE : _____	
	Nombre de relais du village Présents : T / _____ / H : / _____ / F : / _____ /
Nombre care group/ML membre du groupement	

Nombre de Mere graduee membre du groupement	
Nombre de femmes bénéficiaires indirectes membre du groupement	

1. Comment votre groupement a été mis en place et depuis quand
2. Votre groupement a-t-il un statut et règlement intérieur ? (cocher une réponse)
3. Oui /__/ ; Non /__/
4. Combien d'entre vous savent lire et faire des petits calculs t ?(écrire le nombre) / ____/
5. Votre groupement a-t-il un statut et règlement intérieur ? (cocher une réponse)
6. Oui /__/ ; Non /__/
7. Combien de réunion statutaire sont dans le règlement ?(écrire le nombre) / ____/
8. Le groupement tient il actuellement des réunions ? (Cocher une réponse) Oui /__/ ; Non /__/
9. A quand remonte la dernière réunion statutaire du groupement ? (noter le mois et année)
10. Quelles orientations ou formations avez-vous reçu de la part du projet (ex ; Formation, sensibilisation sur les AEN et AEH ?
11. Depuis que avez commencé, quels changements/différences constatez-vous dans votre travail? (Noter les changements évoqués par les participants, demander des exemples concrets pour soutenir les propos, appui recu du projet)
12. Quelles sont les activités menées au sein de votre groupement?
13. En tant que membre du groupement , quels sont les avantages que vous avez recus ? (poser la question et noter la tendance globale des reponses,
14. Quel était le montant au moment au depart ?
 - Epargnes (fonds total de l'épargne) / _____/
 - Crédit en cours / _____/
 - Cotisation fonds social / _____/
 - Amendes / _____/
 - Intérêts / _____/
15. Quels sont les montants actuellement ?
 - Epargnes (fonds total de l'épargne) / _____/
 - Crédit en cours / _____/
 - Cotisation fonds social / _____/
 - Amendes / _____/
 - Intérêts / _____/

16. Quelles dispositions avez-vous prises pour continuer les activités de SILC après le retrait du projet ? (noter les dispositions évoquées par les participants à l'entretien)
17. Si pas de disposition, pourquoi? (*noter toutes les raisons évoquées par les participants à l'entretien*)
18. Quelles suggestions ou recommandations faites-vous dans le cadre du suivi et renforcement des de vos activités en tant que groupement ? (noter toutes les suggestions évoquées par les participants à l'entretien)

Annex III.H.

GUIDE D'ENTRETIEN: Groupement SILC Members

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes]

Identification

	Date de collecte : _____
Nom et prénom de l'agent de collecte	_____
: _____	COMMUNE
VILLAGE : _____	
	Nombre de relais du village Présents : T / _____ / H : / _____ / F : / _____ /
Nombre de care group/ML membre du groupement	

Nombre de femmes graduees membre du SILC	
Nombre de beneficiaire indirecte membre du groupement SILC	

Activités SILC

1. Comment votre groupement SILC a été mis en place et depuis quand
2. Pourquoi (les raisons) avez-vous crée votre groupement SILC? *(cocher les réponses correspondantes données par les participants sans lire la liste des options ci-dessous)*
3. Combien d’entre vous font partie du Care group ? / _____ /
4. Votre groupement a-t-il un statut et règlement intérieur ? (cocher une réponse)
5. Oui /___/ ; Non /___/
6. Combien d’entre vous savent lire et faire des petits calculs t ?(écrire le nombre) / ___/
7. Quelles orientations ou formations avez-vous reçu de la part du projet (ex ; Formation, sensibilisation sur les AEN et AEH ?
8. Depuis que les activités SILC ont commencé, quels changements/différences constatez-vous dans votre travail? (Noter les changements évoqués par les participants, demander des exemples concrets pour soutenir les propos)
9. Quelles sont les activités menées au sein de votre groupement dans le cadre du SILC ? (cocher les réponses correspondantes)
10. En tant que membre du groupement SILC, quels sont les avantages que vous avez recus ? (poser la question et noter la tendance globale qui correspond aux options de reponses, cocher les réponses qui s’appliquent aux réponses des participants)
11. Quel était le montant au moment au depart ?
 - Épargnes (fonds total de l’épargne) / _____ /
 - Crédit en cours / _____ /
 - Cotisation fonds social / _____ /
 - Amendes / _____ /
 - Intérêts / _____ /
12. Quels sont les montants actuellement ?
 - Épargnes (fonds total de l’épargne) / _____ /
 - Crédit en cours / _____ /
 - Cotisation fonds social / _____ /
 - Amendes / _____ /
 - Intérêts / _____ /

13. Quelles dispositions avez-vous prises pour continuer les activités de SILC après le retrait du projet ? (noter les dispositions évoquées par les participants à l'entretien)
14. Si pas de disposition, pourquoi? (*noter toutes les raisons évoquées par les participants à l'entretien*)
15. Quelles suggestions ou recommandations faites-vous dans le cadre du suivi et renforcement des de vos activités SILC ? (noter toutes les suggestions évoquées par les participants à l'entretien)
16. Leçons apprises/ Temoignage/ proverbes sur les activités SILC. (Note : preter attention aux recits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Annex III.I.

GUIDE D'ENTRETIEN: Ministry of Health Staff

Introduction

Bonjour ! Mon nom est : _____ . Je suis ici avec mon collègue dans le cadre de l'évaluation finale du projet Tubaramure- PM2A financé par USAID/FFP. Ce projet est exécuté par CRS/Burundi en collaboration avec la Caritas Burundi et des organisations internationales Food for the Hungry (FH) et International Medical Corps (IMC). Après de 5 ans de mise en œuvre du Programme, CRS en collaboration avec ses partenaires réalise actuellement une évaluation finale afin d'avoir meilleure connaissance sur les changements survenus liés au projet (effets et impact) dans le cadre de l'amélioration de l'état nutritionnel des enfants moins de cinq ans dans les zones d'intervention du projet. Nous voudrions nous entretenir avec vous sur des questions relatives aux activités du projet. Les informations que vous me donnerez resteront strictement confidentielles. Ces informations seront utilisées uniquement pour mieux capitaliser les acquis du projet.

L'interview prendra environ une heure. La participation à cette évaluation est volontaire et vous pouvez refuser de répondre à des questions particulières ou à toutes les questions. Cependant je vous serais très reconnaissant(e) de bien vouloir me fournir le maximum d'informations et en toute sincérité.

(Essayez de mettre le groupe à l'aise et d'encourager la franchise sans être trop formel. Assurez que les personnes clés bénéficiaires du programme sont présentes

Identification :

	Date de collecte
Nom et prénom de l'agent de collecte	_____
_____	COMMUNE
	NOM DE L'ENQUETE :
CENTRE DE SANTE DE : _____	Tel :

1. Pouvez- vous me parlez de votre collaboration avec le programme á travers son partenaire d'exécution dans la lutte contre la malnutrition dans votre aire de santé. Comment était cette collaboration.
2. Les équipements fournis ont été ils appropriés, et ont ils été bien utilisés pour atteindre les résultats escomptés (expliquer comment ? Que peut-on faire pour améliorer cette collaboration
3. les modules de formation ont-ils appropriés ou étaient ils en accord avec le protocole national? Comment peuvent-ils être améliorés dans le futur programme?
4. Que pensez vous du personnel formé (Y a t-il une différence entre le personnel des centres de sante formés et non formés)?
5. Du démarrage du projet à Mars 2012, , quels changements/différences avez vous constaté par rapport aux activité de nutrition dans votre centre de santé (*Note a l'enquêteur : demander les chiffres appuyant les propos de l'enquêté*),
 - 5.1 A la fréquentation du centre de santé pour les cas de malnutrition des enfants de moins 5 ans?
 - 5.2 A la prise en charge des cas de malnutrition des enfants de moins 5 ans
 - 5.3 A la tenue des supports de gestion dans le centre de santé?
 - 5.4 A l'état nutritionnel des enfants de -5ans?
6. Selon vous quelles sont les activités qui ont eu plus d'impacts sur les bénéficiaires? Pourquoi ?
7. Selon vous, quels ont été les points forts du projet Tubaramure?
8. Quels ont été les points faibles du projet Tubaramure?
9. Quels sont les résultats peu susceptible d'être durable et continuer après le retrait du projet? et dites pourquoi?
10. Quelles dispositions avez-vous mise en place pour pouvoir continuer les activités relatives à la prévention/prise en charge de la malnutrition?
11. Quels sont les défis majeurs relatifs à la prévention/ prise en charge des malnutris après le retrait du projet dans le centre de santé?
12. Quelles suggestions ou recommandations avez-vous afin de mieux renforcer les acquis dans le cadre de la nutrition (amélioration de l'état nutritionnel des femmes et des enfants de moins de 5 ans)?
13. Leçons apprises/ Témoignage/ proverbes. (Note : prêter attention aux récits pertinents par rapports aux réussites, échec histoires de changements, si ces aspects sont ressortis durant le focus, après l'entretien approchez la personne et approfondissez son récit en donnant le nom, sexe, l'Age, la période, le résumé sommaire)

Annex IV. Qualitative Data from Focus Groups

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Annex IV.A. Summary Comments from Lead Mothers of CARE Groups

1. What activities do you carry out in the village within Tubaramure? – PM2A (note all activities mentioned by the participants.)

Hygiene and sanitation

- *Construction of latrines and their maintenance (Nyagutoha, Ruhwago, Nyarubabi, Muhene Misugi-Ca, Kaniha-Ca Villages). The advantage is the reduction of disease germs spread. (Rusange Village).*
- *Construction of hand washing stations (Ruhwago, Nyarubabi, Rubanga, Muhene, Busyana-Ca, Misugi-Ca, Kaniha-Ca Villages) and the use of soap while hand washing and dish washing. (Village Rusange, Misugi-Ca).and while doing the laundry (Rusange, Misugi-Ca Villages)*
- *We now understand the importance of hand washing before food preparation, before meals, before feeding children and especially after having been to the water closet /toilet. (Nyagutoha, Ruhwago Villages,)*
- *Shower installation (Misugi-Ca Village)*
- *Teaching good practices in the conservation of drinking water (Nyagutoha Village) [such as using] clean jerry cans with lids (Rusange, Muhene, Misugi-Ca, Kaniha-Ca Villages)*
- *Construction and use of drying racks to keep kitchen utensils clean. (Nyagutoha and Ruhwago, Busyana-Ca, Villages)*
- *Teaching the importance of garbage pits (Ruhwago, Nyarubabi, Rusange, Muhene, Misugi-Ca Villages)*

Health

- *Informing pregnant women on the importance of prenatal and postnatal consultations (Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Nyarurambi, Muhene Villages) to improve the health of pregnant women and lactating mothers (Village Rusange).” For the prenatal consultations, pregnant women must do at least four, while for the postnatal, they have to do three consultations; 3 days, 15 days, and 45 days after child delivery “, (Busyana-Ca, Misugi-Ca, Kaniha-Ca Villages)*
- *Advising pregnant women to seek consultation in the event of complications (e.g., bleeding, false contractions, continuous vomits, fever, headaches) (Busyana-Ca Village), as well as informing them of the signs of fistula (Misugi-Ca Village)*
- *Teaching the signs of an ill child (e.g., fever) (Misugi-Ca Village)*

- *Education of pregnant women on the role a health structure can play child delivery and its importance (Muhene Village)*
- *Informing pregnant and lactating women on the detrimental effects of consuming alcohol and tobacco to their children of under two years. (Rusange Village)*
- *Teaching the importance and practice of family planning (Misugi-Ca Village)*
- *Vaccination of children (Ruhwago, Muhene Villages) and child growth monitoring (Ruhwago, Nyarurambi Villages)*
- *Identifying malnourished children (Kaniha-Ca Village) by using MUAC (Village Nyagutoha)*
- *Screening malnourished children (Misugi-Ca Village)*
- *Preparation of ORS for children suffering from diarrhea (Kaniha-Ca Village)*
- *Use of insecticide treated nets (Nyagutoha Village)*
- *Child growth monitoring (Nyarurambi Misugi-Ca, Kaniha-Ca Villages)*
- *Training women how to detect children suffering from anemia (Kaniha-Ca Village)*

Nutrition

- *Exclusive breastfeeding for 6 months (Rusange, Nyarurambi Villages),*
- *Education on the nutrition of children under the age of two (Rusange Village)*
- *Food/nutrition practices for children under the age of five, pregnant and lactating women (Nyagutoha, Ruhwago, Nyarubabi, Villages) :*
- *Preparation of balanced diets based on local products (porridge) for children and pregnant women (Nyagutoha, Ruhwago, Rubanga, Rusange, Muhene Villages)*
- *Preparation of milk from soya beans (Kaniha-Ca Village)*
- *Educating on respecting the three food groups (i.e., carbohydrates, lipids and proteins) (Busyana-Ca Village)*
- *Increase in meals per day : 3 meals per day for pregnant and lactating women (Misugi-Ca, Busyana-Ca Villages)*
- *Improvement of local food by combining the three food groups (proteins, carbohydrates, and lipids). (« Before the program, during the sweet potato season, we only ate sweet potatoes »). [Nyagutoha, Ruhwago, Rubanga Villages].*
- *Teaching how to self produce small quantities of food such as vegetables, fruits and cereal grains (Nyagutoha Village)*

- *Sensitization on setting up kitchen garden for vegetable production during the dry season « Long ago, vegetables were only grown by families who had marshlands » (Rusange, Muhene, Misugi-Ca Villages)*
- *Supervision of the distribution of flour for porridge, vegetable oil, and small livestock; goats, hens, (Busyana-Ca Village)*

IGA (Income generating activities)

- *Establishment of income generating associations (Rubanga, Nyarurambi Villages)*
- *Teaching how to train groups (Itahe, Misugi-Ca Villages)*
- *Establishment of agro-pastoral groups (Busyana-Ca, Misugi-Ca Villages)*
- *Building association membership (Kaniha-Ca Village)*

13. What activities do you do in your community? (What is Care group/LM ?)

Health

- *One is the detection of disease due to malnutrition using MUAC, and referring the undernourished children in need. (Nyarurambi, Muhene, Itahe, Busyana-Ca, Misugi-Ca Villages) . “In the visits we make, we check if children have no sign of malnutrition or another sign of illnesses. If he has fever, we refer him to the Community Health Agent who in turn gives him a reference card to take to the health center for health care”.(Busyana-Ca Village)*
- *Teaching family planning including birth limitations and birth spacing by using natural methods, breastfeeding children ten times per day and sexual cycle management. (Itahe Village)*
- *Child growth monitoring (Nyarurambi, Busyana-Ca, Misugi-Ca Villages)*
- *Sensitization of parents in case of childhood illnesses in order to go to the health facilities and escort them if necessary. (Nyarubabi Village Village)*
- *« We advise women who consult witchdoctors to give up that practice and to go and consult physicians » (Village Muhene)*
- *Sensitization towards women of the sub groups and other women who are not in the TUBARAMURE programme for the good health of pregnant women and children under five years on the following points:*
- *Prenatal and postnatal consultations, [Nyagutoha, Ruhwago, Rubanga, Nyarurambi, Muhene, Itahe Villages]*

- *The signs of a pregnant woman in danger : bleeding, fistula, headaches, false contractions (Misugi-Ca, Busyana-Ca Villages)*
- *and the signs of an ill child; fever, ... (Misugi-Ca, Busyana-Ca Villages)*
- *Children vaccination, (Villages Ruhwago, Nyarurambi, Muhene, Itahe, Busyana-Ca, Kaniha-Ca)*
- *Child delivery in a health center (Misugi-Ca Village Village Village)*
- *Leader mothers (and other mothers) respect and follow the schedule of prenatal and postnatal care services as well as children vaccination. (Village Rusange).*
- *They also teach mothers the bad effects of alcoholic drinks on pregnant and lactating women and children. These drinks are to be replaced by water, milk, and hot drinks. (Village Rusange).*

Nutrition

- *exclusive lactation from birth to 6 months, (Nyagutoha et Ruhwago, Rusange, Nyarurambi, Itahe, Misugi-Ca Villages);*
- *balanced diet for pregnant women and children by promoting local products (Villages Rusange, Nyarurambi);*
- *nutrition of children from birth to 6 months (porridge and fruits) (Ruhwago, Itahe Villages), 6 to 9 months (mashed food), and 9 to 12 months (Misugi-Ca Village);*
- *how to prepare whole meal and flour by using local products;*
- *the importance of giving porridge containing vegetables and/or avocados. (Itahe, Misugi-Ca Villages) ;*
- *production of soya milk (Itahe Village);*
- *growing some nutrient-rich food products;*
- *planning kitchen gardens that grow vegetables such as amaranths, cabbage, and onions (Nyagutoha, Itahe, Misugi-Ca, Kaniha-Ca Villages);*
- *the importance of the consumption of those vegetables by pregnant women and children older than 6 months. (Rusange Village); and*
- *the importance of 3 meals daily. (Rusange, Itahe, Misugi-Ca Villages)*
- *Culinary demonstration for pregnant and lactating women (Rusange Village)*
- *« As lead mothers, we mentor and supervise the implementation of the practices mentioned earlier. (Itahe Village).*

Hygiene and sanitation

- *We visit of Care Group households for the hygiene and sanitation follow-up, checking the construction , maintenance, and encouraging propoer usage of of latrines and hand washing stations (Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Muhene Villages) as well as sensitization on hygiene practices in the community: construction of latrines, showers, and hand washing stations; hand washing with soap (Rusange, Misugi-Ca, Busyana-Ca Villages) after the toilet, before the meal, and before breastfeeding, et al; construction of a drying platform/rack for kitchen utensils, [Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Rusange, Nyarurambi, Itahe, Misugi-Ca, Busyana-Ca Villages], washing fruits before eating them (Villages Rubanga, Nyarurambi), washing laundry, the construction of garbage pits (Nyarubabi, Ruhwago, Rusange, Muhene, Misugi-Ca, Kaniha-Ca Villages), cleaning the house and yard (Villages Rubanga, Nyarurambi), bathing, and washing the children. (Nyarurambi Village)*
- *Teaching of non beneficiary families of the program about proper practices and the importance of hygiene(Kaniha-Ca Village).*
- *Women of the group collect and store drinking water in jerry cans with lids and encourage most other households to do the same. (Villages Rusange, Itahe)*
- *As leader mothers, we have to serve like models in the implementation of teachings received from Tubaramure in our community. (Itahe Village).*

Creation of groups

- *Sensitization on the creation of groups (Nyarurambi, Muhene Villages). « We play the role of models and we sensitize in our community. » (Nyarurambi Village)*
- *In the promotion of local development, we leader mothers sensitize on the membership and /or group and this, for the putting in common their potential or moral and physical strengths ; it's also an asset of self care taking in case of the support project end . (Itahe Village)*
- *Establishment of an agricultural and pastoral association (Village Misugi)*

14. According to you, what changes /differences have you observed in the nutrition of children under five years? (impacts observed on children. Note all responses, ask participants to illustrate, to give examples if there are any, seek for personal examples to be deeply explored]

Before TUBARAMURE	With TUBARAMURE
There were no healthy food practices as is illustrated by the following points.	They learned healthy food practices. - Mothers exclusively breastfeed their

<ul style="list-style-type: none"> - Child feeding at any month and breastfeeding combined with feeding (Villages Nyagutoha, Ruhwago, Nyarurambi, Muhene, Misugi-Ca, Busyana-Ca, Kaniha-Ca). - The villagers’ diets consisted of meals poor in vital nutrients. “We could give only sweet potatoes to children.” (Villages Nyarubabi, Nyarurambi, Busyana-Ca, Misugi-Ca)) - Emaciation of children pervaded much of the villages (Village Nyagutoha, Nyarurambi, Busyana-Ca) - There was a complete absence of growth monitoring for children (Villages Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Nyarurambi) - Illness due to poor hygiene such as diarrhea was rampant. (Village Nyagutoha, Nyarurambi) as well as significant malaria and anemia (Villages Ruhwago et Rubanga). Copious illness related to malnutrition; kwashiorkor (Village Nyarurambi, Busyana-Ca, Kaniha-Ca) - Hygiene for children was virtually non-existent (they did not wash children) (Village Nyarurambi) - Consumption of tobacco and alcoholic drinks by pregnant women and children under two years (Itahe, Misugi-Ca Villages) 	<p>infants for the first 6 months after birth, (Village Nyagutoha, Rusange, Nyarurambi, Muhene, Busyana-Ca, Misugi-Ca, Kaniha-Ca). « Before, we gave food and even beer to a child under 6 months, but for the time being, women practice exclusive breastfeeding for 6 months » (Village Muhene)</p> <ul style="list-style-type: none"> - Mothers breastfeed their children until 24 months. Mothers now practice and understand the advantages of birth spacing (Village Rusange). - Child seeking at least 10 times (Village Rusange) - Nutrition of children after 9 months (Village Rusange) - Pregnant women and lactating mothers now eat balanced diets. (Hence, their good health), as well as children at the age of 6 months. Since consuming balanced diets, the weights (Villages Nyagutoha, Nyarubabi , Rubanga, Nyarurambi, Misugi-Ca) and heights of these children have substantially increased. (Village Nyarubabi). - Sensitization of TUBARAMURE on prenatal and postnatal care services for pregnant and lactating women, hence the practice of those consultations ; at least 3 times, (Villages Nyagutoha, Ruhwago, Nyarubabi and Rubanga) to avoid miscarriage for pregnant women, (Village Nyarubabi) - Child growth monitoring is now implemented. (Villages Nyagutoha, Ruhwago, Nyarubabi and Rubanga). - Diarrhea and its related illnesses are
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	<p>diminished thanks to trainings received. (Village Nyagutoha, Muhene, Kaniha-Ca) and anemia reduction (Village Rubanga), no illnesses related to malnutrition (Village Nyarurambi, Muhene, Misugi-Ca).</p> <ul style="list-style-type: none"> - The number and severity of malnourished children was reduced (Village Muhene, Kaniha-Ca). - Communities are no longer giving tobacco and alcoholic drinks to children under two years of age (Itahe Kaniha-Ca Villages). - No signs of malnutrition thanks to soya milk (Village Rusange) - Body hygiene for children; they did not wash children (Village Nyarurambi, and hand washing before meals (Village Misugi)
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15. What changes/differences did you observe in the health and nutritional status of pregnant women and lactating mothers who benefited from the program interventions? (Note: all prompts ask participants to illustrate, provide examples (if there are any), explore personal examples, and note whether or not there was improvement.)

Before TUBARAMURE	With TUBARAMURE
<ul style="list-style-type: none"> - Child delivery at home (Villages Rusange, Muhene) - No prenatal and postnatal consultations (Nyagutoha, Ruhwago, Rubanga, Nyarurambi , Misugi-Ca Villages) - No birth spacing (Muhene Village) - Lots of miscarriage because of fatigue (Muhene , Busyana-Ca, Kaniha-Ca) 	<ul style="list-style-type: none"> - Child delivery at hospital or at the health center (Rusange, Muhene, Itahe Villages). «Deliveries are no longer taking place at home because of sensitization. Any complication finds solution in a health facility and not at the witchdoctors»(Rusange, Itahe Villages) - Regular prenatal and postnatal consultations (at least 3 times for the prenatal consultations and 2 times for postnatal consultations) for a timely care

<ul style="list-style-type: none"> - Villages) - Nutrient-poor foods, hence emaciation of mothers and children, their weight ranges from 1.5 o 2 kg (Nyagutoha, Rubanga, Nyarurambi Villages) - Ignorance of a balanced diet; « we ignored the importance of eating vegetables and fruits » (Muhene Village) - One meal or two meals per day, for pregnant women (Ruhwago, Nyarurambi, Misugi-Ca, Kaniha-Ca Villages) - Lots of anemia related to lack of iron, for pregnant women (Ruhwago, Rubanga, Muhene , Busyana-Ca Villages) - Frequence of lots of illnesses (Village Nyarurambi) related to malnutrition (Misugi-Ca Village) - In case of illnesses, we stayed at home (Nyarurambi Village) - Emanciation of pregnant women (Nyagutoha, Ruhwago Villages) - Lack of body hygiene (Nyarurambi, Muhene Villages) 	<p>taking and possibility for complicated cases referral, thanks to TUBARAMURE trainings (Nyagutoha, Nyarubabi, Itahe Villages) and improvement of health for mothers (Village Rusange)</p> <ul style="list-style-type: none"> - Grant of rest to women. « Before Tubaramure, pregnant women miscarried a lot because of fatigue, but for the moment, their husbands understand programme trainings and grant them rest » (Village Muhene) - A balanced diet , for instance, porridge, goat's meat, (Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Itahe Villages) and consumption of viscus (liver, stomach, and other giblets) formerly forbidden to be eaten [Rusange Village] - Stimulation of maternal milk by a balanced diet and not by alcoholic drinks (Village Itahe) - Increase of meal intake per day (3 to 4 meals),(Nyagutoha, Ruhwago, Nyarubabi Villages). - Children are born with an insufficient weight (a woman can give birth to a baby of 4 to 4.5 kg) (Nyagutoha Village) - Mother and child weight recuperation thanks to advice and trainings got from TUBARAMURE (Nyagutoha, Ruhwago, Rubanga Villages) - No anemia because of vegetables consumption and another balanced diet (Rusange Village) - Reduction of illnesses (Village Nyarurambi) - In case of illnesses, we go to hospitals
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	<p>(Village Nyarurambi)</p> <ul style="list-style-type: none"> - Body hygiene for children (Nyarurambi, Muhene Villages)
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16. According to you, what were the strengths of activities? (changes occurred: food practices, improvement of child health status)

Food practices

- *Exclusive breastfeeding for 6 months, (Ruhwago, Nyarurambi, Misugi-Ca Villages)*
- *Breastfeeding a child suffering from diarrhea (Misugi-Ca Village)*
- *Knowledge and consumption of a balanced diet containing three types of foods; proteins, lipids and carbohydrates (Nyagutoha, Nyarubabi, Rubanga, Nyarurambi, Misugi-Ca Villages)*
- *A balanced diet of children; preparation of porridge from local food products (wheat, soya, corn, sorghum, mil, ...),(Nyagutoha, Ruhwago, Rubanga, Kaniha-Ca Villages)*
- *Frequency of food intake /meals per day for pregnant and lactating women (Village Misugi-Ca)*
- *Respect of meal times for children,(Nyagutoha Village)*
- *Food variation in the households (Nyarurambi, Misugi-Ca Villages)*
- *Food distribution to lactating women and pregnant women. (Rusange Village)*
- *Setting up kitchen gardens (Nyarurambi, Misugi-Ca, Kaniha-Ca Villages)*

Improvement of child and mother health status

- *Good health for children under five years and pregnant and lactating women (Muhene Village)*
- *Sensitization on the prenatal consultations (Busyana-Ca Village)*
- *Medical consultations in case of threats/danger for pregnant women (Busyana-Ca Village)*
- *Increase of children's weight (Nyagutoha, Ruhwago ,Rubanga, Nyarurambi, Misugi-Ca Misugi-Ca Villages)*
- *Reduction of illnesses related dirty hands related illnesses (belly swelling, diarrhea) [Nyagutoha, Ruhwago, Rubanga, Nyarurambi, Muhene, Misugi-Ca Villages]*
- *Eradication of illnesses due to malnutrition (Nyarurambi Village)*

- *No illness germs spreading because of sensitization on hygiene and sanitation practices (Rusange Village)*
- *Child growth monitoring (Rubanga, Nyarurambi Villages)*
- *Child vaccination (Nyarurambi, Muhene Villages)*
- *Birth spacing (Misugi-Ca Village)*

Hygiene and sanitation

- *Hygiene and sanitation practice such as construction of latrines with covers, hand washing stations, drying platforms, garbage pits, etc... « Even those who are not in the programme have understood what Tubaramure does» (Muhene, Kaniha-Ca Villages)*

Education for all (Muhene Village)

17. What were the weaknesses of the programme (things that you did not appreciate during the programme)?

- *The programme forgot to provide us with training on HIV/AIDS (Ruhwago Village)*
- *The distribution of chickens did not go together with a health follow up. In addition, some households got roosters (no egg laying) (Rusange Village)*
- *During demonstration of soya milk preparation, a machine was used. Now, we have no machine and we do not know where we can buy one. (Rusange Village)*
- *For soya milk filtering, it is advisable to use a mosquito net which is intended for malaria prevention ; there are no mosquito nets in my community. (Rusange Village)*
- *No programme weaknesses; the pieces of advice and trainings received were useful, (Nyagutoha, Nyarubabi Villages), because women and children are in good health (Rubanga Village).*
- *There are no weaknesses (Busyana-Ca, Kaniha-Ca Villages), except that TUBARAMURE project did not cover the whole population. (Kaniha-Ca Village)*
- *«There are no weaknesses because they taught us food practices for pregnant women and children, hygiene, child growth monitoring, symptoms of ill children and pregnant mothers. Today, we are healthy thanks to TUBARAMURE »(Nyarurambi Misugi-Ca Villages).*
- *“The project allowed for an improvement of sanitary and nutritional status in our families” (Misugi-Ca Village)*

- « *All went smoothly/well* » (Muhene Village)

18. What arrangements did you put in place to be able to continue activities after the project withdrawal? (note all arrangements)

- *Consolidate TUBARAMURE project acquisitions through popularization of internalized methods and practices (Itahe Village)*
- *Continue to apply trainings and pieces of advice in TUBARAMURE programme. For instance, at the nutrition level, we will continue to grow cereals and vegetables, and at health level, we will continue sensitization for prenatal and postnatal consultations, and hygiene in our community. (Nyagutoha, Ruhwago, Nyarubabi, Rubanga, Muhene, Misugi-Ca, Busyana-Ca Villages)*
- *Teach women the importance of birthing in health facilities (Muhene Village)*
- *Teach the importance of exclusive breastfeeding for 6 months (Nyarurambi Village)*
- *Continue to grow soya beans for milk (Nyarurambi, Muhene, Villages) and peanuts as well as corn for porridge preparation (Misugi-Ca Village)*
- *Establish associations (Rubanga, Nyarurambi Villages). « We have established an association called TWIYUNGUNYANE in order to continue to train other women who did not experience programme interventions » (Village Ruhwago). « We have 3 associations on our colline : TWIYUKIRE IBIKORWA BIRAMA, TURAME MU BIBONDO and DUSHIGIKIRANE » (Nyarurambi Village)*
- *Setting up of and progress/develop in groups of 25 members after program withdrawal, (Rusange, Muhene Villages)*
- *Stay in associations (Kaniha-Ca Village)*
- *Continue population sensitization on hygiene, health and nutrition (Muhene, Busyana-Ca, Kaniha-Ca Villages). “ Concerning hygiene, we work with the chiefs of colline /village so that they are taught construction of latrines. If ever there are reluctant people, they are required to pay a fine because hygiene is for everyone.” (Busyana-Ca Village)*
- *Continue to promote kitchen gardens in the households (Ruhwago, Nyarurambi, Kaniha-Ca Villages)*
- *Practice husbandry in order to get organic fertilizers for kitchen gardens (Rubanga Village)*
- *Seek other donors for material and intellectual support in supplementary trainings. (Rusange Village. « We have not yet reflected on other arrangements except those for always implementing the acquired hygienic practices » (Village Nyarubabi).*

19. What suggestions or recommendations do you have to better strengthen project acquisitions in different intervention areas (to improve malnutrition fight and prevention in your village)?

- *Continue food assistance, (Nyagutoha Village)*
- *Grant small domestic animals, (Ruhwago, Muhene, Kaniha-Ca Villages) or big domestic animals (cattle) to continue animal husbandry (Village Kaniha-Ca)*
- *Continue to strengthen training received in TUBARAMURE program through refreshment courses, (Ruhwago, Busyana-Ca Villages)*
- *Put in place another project that would empower the population in nutrition (Nyagutoha Village),*
- *Chemical fertilizers distribution, (Nyagutoha, Ruhwago Villages)*
- *Distribute farms to households that have small plots of land for different crops because the land renting becomes expensive (Ruhwago Village).*
- *Another project/ would train households in nutrition and would build leader mothers capacities. (Nyagutoha, Itahe Villages)*
- *The coming of another project to support agricultural (Nyarurambi Village) and pastoral activities to get organic fertilizers (Busyana-Ca Village)*
- *Build capacities in good agricultural. (Rubanga, Kaniha-Ca Villages), and pastoral practices (Kaniha-Ca Village). “Tubaramure would organize lots of trainings on the associations so that we could understand and that we could transmit messages to our children so that they can also understand” (Muhene Village)*
- *Initiate IGA (agriculture, animal husbandry and small business) for food self-sufficiency (Rusange Village), « because a hungry belly has no ears » (Itahe Village) and for other income generating activities (Misugi-Ca Village).*
- *Need for community health insurance to consolidate the health of members (Rusange Village)*
- *The setup of kitchen gardens must be followed by watering containers. (Rusange, Muhene Villages)*
- *Water adduction by another project because the water point is farther. (Nyarurambi Village)*
- *Distribute casseroles for cooking demonstrations (Muhene Village)*
- *Do advocacy for other projects for material support to strengthen leader mothers ‘activities (Busyana-Ca Village)*
- *Monitoring and evaluation (Muhene Village)*

20. Lessons Learned/ Testimonials/ Proverbs. (Note: pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview, get closer to the person and deepen his/her story by giving name, sex, age, period and summary)

- *A balanced diet is not expensive because we learned to improve local food products.*
- *Consumption of a balanced diet, vegetables and porridge (Kaniha-Ca Village)*
- *Breastfeeding for 24 months is a natural way of spacing births.*
- *Illness prevention can result from good hygiene practices and nutrition.*
- *The prohibition of some food consumption can be the source of malnutrition. (Village Rusange)*
- *« We learnt that if we eat appropriate food, illnesses decrease, and good food practice for children and pregnant women allows for illnesses decrease »(Nyarurambi Village)*
- *Necessity to consult health providers instead of resorting to traditional healers (Kaniha-Ca Village)*
- *Decrease of malnourished children (Village Itahe),*
- *The detection of malnourished children that formerly took place at health center is done at community level. We have at our disposal closer and permanent health care providers to prevent malnutrition. (Itahe Village).*
- *Importance of being in associations (Kaniha-Ca Village)*
- *Ubugirigiri bugira babiri « L'union fait la force » , « individualism does not reach anywhere ». A concrete example, a field of a member which took 30 days to be tilled is now tilled in a single day because groups now understand and offer their members mutual help. (Village Itahe).*
- *Ubwenge burarahurwa « We learn from other people » (Misugi-Ca, Busyana-Ca, Kaniha-Ca Villages)*
- *« God save TUBARAMURE that raised our awareness ; today, we know that instead consulting a witchdoctor for health care, we must go to the health center or to the hospital. One day, a neighbor had gone to see a witchdoctor for her child suffering from diarrhea. The witchdoctor could not do anything for the child. He did not know anything about ORS. As the child was dehydrated, the child died. If she had taken him to the health center, her child would have been cured.» (Village Busyana)*

Annex IV.B. Summary Comments from Graduated Mothers

1. According to you, what are the program's main interventions during the last 5 years, in your community, as far as pregnant and lactating mothers are concerned?

Hygiene and sanitation:

- *Teaching the construction of latrines*
- *Raising awareness of the importance of hand washing with a soap after toileting*
- *Teaching the construction of baths (Itahe village-Ruyigi-Ruyigi)*
- *Raising awareness of the importance of washing kitchen utensils*
- *Teaching the construction of drying platform for kitchen utensils*
- *Raising awareness of the importance of digging garbage pits*
- *Teaching proper hygiene in the home (Muhene Village-Ruyigi)*
- *Raising awareness of the importance of proper body hygiene (Muhene Village-Ruyigi)*
- *Setting up and using the hand washing stations (Busyana village- Cankuzo)*

Health:

- *Sensitization on pre and post consultation for women (4 pre-natal consultations and 2 post-natal consultations)*
- *Monitoring the children's vaccination calendar*
- *Child growth monitoring (Itahe village-Ruyigi)*
- *Training on the screening of malnutrition related diseases*
- *Teaching family planning (Nyamasenga Village-Ruyigi)*
- *Raising awareness of the importance of delivering at the health facilities (Muhene Village-Ruyigi)*
- *Encouraging pregnant women to attend a healthcare appointment if she feels discomfort, bleeding, and ceaseless vomiting. (Muterero village-Cankuzo)*
- *Training on the signs of illness for pregnant women and children (Bumba village-Cankuzo)*

Nutrition:

- *Teaching healthy food practices by stressing on the consumption of three groups of nutrients: protein, lipids, and carbohydrates*
- *Encouraging three meals (Itahe village-Ruyigi)*
- *Raising awareness of the importance of including meat in the meals (Itahe village-Ruyigi)*
- *Educating on the benefits of avoiding alcohol intake (Itahe village-Ruyigi)*
- *Teaching the importance of exclusive breastfeeding for the first 6 months of a child's life*
- *Teaching mothers to change breasts when breastfeeding the child (Itahe vilage)*
- *Teaching balanced diets for children as well as lactating and pregnant mothers (Muhene Village-Ruyigi)*
- *Teaching the production of some food like vegetables and fruit*
- *Cooking demonstration (Muhene Village-Ruyigi)*
- *Teaching the establishment of kitchen gardens*
- *Food distribution to pregnant women and under two year children (Muhene Village-Ruyigi)*
- *Planting maracujas and other fruits trees around the garbage pits (Muhene Village-Ruyigi)*
- *Encouraging the consumption of fruits by pregnant and children (Bumba village-Cankuzo)*
- *Reducing house chores for pregnant women (Kigati village-cankuzo)*
- *Groups creation (Itahe village-Ruyigi)*
- *SILC groups creation (Itahe village-Ruyigi)*

**2. What hygiene actions have you learned with the project's interventions in your community?
Cite the advantages.**

- *“Keeping water in clean and closed utensils (jerricans)”*
- *“Construction of latrines and garbage pits ” (Nyagutoha village-Ruyigi ”*
- *“Households hygiene, house cleaning ” (Kirasira village)*

- *“Drinking clean water. If we fetch river water, we boil it to kill the parasites. Before the project, many people, children and adults suffered from intestinal worms because they don’t know how to prepare and keep water to drink. Now water to drink is well prepared and kept in clean and closed recipient” (Nyamasenga Village-Ruyigi)*
- *“Washing cloths” (Kirasira village)*
- *“Setting up hand washing station” (Nyarubabi village)*
- *“Using water instead of toilet paper after toileting” (Nyarubabi village)*
- *“House and yard cleaning: before the project, we could spend more than two weeks without cleaning our houses” (Nyamasenga Village-Ruyigi)*
- *“Good use of latrines: we must check if the pit is well covered and if the children don’t mess with the latrines ” (Nyamasenga Village-Ruyigi)*
- *“Putting ash in the latrines in order to avoid the stinking smell, we learned these practices to use ash at least two times a month because this allows to avoid the flies, and as it is said, “if you want to avoid flies, you avoid the filth.” With these practices, we don’t see many flies around our homes” (Nyamasenga Village-Ruyigi)*
- *“Washing hand with a soap and clean water after toileting, after the toilet of a child, before preparing food, before child breastfeeding and before eating” (Nyamasenga Village-Ruyigi)*
- *“Washing fruits before eating them, as well as washing vegetables before cooking them”*
- *“Keeping the food in a clean and covered recipient ”(Itahe village-Ruyigi)*
- *“Setting up bathroom” (Gitanga village-Cankuzo)*

Advantages

- *“ Significant reduction in dirty hand related diseases (diarrhea, dysentery and cholera ”*
- *“Getting organic manure because of the garbage pit” (Nyagutoha village-Ruyigi)*
- *“Household’s health improvement ”*
- *“The Neighbors who are not part of TUBARAMURE program have copied the good practices” (Nyamasenga Village-Ruyigi)*

3. What are the good food practices that you have learned with the project’s interventions in your community? (Cite the advantages)

- *Good preparation of food by mixing cereals in order to get a good quality of porridge flour (eleusine, maize, sugar, etc) (Nyagutoha village-Ruyigi)*
- *Preparation and consumption of meats neglected in the past, giblets, viscous, and livers, (Nyagutoha village-Ruyigi)*
- *Pregnant women eat at least three meals a day*
- *Consumption of balanced meals: proteins, lipids and carbohydrates*
- *Food diet variation, rice+beans+endagala+oil, cassava+beans+lengalenga*
- *Keeping food in clean and closed utensils (Itahe village-Ruyigi)*
- *Exclusive breastfeeding for the children under 6 months*
- *Longer breastfeeding which allows a good growth and birth spacing (Busyana village-Cankuzo)*
- *Consumption of cow milk by children (Nyagutoha village-Ruyigi)*
- *Giving eggs to children (Muhene Village-Ruyigi)*
- *Giving colostrum to newborns (Busyana viilage -Cankuzo)*
- *Consumption of soy milk (Muyaga village-Cankuzo)*

Advantages

- *Child good physical and intellectual growth (Nyagutoha village-Ruyigi)*
- *Good health for pregnant and lactating women as well as their children (Nyagutoha village-Ruyigi)*
- *“Preparation of balanced food: before the project, we didn’t know how to prepare food with products that are locally available. For example we ate sweet potatoes and we felt at ease and we forgot that our body is perishing due to the lack of some food nutritive food. Today, I know to prepare a meal, and I include the three food groups. For example, I can prepare beans+vegetable+cassava+oil.” (Itahe village-Ruyigi)*
- *“The advantage of a balanced food is basically linked to the prevention of illnesses caused by malnutrition (Kwashiorkor). If a child is well fed, he must consequently have a good growth. As far as pregnant women are concerned, if they have a balanced feeding, they no longer suffer from anemia.” (Nyamasenga Village-Ruyigi)*
- *Increase of appetite (Itahe village-Ruyigi)*
- *Delivery in health facilities (Muyaga village-Cankuzo)*

- *Complete nutrients such as meat for pregnant women (Muyaga village-Cankuzo).*

4. According to you what have been the advantages of your participation in the program? [We would like to know the advantages drawn from the project, child weight improvement at birth?]

- *Decrease in malnutrition related child mortality*
- *Food in the household improved at a low cost and the local products have been improved too. (Nyarubabi village)*
- *Population hygiene and health improvement*
- *“We are locally monitored in hygiene practice.s” (Busyana village-Cankuzo)*
- *“Knowing the food practices for instance, we have learned how to prepare soymilk. With the trainings in food practices, we have noticed that pregnant women who apply the good food practices give birth to children who are healthy and have a weight which is beyond 2.5 kilograms” (Nyamasenga Village-Ruyigi).*
- *“For instance, there is a mother who, before the project gave birth to a child of 2 kilograms, but, with the project’s intervention, she gave birth to a child of 3.2 kilograms” (Nyamasenga Village-Ruyigi)*
- *Production of vegetables limits the times we go to the market for vegetable supply (Village Busyana-Cankuzo)*
- *Sensitization about pre and post natal consultations, referral of the cases of malnourished children to the health facilities (Nyarubabi village-Ruyigi)*
- *Training family planning (Busyana village-Cankuzo)*
- *Following the vaccination schedule (Muyaga village- Cankuzo)*
- *“Child growth is no longer a dream” (Muhene Village-Ruyigi)*
- *“We received goats”*
- *“Woman emancipation ” (Uhene village)*
- *“Prevention of malnutrition-related diseases as kwashiorkor since people master the 3 foods nutrients that are lipids, carbohydrates, proteins and we know which products from which we can get the 3 nutrient groups the products we know from what we can get” (Muyaga village-Cankuzo)*

- “We work in group and reinforces good cohabitation” (Kaniha village- Cankuzo)
The importance of delivering in health facilities (Gitanga village-Cankuzo)
- Knowledge of signs of a pregnant woman at risk (Gitanga village-Cankuzo)
- Knowledge of signs of a child in danger (Gihanga village-Cankuzo).
- The husbands accompany their wives to the health facilities (Gitanga village-Cankuzo)

Child weight variation

	Name of the mother	Before tubaramure	With Tubaramure	With graduation
Muhene village-Ruyigi	Raifa	1.5 kg	3 kg	3 kg
	Aline	2.5 kg	3,9 kg	3.3 kg
	Joselyne	2.7 kg	3 kg	2.7 kg
Gitanga village-Cankuzo		2.5 kg	3 kg	
		2.0 kg	3.5 kg	
Bumba village-Cankuzo	Marie Rose	2.3 kg	3.5 kg	
	Yollande	2.1 kg	3.7 kg	
	Pascasie	2.5 kg	3.5 kg	

5. What changes/differences did you observe at health and nutritional status due to your participation in the project’s program? (Write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, and note whether there is Improvement or not)

Before TUBARAMURE	With TUBARAMURE
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<ul style="list-style-type: none"> - “The eggs were sold.” - “There were dirty hands related illnesses.” - “There were many fistulas cases because women didn’t visit so often the hospitals for pre and post natal consultations.” - “There were malnutrition related illnesses.” (Itahe village-Ruyigi) - “There was a poor feeding” - “Women didn’t know at what period they should give food to their children, they could even do it for a child who is under 6 months.” - “Maternal milk was not abundant.” (Village Kirasira) - “Children were born with less weight.” (Kirasira village) - “We didn’t know the malnutrition symptoms.” - “Pregnant women ate once or twice a day.” (Nyamasenga Village-Ruyigi) - “We didn’t know how to use locally available products in order to have a balanced diet.” - “Women didn’t know how to breastfeed the children; they do so if they have time only.” - “Women didn’t know that they have to undergo 4 pre-natal consultation and 2 post-natal 	<ul style="list-style-type: none"> - “Eggs are consumed at the households level.” - “There are no dirty hands related illnesses due to hygiene improvement.” - “There are no malnutrition related illnesses” - “There are not many cases of fistulas due to the fact that women visit the health centers or hospital for pre and post natal consultations.” - “There is food improvement in households.” - “They know the period at which they can give food to their children. Example: after 6 months.” - “Maternal milk increased.” (Kirasira village) - “Children, are born with improved weight.” (Kirasira village) - “We know how to screen malnutrition cases.” - “Pregnant women eat three times a day.” Nyamasenga Village-Ruyigi) - “We know how to use the locally available products in order to get balanced diet.” - “Women know that they must breastfeed their children many times and at a real moment.” - “Women know that they must
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<p>consultations.”</p> <ul style="list-style-type: none"> - “There were parents who didn’t bring their children to the health center or hospital for vaccination, or there were some parents who didn’t heed the vaccination calendar.” (Nyamasenga Village-Ruyigi) - “Discomfort and anemia during pregnancy.” (Munazi village) - “There were many cases of child and mother mortality.” (Itahe village-Ruyigi) - “There were cases where mothers would deliver their babies at home.” (Busyana village-Cankuzo) - “Children were not well breastfed.” (Muterero village-Cankuzo” 	<p>undergo 4 pre-natal consultation and 2 post-natal consultations”</p> <ul style="list-style-type: none"> - “Parents know that they must bring their children to the health center or hospital for vaccination and they respect the calendar ” (Nyamasenga Village-Ruyigi) - “Neither discomfort nor anemia during the pregnancy.” (Munazi village-Ruyigi) - “Child mortality cases diminished.” - “Women deliver in health facilities.” - “Children are breastfed up to two years.” (Muterero village - Cankuzo)
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- *“Before the program, we could give a banana to a child, and we didn’t help him when he/she was eating. When the banana falls down and get dirty, we didn’t wash it he could eat it like that. Today, however, we wash our hands, and we help our children to eat the banana.” (Muterero village-Cankuzo)*
- *“The dietary prohibitions reduced or are broken especially in consumption of animal proteins such as meat. In the former times, the meat was consumed only by men.” (Kigati village-Cankuzo)*

6. Give some examples of good sanitation and nutritional practices that you apply now?

Hygiene and sanitation

- *“Our kitchen utensils are always clean.”*
- *“Our households are clean.”*

- *“We use humid enveloping in case a child has fever.”*
- *“We go the hospital or health center for pre and post consultations.”*
- *“We make vaccination for our children.”*
- *“We wash our hands before we take our meal.” (Nyamasenga village-Ruyigi)*
- *“Pre-and post-natal consultations.”(Busyana village-Cankuzo)*
- *“We respect the immunization schedule.” (Muyaga village-Cankuzo)*
- *“Women’s delivery in health facilities.” (Kaniha village-Cankuzo)*
- *“Use of mosquito nets.”(Gitanga village-Rcankuzo)*
- *“In case of diarrhea, we know that we must give a lot of drinks except alcohol to prevent dehydration.” (Muterero village-Cankuzo)*
- *“In case of fever, there is a wet wrap you put on the forehead before arriving at the health facility.” (Muterero village-Cankuzo)*

Nutrition

- *“We prepare soymilk”*
- *“Our children are fed with eggs if they are available.”*
- *“We consume food containing three groups of nutrients such as proteins, lipids, and carbohydrates. We also eat fruits, eggs and we drink milk.” (Nyamasenga Village-Ruyigi)*
- *“We prepare cereal mixture in order to make the porridge for the children.”*
- *“We set up kitchen garden.”*
- *“Preparing food which is rich in nutritious elements:
Example: Bean + Cassava + vegetables, rice + potato + beans + vegetables” (Muyaga village-Cankuzo)*
- *“Drinking clean water” (Muyaga village-Cankuzo)*
- *“Eating 3 or 4 times a day” (Muyaga village-Cankuzo)*
- *“Eating fruits” (Muyaga village-Cankuzo)*
- *“Varying food diets” (Muyaga village-Cankuzo)*
- *“We no longer give alcohol drinks to our children and we know how to make soy milk”
(Kaniha village-Cankuzo)*

7. Lessons Learned/Testimonials/Proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary

- *“In life, we learn from others and the experiences of other people allow improving one’s knowledge. The case of using local products for preparing food mainly the porridges for the children is very relevant. All the products to be used are available at the local level and they are not expensive. What is surprising is that we ignored how to make use of the products which were however available. Now, the milk is not only from animals but also is vegetal (soya milk). If we look at the hand washing station, we observe that it plays an important role in fighting against illnesses related to the lack of hygiene. Still in the area of hygiene, the setting up of latrines equally played a pertinent role in the prevention of dirty hands related illnesses. Before the TUBARAMURE program, people dug a small latrine of 1meter.” (Nyarubabi village-Ruyigi)*
- *“At the health level, women do the pre and post-natal consultations, and this was not done before the program’s intervention. Before, women suffered from fistulas and ignored why. But now that they are sensitized on pre and post-natal consultations, and there are not many cases of fistulas and if there is a problem, the care taking is done on time. As it is said, the curiosity is the mother of science, now we have a lot of knowledge because of the trainings implemented by the program in our favor.” (Nyamasenga Village-Ruyigi)*
- *“Two heads are better than one”, “We learn from others.” (Itahe village-Ruyigi-Ruyigi)*
- *Encouragement to attending FOSA (Busyana village-Cankuzo)*
- *“A bird that moves cannot know where millet is ripe” (Busyana village-Cankuzo), “You learn from others” (Muyaga village-Cankuzo)*
- *“We learned many new things in the trainings provided by the program. We can testify that hygiene was neglected in the past. But now, everyone is mobilized and applies the program’s trainings. Before the program, the production of vegetables was reserved only to the owners of irrigated law lands or swamps, but, now,, even in the dry season, with the kitchen gardens we grow more vegetables. Now we don’t go often to the market to look for vegetables. In the past, the health of a pregnant mother was neglected: a pregnant mother took care of the household chores until the day of delivery, but, now, she can rest and takes a balanced diet three times a day. In combination with the porridge and vegetables, women no longer suffer from anemia and they give birth to children of at least 3 kilograms.” (Muyaga village-Cankuzo)*

- *“Good diet is not related to the consumption of a big quantity; it is, rather, linked to the diversification of meals containing vegetables, fruits, and 3 food groups.” Kigati village-Cankuzo)*
- *“Prevention of diseases is cheap if we apply the health, nutrition and hygiene practices.” (Kigati village-Cankuzo)*
- *“Integrated development of the population may result from groups” (Village Kigati-Cankuzo)*
- *“Everything is possible, simply there is a need of effort. If we apply the advice received and acquired training, we have seen that economic and health development is possible” (Kigati village-Cankuzo)*

Food distribution

21. What do you think of the effect of assistance (food distribution) on the health of beneficiaries (pregnant women and malnourished children under five years)?

- *The food distribution has a positive effect. It has allowed health improvement for children of five years and for pregnant and lactating women (Nyagutoha, Nyarubabi, Rubanga, Nyarurambi, Itahe, Busyana-Ca Villages)*
- *The weight and height of children at birth has increased (Nyarurambi, Itahe, Misugi-Ca, Busyana-Ca, Kaniha-Ca Villages)*
- *The maternal milk has increased for lactating mothers, (Ruhwago Village)*
- *The malnutrition related illnesses for children under five years have decreased (belly swelling, ...) and for pregnant women (anemia, pregnancy related discomfort), (Nyagutoha, Ruhwago, Rubanga, Nyarurambi, Itahe, Kaniha-Ca Villages), malnourished referrals to Health Centers have decreased. (Itahe Village).*
- *The weights of pregnant and lactating women have increased (Nyagutoha, Ruhwago, Rubanga, Nyarurambi Villages),*
- *Good health [has come] for pregnant women; they are more resistant to illnesses (Busyana-Ca, Kaniha-Ca Villages)*
- *The agricultural production has also increased thanks to the women’s good health (Nyarubabi Village),*

22. What difficulties did you encounter?

- *The fatigue and hunger (Village Kaniha-Ca)*

- *The quantity of food to be distributed was reduced; small quantity of vegetable oil : 1.5 litres instead of 2 litres, 15 kg of flour instead of 18 kg; some food was stolen (Nyagutoha, Ruhwago, Misugi-Ca Villages)*
- *Women who have twins received the same quantity of food as those with one baby; those foods could not cover the whole month (Ruhwago Village),*
- *The beneficiaries were removed from the list before 24 months (for instance; at 18 months instead of 24 months). (Ruhwago , Rubanga Villages)*
- *The waiting period for food reception was very long and the beneficiaries got late at home. Ruhwago, Rubanga Villages)*
- *The witchcraft between the beneficiaries and non beneficiaries (Kaniha-Ca Village)*
- *The conflicts between lead mothers and beneficiaries in case of error of early graduation (Itahe Village) by HNP or if some women were not registered as beneficiaries.(Itahe, Busyana-Ca Villages). “We lead mothers are accused of corruption because the HNP had limited the number of beneficiaries”.(Busyana-Ca, Kaniha-Ca Villages)*
- *The misunderstanding between lead mothers and their husbands. “They accuse us for no longer do housework at home”. (Kaniha-Ca Village)*
- *The eligibility criteria for beneficiaries were not objective. (Busyana-Ca Village)*
- *No encountered difficulties (Nyarubabi, Nyarurambi Villages).*
- *«We did not encounter any difficulties because we were given food on time; the number of kilos registered was equal to the number distributed : 18 kg for a pregnant woman and 15 kg for a 6 month child » (Nyarurambi Village)*

23. What are the main challenges related to the care taking of malnourished children at the community level?

- *Malnutrition related illnesses (anemia, belly swelling, insufficient, small height, red hair) [Village Ruhwago]*
- *Lack of appropriate food in some households (Misugi-Ca, Busyana-Ca Villages)*
- *Lack of nutritional support; the harvest was bad because climate changes (Village Rubanga) did not allow our practices and acquisitions to materialize in the caretaking of our children. (Itahe Village).*
- *Women overwork in household chores (Itahe Village).*

- *The detection of malnourished children by community members who did not attend training programme of the project remains a challenge for them because they do not know the criteria for detection. (Nyarubabi Village)*
- *Poverty remains a challenge for malnutrition prevention, because there is a lack of balanced nutrition (Busyana-Ca Village)*
- *The family does not accept referral for malnourished children who did not benefit from TUBARAMURE assistance (Busyana-Ca Village)*
- *No challenges related to the care taking of malnourished children at the village level. (Nyagutoha, Nyarurambi, Kaniha-Ca Villages),*

24. Learnt lessons/ Testimonies/ proverbs. (Note: pay attention to relevant stories related to success, failure, story of changes, if those aspects are ... during the focus, after the interview, get closer to the person and deepen his/her story by giving name, sex, age, period and summary)

- *Food assistance (porridge) has allowed children and pregnant women to improve their health status. Example: increase in weight for children under five years, decrease of dizziness and headaches for pregnant women (Beatrice Butoyi, aged 33 years old), (Nyagutoha, Busyana-Ca, Kaniha-Ca Villages), mortality decrease in children under five years, thanks to food practices and hygiene; construction of latrines and body hygiene for children and mothers. (Muhene Village)*
- *The preparation of porridge from local food products in the community (Busyana-Ca, Kaniha-Ca Villages)*
- *The distinction between iodized salt and non iodized salt (Kaniha-Ca Village)*
- *Tubiri tuvurana ubupfu « Two people heal each other's weaknesses »*
- *Ntawusimbiza uwutisimbije « You cannot help anyone against his will»*
- *Ubwiza buca mu kanwa "the beauty passes through the mouth/ food is source of beauty" (which means that when one eats good food, he becomes healthy.) (Misugi-Ca Village)*

SILC activities

25. Since SILC activities began, what changes/differences do you observe in your work ? (Note the change mentioned by participants, ask for concrete examples to support your opinion)

Before SILC	After SILC
<ul style="list-style-type: none"> - Lack of credit. Women had lots of daily family needs but had no one to ask for a credit. If they asked from their neighbors, their neighbors did not have any money to lend them.(Nyagutoha, Rusange,Muhene, Misugi-Ca, Busyana-Ca Villages) - Lack of money to cover family needs; to buy small domestic animals (Villages Nyagutoha, Rusange,Muhene) - Credit with a higher interest (0%) and with a guarantee (Nyagutoha, Rusange,Muhene, Misugi-Ca, Busyana-Ca Villages) - No savings (Misugi-Ca Village) - Misuse of money (drinking in pubs)(Village Misugi-Ca) - Lack of social cohesion (Muhene, Misugi-Ca Villages) 	<ul style="list-style-type: none"> - Easy access to credit since women joined SILC, they have the ability to save and ask for credits allowing them to cover their family needs. (Nyagutoha, Rusange,Muhene Villages) - Purchase of small domestic animals thanks to SILC credit. (Nyagutoha, Rusange, Muhene, Misugi-Ca, Busyana-Ca Villages) - Reasonable interest (10%) and without a guarantee (Nyagutoha, Rusange, Muhene, Misugi-Ca, Busyana-Ca Villages) - Savings (Village Misugi-Ca) - Friendship establishment (Muhene, Misugi-Ca Villages) - Reduction of poverty (Rusange Village) - Availability of seeds for ongoing seasons (Rusange Village) - Children education is supported. « We manage to pay the school fees for our children thanks to SILC». (Rusange Village)

26. What arrangements did you make to continue SILC activities after the project withdrawal? (note arrangements mentioned by participants at the interview)

- *Continue the contributions, savings and credits (Nyagutoha, Muhene, Misugi-Ca Villages)*
- *Pay back the credits with interests (Nyagutoha, Muhene Villages)*
- *Rent the fields for agriculture (Busyana-Ca Villages Villages)*
- *Practice agriculture and animal husbandry (Misugi-Ca Village)*
- *Need for them to have a farm for crops so that they can sell their harvests in order to increase their capital. (Nyagutoha Village)*
- *Buy small domestic animals to have organic fertilizers (Busyana-Ca,Misugi-Ca Villages)*

- *Continue the group functioning (Rusange Village)*
- *Entertain relationship. (Muhene Village)*

27. What suggestions or recommendations do you make within the follow up and reinforcement of SILC activities? (note all suggestions evoked by participants at interview)

- *Organize training sessions and visits (Nyagutoha, Muhene, Misugi-Ca Villages) « We need experts who can train us on the follow up and reinforcement of our activities particularly by showing us how we can earn a lot of money».(Nyagutoha Village)*
- *Build capacities for SILC members (Misugi-Ca Village)*
- *Initiate income generating activities; provision of millstones and cattle (Muhene, Misugi-Ca Villages)*
- *Distribution of watering containers, improved seeds (Muhene Village) and small domestic animals to continue SILC activities (Busyana-Ca Village)*
- *Support materially, morally, and financially the group to elevate the level of credits (Villages Muhene, Rusange), Reinforce SILC cash (Rusange Village)*

Annex IV.C. Summary Comments from Non-beneficiary Mothers

- 1. I would like to talk with you about children's health and nutrition status before the arrival of Tubaramure program in your area. (What were the frequent diseases? Do you know the symptoms of malnutrition? How was the care organized?)**

Health status

- *“Before the program, Tubaramure, arrived in our community, many households had no latrines or platforms for utensils. Also, there were no hand washing stations. However, with the coming of TUBARAMURE program, households have set up latrines and washing stations. Hygiene has improved and people know the most critical moments during which they must wash their hands.”(Nombe village- Ruyigi-Ruyigi)*
- *“Diseases like diarrhea, cholera and kwashiorkor were frequent in our locality.” (Itahe village-Ruyigi)*
- *“Children have swelled cheeks and feet (Itahe village-Ruyigi-village-Ruyigi)”*
- *“Some diseases were related to malnutrition. For example, I have a child who was suffering and I did not know what illness he was suffering from. I began to see that he was losing weight and after a few days, feet, arms, and cheeks started to swell and I thought he regained weight. But after the hair became red. My neighbors told me that it was kwashiorkor. At the health center, we were given porridge, but they did not teach us how to prepare our own food at home.” (Itahe village)*

Nutritional status

- *“Before TUBARAMURE program, there were many cases of malnutrition of children and pregnant women. Women suffering from malnutrition believed that they were bewitched and refused to go to the hospital or health center.” (Nombe-village Ruyigi)*
- *“The most common diseases are diarrhea, intestinal worms, and they are especially common amongst children. These diseases are related to malnutrition” (Nombe village-Ruyigi)*
- *“The signs of malnutrition: swelling of the cheeks, swollen elbows, swelling of the feet, and the hair becomes red and smooth.” (Itahe village-Ruyigi)*
- *“We did not know how to feed our children; for example, after weaning, even if the child was less than a year old, he would leave the house with a plate of sweet potato, and it was [his food] for the whole day.”(Itahe village-Ruyigi)*

- *“There were people who would consult the doctors at the health facilities and others who go to the witch doctors” (Nombe village-Ruyigi)*

2. According to you, what are the program’s main interventions during the last 5 years in your locality as far as pregnant and lactating mothers are concerned?

Health

- *“The program has taught women the importance of attending health centers for prenatal and postnatal consultations.” (Itahe village-Ruyigi)*

Nutrition

- *“The program distributed food for pregnant and lactating women” (Nombe village- Ruyigi- Village-Ruyigi)*
- *“The program gave trainings on the preparation of complete nutrients including carbohydrates, lipids and proteins from local products for example preparing porridge from boiled beans, corn, soy, peanuts. The program organized cooking demonstrations except that we did not have the opportunity to participate” (Itahe village–Ruyigi)*

Groups

- *« Many beneficiaries were trained on the creation of groups, and they received books, chickens» (Itahe village-Ruyigi)*

3. What hygiene actions did you learn with the project intervention? In your locality? Give the advantage?

- *“Washing hands with soap before feeding children, before and after meals and after using the toilet” (Nombe village-Ruyigi)*
- *“Wash hands with clean water and soap before eating, after toilet, before breastfeeding. We need a well-built and maintained toilets even if we do not do like TUBARAMURE beneficiaries, we try to imitate them. This allows us to prevent diseases such as diarrhea, dysentery, and malaria. We learn all these actions from our neighbors who are TUBARAMURE beneficiaries. It is time we increased public awareness further because these good hygiene practices are gradually disappearing. For example, garbage pits are barely functional in many households.” (Itahe village- Ruyigi)*
- *Digging latrines and compost (Nombe village-Ruyigi)*

- *“These hygiene good practices are copied from our neighbors who underwent sensitization provided by the Tubaramure Program.” (Nombe Village-Ruyigi)*

4. What are the good food practices did you learn from in your locality?

- *Consumption of balanced meals consisting of proteins, lipids, carbohydrates more vegetables "(Nombe village- Ruyigi)*
- *“We eat what we grow here” (Itahe village-Ruyigi)*
- *“Today, we know how to prepare some food. For example, I know that when I prepare beans + vegetables (lengalenga), I can add peanut flour” (Itahe village-Ruyigi)*
- *“For the food practices, it depends on the resources and the responsibility of the people because, there people who may have different types of food but don’t know how to prepare them, and others who know how to prepare food but are not able to get it” (Itahe village-Ruyigi)*
- *«If we look at our neighbors who learned how to prepare food in TUBARAMURE, there are people who don’t even try in their households (Village Itahe-Ruyigi)*

5. What changes/differences did you observe at health and nutritional status due to your participation in the project’s program? (write down all the answers; ask the participants illustrate; give examples, if there are any; look for personal examples to be deeply explored; note whether there is Improvement or not]

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - Cases of malnutrition were many - Women did not vaccinate their children - Mothers gave alcohol to children - There were too many childhood diseases such as diarrhea, dysentery, and malnutrition-related diseases 	<ul style="list-style-type: none"> - Malnutrition cases decreased significantly - Women have their children vaccinated - Mothers do not give alcohol to their children

6. Learned lessons/testimony/proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary)

- *"We must take into consideration the great importance of children's health because they are the Burundi of tomorrow." (Nombe village -Ruyigi)*
- *"We learned how to prepare porridge with local products to prevent diseases related malnutrition" (Itahe village Ruyigi)*
- *"We know in general that if children eat meals that contain vegetables and oil or peanuts. Children have a good weight gain "(Itahe village-Ruyigi)*
- *"We learned how to prepare the gardens to produce vegetables"*
- *"We learned how to build latrines and we wash our hands with soap and water" (Itahe village-Ruyigi)*

7. Are you member of pastoral group?

- *No*

8. Are you a member of SILC group?

- *No*
- *"We say that all these activities are limited to the beneficiaries of TUBARAMURE. Even in the release at the church, they invite only beneficiaries. Back from the meetings, the beneficiaries do not share the acquired knowledge with their non-beneficiary neighbors. We believe that it does not concern us" (Itahe village Ruyigi)*

Annex IV.D. Summary Comments from SILC Group Members

1. How your SILC Group established?

- *By TUBARAMURE Program sensitization and mobilization on the importance and advantages of SILC Groups (savings, loans without guarantor and mortgage, social cohesion, mutual assistance) [Rubanga, Busyana-Ca, Misugi-Ca, Kigati-Ca Villages],*
- *Our group was established after the development of internal regulations and facilitation program for the act of recognition by the Commune. (Nyamasenga and Nyarurambi Villages),*
- *It was established after the trainings based on savings and loans, health care, hygiene and nutrition. (Misugi-Ca Village)*
- *It follows from Tubaramure sensitization on the sustainability of the project activities on one hand, and, on the other hand, on the preparation of beneficiaries self care after the program withdrawal. (Village Muterero-Ca).*
- *We started the group activities on 18 April 2014 and we called it SILC KEREBUKA. (Muterero-Ca Village).*

2. Why did you establish your SILC Group?

- *Maintain TUBARAMURE good practices (Kaniha-Ca Village)*
- *In order to save and provide for our daily needs (Nyagutoha Village) such as the purchase of school materials and payment of school fees for the children (Kigati-Ca Village)*
- *To help one another (for example, a partner who lost an immediate family member, a hospitalized member, a member who gave birth, ...), and maintain social cohesion (Nyarubabi, Busyana-Ca, Gitanga-Ca, Kigati-Ca Villages).....*
- *To do common agricultural activities to counteract climate hazards (Muterero-Ca Village)*
- *To establish dialogs on the households issues (Misugi-Ca Village)*
- *To access to loans easily (Nyarubabi, Misugi-Ca Villages) without much interest rate (Village Misugi-Ca). “Before SILC, when I borrowed money from my neighbor, he could accept or decline. If he would lend me the money, he asked me to give him my property over a high interest rate. It even happened that the entire property could become his property”. (Nyarubabi Village)*
- *Be able to save (Misugi-Ca Village)*
- *Avoid mortgaging our fields (Busyana-Ca Village) (Busyana-Ca Village)*

- *For the SILC member, if you lend money, you pay back 10% of what you give and the 10% that you put back in the fund becomes your own money as dividends.. (Nyagutoha, Misugi-Ca Villages)*
- *Continue to provide balanced nutrition for our children so that they remain healthy (Kaniha-Ca Village). "The food distribution was no longer taking place; we had to find other ways to get appropriate foods for our children". (Kaniha-Ca Village)*
- *Be able to self finance IGA (Nyamasenga , Munazi, Gitanga-Ca, Villages), agriculture, animal husbandry and small businesses. (Gitanga-Ca, Kigati-Ca Villages)*
- *Take care of self medically (Nyamasenga Villages)Se prendre en charge médicalement (Villages Nyamasenga, Kigati-Ca),*
- *Create the currency when sharing dividends (Nyamasenga, Munazi Villages)*
- *For self development and development of households and locality (Villages Kaniha-Ca, Gitanga-Ca, Kigati-Ca)*
- *Be able to find a body for channeling aids (Muterero-Ca Village)*
- *"Our group was created to see if we can reduce poverty and sustain cohesion and social support" (Nyarurambi, Misugi-Ca, Busyana-Ca Villages)*

3. What guidance or trainings did you receive from the project (ex; Training, sensitization on EAN and EAH?)

Nutrition

- *We received initial training to be able to start the group, awareness and training on EAN and EAH as well as the importance of becoming a member of a group (savings and loans) (Nyamasenga , Munazi Villages).*
- *Exclusive breastfeeding for 6 months, (Rubanga, Nyarurambi, Misugi-Ca, Kaniha-Ca Villages)*
- *Light diet (porridge)for a child from 6 months (Kaniha-Ca, Kigati-Ca Villages)*
- *Development of kitchen gardens (Rubanga, Nyarurambi, Busyana-Ca, Misugi-Ca, Kaniha-Ca, Gitanga-Ca, Kigati-Ca Villages)*
- *Food variation (Nyarurambi Village) for pregnant and lactating mothers and children (Misugi-Ca Village)*
- *Intake of foods containing carbohydrates, lipids and proteins 3 times a day (Nyarurambi, Busyana-Ca, Kaniha-Ca Villages) for children under five and pregnant and lactating women (Kaniha-Ca Village). «On EAN, we received trainings on food practices; preparation of a*

balanced diet containing carbohydrates, proteins and lipids » (Nyarurambi, Busyana-Ca, Muterero-Ca, Gitanga-Ca, Kigati-Ca Villages),

- *Preparation of soy milk (Kigati-Ca Village)*

Hygiene

- *On EAH, we learnt how to construct hand washing stations, the hand washing moments (Nyarurambi, Misugi-Ca, Kaniha-Ca, Muterero-Ca, Gitanga-Ca, Kigati-Ca Villages), how to construct drying racks for kitchen utensils and how to maintain them, to clean inside and outside the house (Kaniha-Ca, Gitanga-Ca, Kigati-Ca Villages), how to construct latrines with a cover (Busyana-Ca, Gitanga-Ca, Kigati-Ca Villages), how to do laundry, to keep water in clean jerry cans and develop garbage pits (Rubanga, Nyarurambi, Misugi-Ca, Muterero-Ca, Gitanga-Ca, Kigati-Ca Villages), how to install showers for personal hygiene, as well as when and how to change children's clothes (Busyana-Ca Village)*
- *Two members of the group received the training on the fund management and the handling of contributions and loans register. (Nyamasenga, Munazi Villages)*
- *« We learnt nothing on nutrition and health. The community agent came and talked only about SILC ». (Nyagutoha Village).*

Sensitization on Health

- *Prenatal consultations for pregnant women at least times before delivery and postnatal consultations after delivery (Gitanga-Ca, Muterero-Ca, Kigati-Ca Villages)*
- *Medical consultation in case of children's illnesses (Kigati-Ca Village)*
- *Children immunization, (Misugi-Ca, Gitanga-Ca Villages)*
- *Regular child growth monitoring to be aware of increase or decrease in weight. (Misugi-Ca, Gitanga-Ca Villages)*
- *Use of MUAC (Misugi-Ca Village)*
- *Care after delivery (2weeks) (Nyarurambi Village)*
- *Compliance with the Statute and the Rules of Procedure (Busyana-Ca Village)*
- *Use of mosquito nets (Gitanga-Ca Village)*
- *Respect of children and pregnant women's immunization schedule (Gitanga-Ca Village)*
- *Family planning (Kigati-Ca Village)*

4. Since SILC activities began, what changes/differences do you observe in your work? (Note the changes evoked by participants, ask for concrete examples to support your opinions)

Before SILC group	With SILC activities
<ul style="list-style-type: none"> - Lack of money in the households for family needs (Nyagutoha, Nyarurambi, Busyana-Ca, Kaniha-Ca Villages) - No savings (Misugi-Ca Village) - Loans with high interest rate and with mortgage or guarantor (Nyagutoha, Nyamasenga, Nyarurambi, Munazi, Busyana-Ca, Misugi-Ca Villages) - We could not provide us with basic needs (soap, clothes, salt, cooking oil, body lotion, etc...).[Nyamasenga and Munazi Villages]. - “We were afraid of approaching anyone to borrow money from him. If someone accepted, you paid him back with a very high interest rate.” (Nyagutoha Village). - We had to go through Tanzania, neighboring country to search for a job in order to start up IGAs (Nyamasenga Village). - We did not have funding for a small business; there was no social activity (Munazi Village). Women depended heavily on their husbands.(<ul style="list-style-type: none"> - Grant of credits without guarantor or mortgage (Munazi , Nyarurambi, Busyana-Ca, Misugi-Ca, Kigati-Ca Villages) to members with a reasonable interest rate and possibility to provide us with basic needs such as seeds, clothes, money for medical care, school fees and school materials for children, kitchen utensils, etc ... (Nyagutoha, Nyarurambi, Kaniha-Ca., Gitanga-Ca, Kigati-Ca Villages). - Savings (Misugi-Ca, Gitanga-Ca, Kigati-Ca Villages) - Purchase of small livestock (Villages Kaniha-Ca, Kigati-Ca) - Change of behavior for SILC members as well as other people in their community who get closer to them. People in the community take example on group members. (Nyagutoha Village). The emancipation of women is another change that occurred. Women are no longer waiting for their husbands incomes. They have a financial capital enabling them to undertake IGA and agro-pastoral activities because of contracted loans and dividends. The migrations in Tanzania to search for jobs have decreased. (Nyamasenga, Busyana-Ca Villages). “The lifestyle has changed. Now, I can buy clothes for my whole family. I do income generating activities thanks to contracted loans and dividends” (Busyana-Ca Village) - Improvement of households standards of living (Nyamasenga, Busyana-Ca, Gitanga-Ca, Muterero-Ca Villages,) - Crop rotation assistance among members in farming (Busyana-Ca Village) - Material and financial support among SILC members in case of illnesses (Busyana-Ca, Misugi-

<p>Nyamasenga Village).</p> <p><u>Hygiene</u></p> <p>Before Tubaramure program by CRS that initiated SILC, some hygiene rules were not at all respected ; for instance, we didn't wash our hands after toileting. (Nyamasenga Village)</p> <p><u>Health</u></p> <p>No prenatal and postnatal consultations for pregnant women (Nyagutoha, Nyamasenga,)</p> <p>Feeding children under six months (Munazi Village)</p> <p>No child growth monitoring (Gitanga-Ca Village)</p> <p>No respect for child immunization schedule (Munazi, Gitanga Villages)</p> <p><u>Nutrition</u></p> <p>No balanced diet (Nyagutoha Village)</p>	<p>Ca, Gitanga-Ca, Muterero-Ca Villages)</p> <p>- Dialog on the households issues (Rubanga Village)</p> <p><u>Hygiene</u></p> <p>With Tubaramure program by CRS, members learnt to wash their hands after toileting, before food preparation, before feeding children, etc... Thus, they learnt to set up hand washing stations. They also learnt to build drying racks for kitchen utensils to maintain them clean after washing them, to build latrines and maintain them clean. (Nyamasenga Village),and set up and use garbage pits .(Nyamasenga Village)</p> <p><u>Health of Mother</u></p> <p>Pregnant women are aware of the importance of prenatal consultations (4 consultations) and postnatal consultations and go for them (Nyagutoha, Nyamasenga Villages). Thus, some illnesses decreased.</p> <p><u>Health of Children</u></p> <p>Exclusive breastfeeding for 6 months, respect of child immunization schedule, and regular growth monitoring.(Munazi, Gitanga-Ca Villages)</p> <p><u>Nutrition</u></p> <p>Women learnt good nutrition practices: to prepare a balanced diet that contains three food groups (carbohydrates, lipids and proteins), prepare whole flour by using local products, porridge from soy to feed their children. They also learnt to set up kitchen gardens to improve nutrition for their households. “ We have to make children eat vegetables from our kitchen gardens because we know their usefulness in the nutrition “ (Nyagutoha Village)</p>
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5. What activities are carried out within your group in the context of SILC ?

- Meeting organizations, (Nyagutoha Village)

- *Monthly savings by members.*(*Munazi , Nyarurambi, Misugi-Ca, Gitanga-Ca,Nuterero-Ca, Kigati-Ca Villages*)
- *Granting of loans to members, (Munazi, Nyamasenga , Nyarurambi, Misugi-Ca, Busyana-Ca, Muterero-Ca, Kigati-Ca Villages). “We give one another small loans for doing IGAs” (Busyana-Ca Village)*
- *Collection of contributions, (Munazi, Nyamasenga, Kaniha-Ca, Kigati-Ca Villages)*
- *Members’ mutual and social assistance (visits to inpatient relatives of SILC group members, visits to mothers who have given birth, members who have lost their family members, sharing Christmas and New Year holidays, purchasing glasses for a member who is in need , etc.,.. (Nyarubabi, Munazi, Nyamasenga, Nyarurambi, Misugi-Ca, Kaniha-Ca, Muterero-Ca, Gitanga-Ca, Kigati-Ca Villages).*
- *Community farm works (Munazi, Busyana-Ca, Muterero-Ca Villages)*
- *Agriculture (cassava, soy,beans) [Misugi-Ca Village) and goats breeding (Rubanga, Misugi-Ca, Kaniha-Ca Villages)*
- *Renting fields for a common farming (Busyana-Ca, Kaniha-Ca Villages)*
- *Growing of tripsacum and its sale to breeders (Kigati-Ca Village)*

6. As a member of SILC group, what are the benefits that you received? (ask and note the overall trend that corresponds to response options, select all responses that apply to participants' responses

- *The ability to save for, request and receive loans without guarantor and mortgage (Villages Nyarubabi, Nyamasenga, Munazi, Muterero-Ca) and with a reasonable interest rate (Nyagutoha, Munazi, Misugi-Ca, Busyana-Ca, Muterero-Ca, Kigati-Ca Villages). “The mortgage of our fields is no longer appropriate”. (Village Busyana-Ca)*
- *Self-development (possibility to start up a business, carry out animal husbandry and agriculture that can generate incomes. (Nyamasenga, Munazi, Kaniha-Ca, Muterero-Ca Villages)*
- *Reduction of hoarding and vagrancy in pubs, money can be stolen whereas it’s for saving not for wasting. (Nyamasenga Village).*
- *Nutrition and health improvement , (Nyagutoha Village)*
- *No sowing delay (Kaniha-Ca, Kigati-Ca Villages)*

- *Purchase of school materials for children, payment for school fees, purchase of clothes for the family, building materials, such as tôles, and small livestock, such as pigs [Nyarubabi, Misugi-Ca, Busyana-Ca, Kaniha-Ca, Kigati-Ca Villages].*
- *Mutual assistance (Busyana-Ca Village) in the plowing of fields. (Misugi-Ca, Muterero-Ca Village),*
- *Social cohesion; gain friends. (Misugi-Ca Village)*

7. What arrangements did you make to continue SILC activities after project withdrawal? (note arrangement expressed by participants in the interview)

- *Follow the advice, guidance from Tubaramure program and implement them. ‘ ‘ Even if the project withdrew today, our group will continue’’. (Nyarubabi, Nyamasenga, Munazi , Rubanga, Busyana-Ca Villages),*
- *Continue SILC activities of savings, loans, and contributions (Nyamasenga, Munazi, Rubanga, Nyarurambi, Misugi-Ca, Busyana-Ca, Gitanga-Ca, Muterero-Ca, Kigati-Ca Villages) and increase the latter. Before, we contributed between BIF 500 and BIF 2,500, but, today, we contribute between BIF 1,000 and BIF 5,000,(Kigati-Ca Village)*
- *Increase savings per month up to BIF 5,000 because every member saves BIF 2,000 (Nyagutoha, Busyana-Ca , Muterero-Ca, Kigati-Ca Villages).*
- *Benefit training seminars in funds management; “we only had one training at the beginning of the project. The training would enable us to keep well the cash books of the group”. (Nyagutoha, Muterero-Ca Villages),*
- *Earn more money to buy land for cultivation (Village Nyarurambi)*
- *Continue joint agriculture and livestock activities (Rubanga, Busyana-Ca, Muterero-Ca, Gitanga-Ca Villages)*
- *Auto assistance in the provision of accounting documents such as registers, account books, notebooks, and rulers, etc, because TUBARAMURE project did not give any. (Nyarubabi Village).*
- *Stay in association considering the benefit we derive from the latter. (Nyarubabi Village).*
- *Continue social cohesion (Munazi, Busyana-Ca, Gitanga-Ca, Villages).*
- *Continue to promote dialog around households issues (Rubanga and Nyarurambi Villages)*
- *Continue sensitization to other women on the trainings received from Tubaramure program (Nyarurambi, Misugi-Ca Villages)*

- *Rent fields for SILC group agriculture (Village Kigati)*
- *Put in place the Statutes and increase fines to discourage members who do not pay back the loans. (Kigati-Ca Village)*

8. What suggestions or recommendations do you make in the context of monitoring and reinforcement of your SILC activities ? (note all the suggestions raised/expressed by the participants in the interview)

- *Encourage members in SILC activities ; Continue to give contributions (Nyarurambi, Misugi-Ca, Kigati-Ca Villages)*
- *Organize training seminars for the group leaders; the chief and his/her deputy. The reason for the training of 2 people per group is that if one is not available for various reasons, the other one will in turn the members of her/his group. As there are 3 SILC groups in our village, there would be 6 beneficiaries o the training. (Nyagutoha, Nyarubabi Villages)*
- *Train supervisors from the villages where SILC group is carrying out its activities, which, in turn, can train their members (Nyagutoha, Nyarubabi Villages).*
- *Organize trainings by experts in connection with SILC activities. (Nyagutoha, Munazi, Rubanga Villages)*
- *Provide additional training on SILC activities (Rubanga, Misugi-Ca Villages) and enable exchange of experience with other SILC groups in other provinces of the country and those of neighboring countries. (Nyamasenga, Munazi, Muterero-Ca-Ca, Gitanga Villages)*
- *Raise awareness of those who did not join SILC groups (Nyagutoha, Nyarubabi Villages)*
- *Support SILC groups materially by providing watering cans, hoes, improved seeds, chemical fertilizers, etc (Busyana-Ca, Kigati-Ca Villages) and financially by giving sufficient capital in order to do business and diversify projects such as agriculture and livestock projects (Nyarubabi, Nyarurambi, Busyana-Ca Villages).*
- *Provide safety deposit boxes, books and calculators (Nyarubabi Village)*
- *Support the funds for the groups because credit applications often exceed the limits of the funds. (Nyamasenga and Munazi Villages)*
- *Motivate the head (chairperson) of the group / community worker with a salary or lump sum of money periodically (Nyamasenga, Muterero-Ca Villages)*
- *Support the responsible for SILC group in communication and transportation (Muterero-Ca Village)*

- *"Continue to consolidate our SILC for self development and self-production thanks to our strength" (Nyarurambi Village)*
- *Raise awareness on the importance of Statute and Rules of Procedure (Kigati-Ca Village)*
- *Regularly monitor the groups (Nyarubabi Village).*

9. Lessons Learned / testimonials / proverbs on SILC activities. (Note: pay attention to relevant reports related to success stories, stories of failure, stories of changes, if these aspects emerged during the focus, after the interview, approach the person and deepen his/her story by giving the name, sex, age, the period, the brief summary)

- *"I learned to save. Before SILC, when I harvested, I sold everything and I was just drinking beer. SILC is like a SACCO that is in our community. "(Busyana-Ca Village)*
- *Raising the standard of living of households because of the active participation in groups. (Nyamasenga, Munazi, Villages)*
- *Acquisition of knowledge about nutrition, health and hygiene by Tubaramure program. (Nyagutoha Village)*
- *Self-development with Poverty Reduction through easy access to credits and purchase of basic needs (Nyagutoha Village),*
- *Purchase of seeds during the agricultural/growing season (Nyagutoha Village)*
- *Hospital care thanks to credits. There are also emergency credits that are granted to members of SILC group. (Nyagutoha Village) ..Achat des semences pendant la saison culturale, (Villages Nyagutoha*
- *Social cohesion sociale and mutual assistance. " We, group members, we assist one another and are very close ; one can say that we come from the same family. Our group has reinforced our relationships"*
- *Disciplinary measures to overcome the absences and delays in meetings were taken. For absence, the fine is BIF500, for a delay of 0-10 minutes, 10-20 minutes, 20-30 minutes, 30-40 minutes, 50 minutes or more, the fine is respectively BIF100 , BIF200, BIF300, BIF400 and BIF500. Regarding the delay in the repayment of the loan, the amount is BIF500. (Nyagutoha Village).*
- *Ubugigiri bugira babiri "Unity is strength" (Villages Nyagutoha, Nyarubabi, Munazi, Nyamasenga, Busyana-Ca, Gitanga-Ca),*
- *Inyakamwe inyaga imwe ., A lonely person will confiscate only one cow (Village Nyarubabi)*

- *Nyamwigendako ntarimira impeshi.* '' If you are alone, you will not plow for the dry season ''(Villages Nyarubabi, Munazi, Nyamasenga)
- *Ubwenge burarahurwa .* « We learn from others » (Nyarubabi Village)
- *Tubiri tuvurana ubupfu* «Unity is strength », If two people are together, they heal each other's weaknesses ''(Village Nyagutoha,Nyamasenga)
- *Umutwe w'umwe ntiwigira inama.* "Two heads are better than one"(Villages Nyarubabi, Munazi, Nyamasenga, Nyarurambi).
- *Akanyoni katagurutse ntikamenya iyo bweze* "If a bird stays in one place, it won't know where the finger millet/wheat is ripe" (Nyarubabi, Munazi, Nyamasenga, Muterero-Ca Villages)
- *Ibisangiye imizi bisangura n'ukuma* "Those who share roots share problems" (Nyarubabi , Nyamasenga Villages)
- *Imitwe ikora ikoranye* (Gitanga-Ca Village) "Many heads together become efficient"
- *Ugenda utabaza ugasaza utamenye* (Gitanga-Ca Village) "If you go without asking, you will remain ignorant"
- *Bukebuke nirwo rugendo* (Village Muterero-Ca). "By walking slowly but surely, you achieve your goal"
- *"We do not support one person, we support the group* " the donors' Policy "(Village Nyarurambi)

Annex. IV.E. Summary Comments from Groupement Members

1. How and when was your group established?

- *“We would like to point out that we were women beneficiaries of food distributed by TUBARAMURE. When the program stopped giving us food, Health and Nutrition Promoters suggested that we regroup in associations, after being taught by TUBARAMURE of CRS and the media the importance of groups (Nombe Village) and the merits of being in associations/groups to carry out development activities such as agriculture and animal husbandry (Nyagutoha Village). We then created the group TWIYUNGUNYANE. (Ruhwago Village). In addition, it is easier to support an association/group than an individual (Nyamasenga, Muyaga-Ca Villages). The groups started respectively on 09 April 2013 (Nyagutoha Village), on 14 August 2013 (Nombe Village), in August 2013 (Nyamasenga Village), in April 2013 ; « it follows from trainings received from the program preaching independence of groups after donors withdrawal. A motivation to get goats is also promoter” (Muhene Village).*
- *Indeed, TUBARAMURE program activities were precursors and initiators of groups in our community. (Nombe Village). « Our group was put in place on 27 September 2013. It followed from trainings received by TUBARAMURE PM2A project, and focused on the interest of working in groups (social cohesion, mutual assistance) » (Busyana Village).*
- *Our group is called TUGARUKIRE AGATEKA K'IBIBONDO (protect the rights of children), established on 14 December 2013.*
- *Our group was set up in March 2012. This group was first SILC group, but, as we didn't have money, we changed it into agro-pastoral group to be able to benefit from assistance. (Kaniha-Ca)*
- *Tubaramure raised our awareness of the merits of being in associations after graduation. Their ideas pleased us and we got together to make up a group called « DUZIKIVI » on 23 June 2013. (Kigati-Ca Village).*
- *Tubaramure agents taught us that, together, we could achieve better development. Our group was put in place on 24 May 2012. (Bumba-Ca Village).*

2. What guidance or trainings did you receive from the project (ex ; Training, sensitization on EAN and EAH?)

- *Building public awareness of the importance of EAN*
- *Exclusive breastfeeding for the child from birth to 6 months (Muyaga-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Breastfeeding the child immediately after birth (Kigati-Ca Village)*

- *Preparation and consumption of a balanced diet , containing carbohydrates, lipids, and proteins, for pregnant and lactating women and children under five. (Busyana-Ca, Muyaga-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca)*
- *Porridge preparation (Bumba-Ca Village)*
- *Transformation of soy into milk (Muyaga-Ca, Kigati-Ca Villages),*
- *Layout of kitchen gardens around houses (Muyaga-Ca, Bumba-Ca Villages).*
- *Frequence of meals per day ; 4 times (Kigati-Ca Village)*

Building public awareness of EAH

- *Moments of hand washing (Busyana-Ca, Muyaga-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Installation and use of hand washing stations (Busyana-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Construction of improved latrines with lids (Busyana-Ca, Muyaga-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Development of garbage pits (Busyana-Ca, Muyaga-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Lay out of drying racks for kitchen utensils (Muyaga-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Preservation of clean water in sealed jerry cans (Muyaga-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Personal hygiene for all the household members. (Busyana-Ca, Kaniha-Ca, Bumba-Ca, Kigati-Ca Villages),*
- *Construction of showers (Bumba-Ca Village)*
- *Cleanliness of the house and the yard (Bumba-Ca Village)*

3. Since you started, what changes/differences do you observe in your work? (Note the changes mentioned by participants; ask for concrete examples to support the opinions and support received from project)

- *Mutual assistance has developed, especially in the field of agriculture, (Village Muhene) and the joint work increases, (Ruhwago, Nombe, Nyamasenga, Muyaga-Ca, Kigati-Ca, Bumba-Ca Villages),*
- *Acceleration of agricultural work; rotative assistance in the plowing of our fields (Busyana-Ca, Kigati-Ca Villages)*

- *Women behavior change , (Village Nyagutoha)*
- *Delivery in a health facility, hence reduction of maternal mortality in childbirth (Muyaga-Ca Village)*
- *Savings (Bumba-Ca Village)*
- *Easy access to credits to purchase seeds, for health care or other emergencies, reasonable interest (Ruhwago, Nyamasenga, Muhene, Muyaga-Ca, Bumba-Ca, Kigati-Ca Villages)*
- *Low interest rate (5%) (Kaniha-Ca, Bumba-Ca Villages)*
- *Knowledge of a balanced diet for their children,(Ruhwago , Nombe Villages)*
- *Construction of appropriate latrines and hand washing before preparing food or before meals (Ruhwago, Nyamasenga, Muhene, Villages)*
- *Development of garbage pits, (Ruhwago, Nyamasenga, Muhene Villages)*
- *Self-sufficient and surplus production, hence the fight against hunger in households (Nyagutoha , Nombe, Kigati-Ca Villages)*
- *Gradual reduction of poverty (Kaniha-Ca, Bumba-Ca Villages)*
- *Membership of men in groups and change of their behavior (Ruhwago Village).*
- *Ability to set up a project due to intellectual training by TUBARAMURE (Nyamasenga Village)*
- *Support for soy seeds (Busyana-Ca Village)*
- *Auto care in case of illnesses for a member (Busyana-Ca Village)*
- *Massive participation of women in development activities (Muyaga-Ca Village)*
- *Creation of friendship (Kigati-Ca Village)*
- *Dialog on sur les questions des ménages (Village Bumba-Ca)*

4. Which are the activities carried out within your community?

- *Savings and granting of credits (Nyagutoha, Ruhwago, Muyaga-Ca, Kaniha-Ca, Kigati-Ca, Bumba-Ca Villages)*
- *Joint agriculture (cassava, corn, peanuts, soy, beans, vegetables, potatoes, etc...),(Ruhwago , Nombe, Muhene, Kaniha-Ca, , Kigati-Ca, Bumba-Ca Villages) ,*

- *Breeding of goats given by CRS (Ruhwago ,Nombe , Nyamasenga, Muyaga-Ca, Kaniha-Ca, Bumba-Ca Villages) , and poultry (CRS gave a rooster and the group had to look for a hen (Ruhwago Village),*
- *Labor alternated to increase agricultural production in households (Nombe, Bumba-Ca Villages)*
- *Rent a field to be plowed to a member and use the money from the fund for this purpose (Nombe, Busyana-Ca Villages)*
- *Mutual assistance (in the case of happiness and unhappiness) (Kaniha-Ca, Kigati-Ca Villages)*
- *Regular meetings to raise awareness on the contributions (Nyagutoha, Muyaga-Ca Villages)*
- *Self financig thanks to credits received (Bumba-Ca Village)*

5. As a member of the group, what benefits did you get? (ask the question and note the question and the overall trend of responses)

- *Good hygiene practices: construction of latrines, hand washing stations, drying racks and development of garbage pits (Nyagutoha, Ruhwago, Nyamasenga Villages),*
- *Behavior change, (Nyagutoha Village),*
- *Ability to meet family needs; "We no longer lack soap or salt" (Village Kaniha-Ca)*
- *Social Cohesion (Nombe Village), gain friendships, mutual assistance in all areas; health, education (Busyana-Ca, Muyaga-Ca Villages)*
- *Mutual Assistance in plowing fields (Kaniha-Ca, Kigati-Ca Villages)*
- *Knowledge in the preparation of a balanced diet (Nyagutoha, Nyamasenga Villages)*
- *Preparation of soy (soy milk extraction and preparation of the sauce with the leftovers) and*
- *Knowledge management in the vegetable garden, hence vegetables continuously even during the dry season [Villages Ruhwago, Nyamasenga, Muyaga-Ca], and cultures associated (Ruhwago Village)*
- *Savings in SACCOs (Busyana-Ca, Kaniha-Ca Villages), no hoarding or stealing money (Kaniha-Ca Village)*
- *Easy Loans without guarantor (Kaniha-Ca Village)*
- *Increase in household incomes as harvests have increased (Busyana-Ca Village)*
- *Poverty reduction (Kigati-Ca Village)*

- *Breeding of small ruminants and acquisition of organic manure (Nyagutoha Village)*
- *Sowing and planting are timely (Nombe, Busyana Villages),*
- *" No advantage today due to climate hazards including drought that has damaged our common crops of the group" (Muhene Village)*

6. Quelles dispositions avez-vous prises pour continuer les activités de SILC après le retrait du projet ? (noter les dispositions évoquées par les participants à l'entretien)

- *Follow TUBARAMURE Program's advice and trainings, (Ruhwago, Bumba-Ca Villages) on groups (Busyana-Ca, Muyaga-Ca, Kaniha-Ca, Bumba-Ca Villages)*
- *Continue agriculture and animal husbandry, doing tasks and the money earned goes into our fund,(Nyagutoha , Nyamasenga, Bumba-Ca et Kigati-Ca Villages),*
- *Provide the group members and other community members with refreshment courses on SILC (Nombe Village),*
- *Continue working together (Ruhwago, Nyamasenga, Kigati-Ca Villages) and develop animal husbandry (purchase of other goats) [Nyamasenga Village]. "Consolidate our group using our strengths for collective farming" (Muhene Village)*
- *Stay together in groups after TUBARAMURE program withdrawal (Nyamasenga Village)*
- *Continue the contributions (Muhene Village) and increase them (Kigati-Ca Village)*
- *Look for other partners for support (Muyaga-Ca Village), "We have already made the request in World Vision" (Muyaga-Ca Village)*
- *Continue to develop kitchen gardens (Village Muyaga-Ca)*
- *Participate in meetings scheduled by the general assembly of the group (Village Muyaga-Ca)*
- *Keep Tubaramure Project posters (Village Kaniha-Ca) carefully. "We will keep the posters that Tubaramure program gave us to remember the project activities and continue to educate others who were not beneficiaries of the project." (Village Kaniha-Ca)*
- *Collaborate with technicians in agriculture and animal husbandry for assistance in agricultural and pastoral projects (Village Kaniha-Ca, Kigati-Ca)*
- *Promote dialog on the households issues (Village Bumba-Ca)*
- *Raise awareness of other people who are not in the program on groups (Village Bumba-Ca)*

7. What suggestions or recommendations do you make in the context of monitoring and strengthening of your activities as a group? (note all suggestions mentioned by participants in the interview)

- *Distribute small livestock; goats and pigs for manure, (Nyagutoha Village) or even cattle (Villages Nyamasenga, Busyana-Ca, Muyaga-Ca, Bumba-Ca, Kigati-Ca), "We would like to ask the Tubaramure program to provide us with at least five goats per group" (Muyaga-Ca Village)*
- *Provide improved seeds (potatoes, beans, soy, vegetables...), cuttings resistant to mosaic (cassava) [Nyagutoha, Nombe, Nyamasenga, Kigati-Ca Villages].*
- *Distribute chemical fertilizers (Nyagutoha , Nombe, Busyana-Ca, Kigati-Ca Villages),*
- *Distribute pesticides (Kigati-Ca Village)*
- *Conduct additional training seminars in other provinces and share experiences in agro-pastoral techniques (Nombe, Nyamasenga, Bumba-Ca, Kigati-Ca Villages).*
- *Provide watering cans, hoes and tridents to groups (Village Nyamasenga)*
- *Monitor the activities of groups by TUBARAMURE (Villages Nyagutoha and Nyamasenga).*
- *"The material and financial support is our recommendation" (Village Muhene)*
- *Launch again the program (Village Muhene)*
- *Renew Tubaramure project to support us in agriculture animal husbandry (Village Busyana-Ca)*
- *Have a permanent coach for groups (Village Busyana-Ca)*
- *Have technicians in agriculture and animal husbandry for assistance in our agro-pastoral activities(Villages Bumba-Ca, Kigati-Ca)*
- *Multiply the IGA to consolidate our group (Village Busyana-Ca)*
- *Monitor graduated women to observe their improvement (Village Muyaga-Ca)*
- *Make Tubaramure activities visible (Village Muyaga-Ca). "We call upon Tubaramure program to show our leaders the activities carried out, so that tomorrow or after tomorrow, these leaders can find other donors for us." (Village Muyaga-Ca)*
- *Look for other donors for support (Village Kaniha-Ca)*
- *Benefit from groups mentoring by the Ministry of Agriculture and Animal Husbandry (Village Kaniha-Ca)*

8. Lessons Learned / testimonies / proverbs on Group activities. (Note: pay attention to relevant stories related to success stories, stories of failure, stories of changes, if these

aspects emerged during the focus, after the interview, approach the person and deepen his/her story by giving the name, sex, age, the period, the brief summary)

- *Good knowledge on the latrine, drying racks and hand washing stations construction, hygiene, kitchen garden development, balanced meals, and hand washing moments (Nyagutoha, Ruhwago, Nombe, Nyamasenga, Muhene, Busyana-Ca, Muyaga-Ca, Kaniha-Ca, Bumba-Ca, Kigati-Ca Villages)*
- *Gradual poverty reduction in households, (Nombe Village)*
- *Knowledge in the field of agriculture and animal husbandry, (Nombe Village)*
- *Decrease of malnourished children, (Nombe Village)*
- *Women are more open; they are no longer as shy as they were before thanks to groups (Nombe Village)*
- *"If the bird stays in one place, it won't know where finger millet is ripe" (Nyagutoha Village)*
- *Nyamwigendako ntarimira impeshi "If you stay alone, you cannot go further" (Nyagutoha Village)*
- *Ukuri gushirira mu kuyaga "Truth is revealed while talking" (Nyagutoha Village)*
- *Ubugirigiri bugira babiri "Unity is strength" (Village Nyagutoha)*
- *Ukuboko kumwe kuriyaga ntikwimara "One arm cannot scratch itself properly" or "One person is always limited" (Nombe Village)*

9. How will you continue activities after TUBARAMURE program withdrawal

- *Training for capacity building and refreshments for trainings received by Tubaramure Program (Bumba-Ca Village)*
- *Provide trainings on other life skills (Bumba-Ca Village)*
- *Work together while using our own means (Kigati-Ca Village)*
- *Continue to apply acquired knowledge (Kigati-Ca Village)*
- *Continue to raise awareness on groups (Kigati-Ca Village)*

10. What is your motivation to continue activities?

- *Social cohesion (Kigati-Ca Village)*
- *Our physical and moral strengths (Kigati-Ca Village)*
- *Capital to do small businesses (Bumba-Ca Village)*

Annex IV. F. Summary Comments from Tubaramure Fathers

1. What do you know about Tubaramure program in your locality?

- *“The program has distributed food (vegetable oil and CSB) for pregnant women and children under two years.” (Nyarurambi village)*
- *“Encouraging the beneficiaries not to sell the distributed food” (Nyarurambi village)*
- *“The program gave trainings on hygiene. They sensitized us on the construction of latrines and the setting up of hand washing station as well as the garbage pit. They equally, clean the kitchen utensils and the jerry can to keep water to drink ”*
- *“ The program set up the kitchen garden ”*
- *“ The program sensitized women to attend health centers or hospitals for pre and post-natal consultations”*
- *“ The program sensitized on child vaccination ”*
- *“ The program set up groups ”*
- *“ The program set up SILC groups ” ((Nyarubabi village)*
- *“ the program distributed goats and chickens” (Munazi village”*
- *“ The programme distributed soya seeds” (Nyarurambi Village)*
- *“ The program sensitized on family planning ” (Munazi village)*
- *“ The program gave us kits: training modules, buckets, umbrellas ” (Munazi Village)*

2. What is your involvement level in the program’s activities?

Nutrition

- *“As Tubaramure, we teach the households that they can feed their children by including in their diet the three food groups, such as proteins, lipids and carbohydrates, that we can draw from the local products. We show them the importance of kitchen gardens. We call upon the parents to give fruits to their children.” (Nyarubabi village)*

Hygiene

- *“We equally encourage the households to take into consideration the hygiene practices mainly the setting up the latrines and garbage pits. Each household constructed the platforms for the*

utensils. Still in the framework of hygiene, we advise the parents to buy cosmetic products like soaps the hygiene of the bodies of their children as well as the laundry. Furthermore, we show them how to set up the hand washing station. This allows fighting against the dirty hands related illnesses.” (Village Nyarubabi).

Health

- *“We taught the parents the importance of bringing their children to the hospital for vaccination and growth monitoring” (Nyarubabi village)*
- *“We encouraged the households to actively participate in the observation of family wellbeing and specially the well being of children.” (Nyarubabi village)*
- *“A Tubaramure fathers, we changed the behavior in our households. For example, before the project, fathers left their wives alone in the farms, but due to the trainings and advices from the project, Tubaramure fathers do the farm works and they do the works which require strength like the construction of latrines and garbage pits, etc...” (Nyarurambi village)*
- *“In the area of livestock, we teach the beneficiaries of the small livestock how to take care of the animals received from Tubaramure program.” (Kaniha village-Cankuzo)*

3. According to you, what are the activities that had more impacts on beneficiaries? Why ?

Education on health:

“Due to the trainings given by the program, we have observed a strong birth decrease as well as malnutrition related illnesses.” (Nyarurambi village)

Food distribution:

“Food distribution had a very important impact on the beneficiaries in the sense that women who were pregnant got a good health and consequently, they gave birth to babies who have good weight in comparison with the situation before the program’s intervention. As far as children are concerned, there was a significant impact since the malnutrition cases considerably diminished” (Munazi village)

Education on nutrition:

“The program, through the planned trainings in matter of nutrition, the households is sensitized on the way of preparing meals by using locally available products such as soya flour, peanuts, sorghum flour, beans, corn, etc... The pertinent aspect of the sensitization is related to the use of local products and mainly the setting up of kitchen garden. As impact, you find kitchen gardens in many households.” (Nyarurambi village)

Example: “When I see that the weight of my child doesn’t increase, I take the flour of sorghum + peanuts flour + ndagala flour + ananas and I give them to my child and the latter increase weight.” (Misugi village-Cankuzo)

Education on hygiene:

“Before the program, there were households that didn’t have latrines, but with the program’s interventions, the majority of the households have latrines, and they know the hygiene critical moments.” (Nyarubabi village)

Example: “There were people who defecate in the nature before TUBARAMURE program, but with the program sensitization, this bad habit is decreasing ” (Misugi village-Cankuzo)

Creation of groups:

“Setting up of groups allowed the members to create income generating activities. Example: saving and loan.” (Nyarurambi village)

4. What changes/differences did you observe on children due to project’s intervention? (write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, note whether there is Improvement or not)

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - “The children had malnutrition problems”(Nyarubabi village) - “There were many cases of death related to malnutrition” (Nyarurambi village) - “There were many children who were not vaccinated, and the child growth monitoring was not well done” - “No child growth monitoring” - “There were many diseases related to dirty hands.” (Misugi village-Cankuzo) 	<ul style="list-style-type: none"> - “The children don’t have malnutrition related problems and they are in good health.” (Nyarubabi village) - “The malnutrition cases sensibly decreased.” (Nyarurambi village) - “Many children are vaccinated and there is a good child growth monitoring.” - “Dirty-hand related illnesses decreased.” (Misugi village-Cankuzo)

“My wife was the program beneficiary, and she received food when she had three months pregnancy. When she delivered, the baby weighed 3.10 kilograms. After graduation, the weight improved until 3.90 kilograms, and, through time, the child grew well and without any health concern.” (Munazi village)

5. What changes/differences did you observe at health and nutritional status due to your participation in the project’s program? (write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, note whether there is Improvement or not]

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - “Most of pregnant women didn’t go to the health centers or hospitals for pre and post natal consultations” (Nyarubabi village) - “They didn’t know how to feed their children and at what age they should start to give food to their children.” (Rubanga village) - “There was no family planning.” (Nayrubabi village) - “There were many problems in the households because there were conflicts between the husbands and their wives.” Munazi village) - “Women didn’t deliver at the hospitals.” (Misugi village-Cankuzo) 	<ul style="list-style-type: none"> - “Most of the women go to the health centers or hospitals for delivery for pre and post natal consultations” (Nyarubabi village) - “They know how to feed their children and from what age they can start to give food to their children.” (Rubanga village) - “There was no family planning.” (Nyarubabi village) - “There is no conflict between husbands and wives.” (Munazi village) - “ Body hygiene improved and the households are clean.” (Nyarurambi village) - “Pregnant women deliver at the hospital.” (Misugi village-Cankuzo)

“Before the program, women rarely consulted health care facilities, but with the program, women consult the health facilities for pre and post-natal consultations when the pregnancy is 3 months, 6 months, 8 months and 9 months.” (Munazi village- Ruyigi)

“Before the Tubaramure program’s intervention in our locality, many men left their wives at home and went to work in Tanzania. But today, due to the trainings provided by TUBARAMURE program, we have noticed that the movement of men going to Tanzania diminished.” (Rubanga village-Ruyigi)

6. According to you what were the strength of Tubaramure project?

- *“Tubaramure project gathers people. Before the project’s intervention, people were disorganized, there was no exchange of experience between different households because there was no known framework that should have gathered them and trained them. However, with the program’s intervention, people got organized and gathered and trained. The pertinent point is related to groups and SILC groups. In addition to activities carried out together and the material profit drawn from the project, people got a significant moral and social profit in the sense that the social cohesion is reinforced and solidarity between groups and households is strengthened because the people are feeling connected.” (NYARUBABI village -Ruyigi)*
- *“The project prevented and fought against malnutrition through food distribution and sensitization on food practices.” (Munazi village-Ruyigi)*
- *“Kitchen garden allowed getting vegetables to be easy.” (Nyarurambi village-Ruyigi)*
- *“The project sensitized the population on the way of improving hygiene in the households (Munazi village - Ruyigi)*
- *“The program sensitized the parents on child growth monitoring.” (Nyarurambi village-Ruyigi)*
- *“Due to the trainings provided by the program, the population of our locality changed the behavior of men as well as women.” (Village Misugi-Cankuzo)*

7. What were the weaknesses of the Tubaramure project?

- *“The program didn’t distribute improved seeds.”*
- *“The program didn’t reach a large number of population since a large there are many people who are really in case of need.” (Nyarubabi village- Ruyigi)*
- *“The program distributed a small number of goats because 2 are not sufficient for more than 30 persons.”(Nyarurambi village-Ruyigi)*
- *“Sometimes, there were injustice cases in food distribution because some mothers didn’t receive food whereas they were beneficiaries.” (Munazi village-Ruyigi)*
- *“The lack of food distribution committee in our locality, that’s why we observed the food theft cases.” (Misugi village-Cankuzo)*
- *“The food distributors sometimes use truncated scales” (Misugi Village-Cankuzo)*

8. What are the current challenges in Tubaramure project villages?

- *“We don’t see any challenge.” (Nyarubabi village-Ruyigi)*

- *“There are no challenges.” (Munazi village-Ruyigi)*
- *“The project was short because changing the community requires too much time” (Nyarurambi village-Ruyigi)*
- *“Decrease of number of beneficiaries” (Village Misugi-Cankuzo)*

9. What suggestions or recommendations do you make in order to strengthen the project acquisitions in different zones?

- *“We suggest the continuation of trainings or refreshments.” (Nyarubabi village-Ruyigi)*
- *“Distribution of improved seeds and chemical fertilizers in order to increase farm productivity distribution.” (Nyarubabi village-Ruyigi)*
- *“Distribution of animals for getting organic fertilizers and consequently increase farm productivity.” (Nyarurambi village-Ruyigi)*
- *“Capacity building for leader Mothers and Tubaramure fathers.” (Rubanga village-Ruyigi)*
- *“Giving T-shirts to Tubaramure fathers as it is done for Leader mothers.” (Rubanga village-Ruyigi)*
- *“Continuation of food distribution for children, and if possible, extend the project in all localities of the country.” (Nyarurambi village-Ruyigi)*
- *“The program should continue to support the groups in our locality, and this may improve households living conditions.” (Nyarurambi village-Ruyigi)*
- *“In the future, there should be a committee for food distribution management in order to avoid theft cases.” (Misugi village-Cankuzo)*
- *“In the future, if possible, the project should provide bicycles to Tubaramure fathers, and this will facilitate sensitization in our locality.” (Misugi village-Cankuzo)*

10. Learned lessons/testimony/proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary)

- NJEJIMANA Ildfonse 32 years old, Male: *“I was enthusiastic because of the trainings on how to feed children since before the project, I didn’t know how to prepare meals by including three food groups such as proteins, carbohydrates and lipids. I am interested by the way the people responded to the education about children’s vaccination as well as child growth monitoring. The*

other pertinent aspect of Tubaramure program is setting up group systems in which the people carry out activities together and consequently strengthen social cohesion.”(Nyarubabi village-Ruyigi)

- *HAKIZIMANA Eric: “Before the program, I didn’t see the importance of improved latrines. However, with the Tubaramure program, I know how to set up improved latrines with hand washing stations near on the way to the latrines.” (Nyarurambi village-Ruyigi)*
- *NIYONGABO Jean Berchmans: “Before the program, I didn’t know how to set up kitchen gardens around my home, but with the program, I do it myself” (Nyarurambi village-Ruyigi)*
- *KAGOMA Emmanuel: “Before the program, I ate only beans with cassava and sweet potatoes with beans; I ignored the vegetables. With the project my wife we learned how to prepare balanced meal, it means a meal that contains lipids, carbohydrates and proteins.” (Nyarurambi village-Ruyigi)*
- *“Before the beginning of the program, I didn’t know the importance of washing hands after toileting. Today, with the program, I must wash my hands.” (Misugi village-Cankuzo)*
- *“Before the project, I rarely ate vegetables, but, with the project, I always eat vegetables because of the garden kitchen.” (Misugi village-Cankuzo)*

Annex IV.G. Summary Comments from Community Health Workers

1. What activities did you carry out in your village in the framework of Tubaramure-PM2A?

(Note: all activities mentioned are quotes from the participants.):

Sensitizing the population on nutrition:

“They told us to eat food containing three groups of nutrients: carbohydrates, lipids and proteins. They showed us how to prepare good food by using local products. This balanced nutrition is necessary for children as well as adults? We equally visit the households for screening the malnutrition cases.”

(Nyagutoha village –Ruyigi)

Sensitizing the population on hygiene

- *“We give trainings on hygiene by teaching the participants to set up latrines and to wash their hands before eating, after using the latrine, after the kid’s toilet, before feeding or breastfeeding a child, when you want to prepare food for the family” (Nyagutoha Village-Ruyigi)*
- *Setting up kitchen gardens in the households (Nyarubabi village-Ruyigi)*
- *Creation of SILC groups (Nyarubabi village-Ruyigi)*
- *Creation of groups (Nyarubabi village-Ruyigi)*
- *Food distribution (Nyarubabi village-Ruyigi)*
- *Building public awareness about the importance of prenatal and post natal consultations (Rusange village-Ruyigi)*
- *Building family planning public awareness (Rusange village-Ruyigi)*
- *Sensitization on following the vaccination calendar (Rusange village-Ruyigi)*
- *Training the leader mothers on how to sensitize the households (Rusange village-Ruyigi)*
- *“Visiting pregnant and lactating women as well as children. If we find that a woman or a child is sick, we refer them to the health centre with a referral form” (Rusange village-Ruyigi)*
- *Building public awareness of how to fight against HIV/AIDS, leprosy, tuberculosis and malaria*

2. What activities do you carry out in your locality (what are your roles as Community Health Agents)?

Sensitization on hygiene:

“We focus on body hygiene by calling upon the people to put on clean clothes. We train people on hygiene critical moment such as washing hands before eating, after toileting, after the kid’s toilet, before feeding or breastfeeding a child, and when you want to prepare food for the family. We also tell people set up latrines and garbage pits. We advise them to set up hand washing station as well as platforms for utensils and to keep water in clean jerry can ” (Nyarubabi village-Ruyigi)

Nutrition

“We sensitize the population to consume three groups of nutrients such as carbohydrate, proteins, and lipids. The proteins are found in beans, meat, eggs etc, and carbohydrate are found in cassava, sweet potatoes, corn, rice, etc. (Village de NYARUBABI-Ruyigi)

Health

“We teach the population to bring their children to the health facilities for vaccination, and as far as women are concerned, we call upon them to attend the health facilities for pre and post natal consultations. We tell the parents to bring their children to the health centers for growth monitoring. In the framework of fighting against HIV/AIDS, we teach the population the importance of attending the health facilities for screening and fighting against sexually transmissible illnesses. We do the screening of malnutrition with the Mid Arm Circumference. If the MIAC shows a yellow color, we tell the parents what types of food to give to their children. If the color is red, we refer the child to the health facility. In the framework of malaria, we encourage the population to use the insecticide treated nets, to avoid stagnant water around the house and to cut the grasses around the house. (NYARUBABI village-Ruyigi)

3. What changes/differences did you observe at health and nutritional status of children of under 5 years? (observed effects on children, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored)

Before Tubaramure	After Tubaramure
<ul style="list-style-type: none"> - Giving food to 5 month old children - Giving alcohol to children - Breastfeeding the child when they only have time - Unbalanced diet, without taking into consideration the 3 groups of nutrients (Rusange village-Ruyigi) - Many cases of malnutrition (Nyagutoha village-Ruyigi) 	<ul style="list-style-type: none"> - Giving food to the 6 month old child - Exclusive breastfeeding until 6 months - Balanced diet taking into consideration 3 groups of nutrients (Rusange village-Ruyigi) - Malnutrition cases sensibly diminished - No malnutrition related death cases (Nyagutoha village-Ruyigi)

<p>- Many death cases due to malnutrition (Nyagutoha village-Ruyigi)</p>	
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“We have noticed that in our locality, the 5 year old children have a height of 7 year old children before TUBARAMURE program’s interventions.” (Rusange village)

4. What changes/differences did you observe at health and nutritional status of pregnant and lactating women who benefited from the program’s interventions? (Write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, note if there is improvement or not)

“Before the program’s intervention, when pregnant women felt a discomfort, they went to consult the witch doctors. Now, with the public awareness campaign carried out by the program, pregnant women go to health facilities for prenatal and postnatal consultations. Before the program intervention, women would deliver at home without attending health facilities. At the nutritional level, lactating women are now in good health because they learned how to prepare meals with local products such as eggs and vegetables. Due to sensitization, we observe that malnutrition related illnesses for pregnant women sensibly decreased and they no longer take alcohol during pregnancy and they don’t give alcohol to their children anymore”. (Rusange village-Ruyigi)

5. According to you, what are the strengths of the activities? (Occurred changes: food practices, improvement of children’s health)

“Instead of giving fish to children, teach them how to fish. The program distributed food and it trained us how to get a balanced diet by using locally available products. In effect, the program sensitized on the good food practices. Because of the program, people know how to set up the kitchen garden for growing necessary vegetables for feeding children as well as adult persons. Another important point for the program is the involvement of the local administration. This facilitates the Health Community Workers in their daily activities and consequently allows the sustainability of the program’s acquisitions” (Rusange village-Ruyigi),

6. What are the weaknesses of the program (things you didn’t appreciate during the program)?

- *Food distribution has caused laziness in some graduated beneficiaries of the program who do not want to listen to Community Health Agents and follow their advice under the pretext that they no longer receive food should they do otherwise.*

- *There are times when meetings are scheduled and those who are supposed to hold it get absent at the last minute. So it's a waste of time for participants who could do something else.*
- *The program promised to give us improved seeds but has not yet honored their promise*
- *The distributed Goats are not sufficient—(2) for an association of 30 people*
- *The program didn't give enough bikes because one must travel a long distance for raising public awareness, as some villages are very far.*

7. What arrangements did you undertake so that you could continue the activities in your locality after the project withdrawal? (Note all the arrangements)

- *"We will stay in groups together so as to try to remind one another the lessons we have received from the program" (Nyarubabi village-Ruyigi)*
- *"Put into practice what we learned in the trainings on the nutrition so that our children can stay healthy" (Nyagutoha village-Ruyigi)*
- *"We will continue to sensitize villages".(Nyagutoha village-Ruyigi)*
- *"We will continue to work as volunteers because we know that we work for our good and for the good of our children" (Rusange village-Ruyigi)*
- *"We will strengthen the groups and teach others to join the groups" (Rusange village-Ruyigi)*

8. What suggestions or recommendation you can make in order to strengthen the project's acquisitions in different areas of the project's intervention (in order to improve the fight and prevention of malnutrition in your village)?

- *"Continue and multiply trainings on nutrition and hygiene because most often men don't participate under the pretext that they are busy with other activities "*
- *"It is necessary that the villages pay visits to each other in order to exchange experiences"*
- *"Distribution of seeds and watering cans" (Village Rusange)*
- *Name: Jonathan Ntihabose: 35, male: "Malnutrition cases do not exist in our community and this is due to the fact that Tubaramure program has played a relevant role in the training on how to fight against malnutrition. Before the program, there were many cases of child mortality due to malnutrition. The setting up of kitchen garden is the most interesting case because the vegetables that play an important role in nutrition are now grown in the households. Most people know that it is necessary to give the child three groups of nutrients including proteins, lipids and carbohydrates". (Nyagutoha village- Ruyigi).*

- *“In the domain of health, women are aware of the pre and post natal consultations, and lactating mothers know that they must breastfeed their children exclusively 6 months and they do not give alcoholic beverages to their children.” (Rusange village-Ruyigi)*

Food Distribution

9. What do you think of the impact of assistance (food distribution) on the health of beneficiaries (pregnant women and under 5 year malnourished children)?

- *“Children don’t suffer from malnutrition anymore, and pregnant women gave birth to babies who are in good health.”(Rusange Village-Ruyigi)*

10. What main difficulties did you encounter?

- *The quantity of distributed food was not sufficient especially when the family has other children to feed (Nyarubabi village-Ruyigi)*
- *“It was difficult to sensitize households which don’t benefit from the food distributed by Tubaramure program. For example: people may say that they don’t have time to listen to us because it is not about food assistance.” (Rusange village-Ruyigi)*
- *“There are work tools like image box that we got later, and consequently it was not easy for us to explain certain things” (Rusange village-Ruyigi)*

11. What are the main challenges related to the care of malnourished children at the level of your village?

- *“ Sometimes we must visit remote villages when we go to see the children, so we have the transportation related problems.”(Nyagutoha village-Ruyigi)*
- *“ There are times when we refer children and the parents don’t bring them to the health centers” (Rusange village-Ruyigi)*

12. Learned lessons/testimony/proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary

- *NIYONKURU Théodomire, 40 years, Male: “Food distribution is one of the elements of the project that played a very important role in the prevention and fight against malnutrition in our community. The importance occurs in the context where we don’t observe many cases of*

malnourished children, and they have a better health compared to the situation before Tubaramure program (Nyagutoha village-Ruyigi) period.

- *“Sensitization on food practices played a crucial role in the promotion of locally available products” (Rusange village-Ruyigi)*

SILC activities

13. How many of you are members of SILC group? / _____ /

- *Nyagutoha village, no SILC activity*
- *Nyagutoha village 1*
- *Rusangi village 5*

14. From the time SILC activities started, what changes/differences did you observe in your life?(Note the changes expressed by the participants, ask examples in order to support their opinions)

- *“Now, if there is an emergency situation, we contract a loan that we will pay back. We received knowledge about loan and saving”. (Village Rusange)*

15. What arrangement did you undertake to continue SILC activities after the project withdrawal? (Note all the arrangement expressed by the participants during the focus group?)

- *“ Regular contribution for supplying the fund” (Rusange Village-Ruyigi)*
- *“Creation of Income Generating Activities ” (Rusange Village-Ruyigi)*

16. What suggestion or recommendation can you make in the framework of monitoring and reinforcement of SILC activities? (Note all the suggestions expressed by the focus group participants.)

“The income generating activities could help in the sustainability of SILC activity, but the lack of material resources hinders us because we started very recently SILC activities very recently. Therefore, we would like to have a support for starting the Income Generating Activities. Our suggestion is that there should be an advocacy with other projects that could support our groups.”(Rusange village-Ruyigi)

17. Learned lessons/testimony/proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary.)

Two heads are better than one, and a standalone person cannot go further. We must join others with the vision of working together. In these activities, we found that there was a strengthening of relationships between members; the mutual support and social cohesion are consolidated. There is a peaceful resolution of conflicts within the households. (Village Rusange)

Annex IV.H. Summary Comments from Men

1. What do you know about Tubaramure program in your locality?

- *The program distributed food for pregnant women and children under two years of age.*
- *The program gave training sessions on hygiene.*
- *“We are sensitized on the construction of improved latrines, setting up hand washing stations, garbage pits, drying rack for the utensils, and to have clean jerry can for keeping water to drink.” (Nombe village-Ruyigi).*
- *The program trained on how to set up a kitchen garden. (Nombe village-Ruyigi)*
- *The program sensitized women on attending health facilities for pre and post natal consultations (Nombe village-Ruyigi)*
- *The program sensitized the parents on attending health facilities for vaccination*
- *The program established groups.*
- *The program established SILC groups (Nombe village-Ruyigi)*
- *The program distributed goats and chicken. (Nyamasenga village-Ruyigi)*
- *The program sensitized women on not drinking alcohol during pregnancy and not giving alcohol to their children. (Rusange village-Ruyigi)*

2. What was your level of involvement in the activities of this program?

- *“We participated in building public awareness of proper hygiene, which included focusing on the construction of latrines of 12 meters deep. Equally, we taught the construction of drying racks for the kitchen utensils. As far as food good practices are concerned, we call upon the households to feed well their children, taking into account the three food groups such as proteins, carbohydrates, and lipids. We sensitize people to grow vegetables in the kitchen gardens and we give them examples by doing this in our households”. (Kirasira village-Ruyigi)*
- *“As far as health domain is concerned, we provide advices related to children vaccination, and for women, we teach them the importance of attending health facilities for pre and natal consultations. We equally encourage them to participate in the trainings organized Tubaramure program. For example, we carry out household activities when our wives participated in the activities of the program.” (Muhene Village-Ruyigi)*

- *“Avec nos femmes nous appliquons les pratiques alimentaires car avant la sensibilisation par le Programme Tubaramure, nous vendions presque tous les aliments utile dans l’alimentation notamment les œufs. Mais avec les enseignements prodigués par le programme, nous connaissons dès lors que les œufs sont très utiles et pour nous et pour nos enfants” (Muhene village-Ruyigi)*

3. According to you, which activities had relatively greater impacts on the beneficiaries?

Sensitization on hygiene good practices

- *“Before the program, many people didn’t know the hygiene critical moments, especially when one must wash the hands. Now, however, with the project, people know the good hygiene practices and set up the improved latrines and garbage pits.” (Kirasira village-Ruyigi)*

Sensitization on good food practices

- *“Before the project, people didn’t know how to use the locally available products for putting together balanced diets. But now, people know how they can combine the local products so as to get balanced diet. The kitchen garden plays an important role in growing necessary vegetables which are vital for our health.” (Muhene village-Ruyigi)*
- *Food distribution for pregnant women and under two year children*
- *“SILC group have a positive impact in the sense that the loan contracted by the parents allows them to pay the schools’ fees and for school materials for their children. In the moment oh share-out, one can buy a goat or something else which is useful for the family.” (Nyamasenga village-Ruyigi)*
- *“Because of groups, people help one another, friendship relations are consolidated.” (Rusange village)*
- *“Because of the education on good food practices, the people who are not part of Tubaramure program copied the good practices and set up kitchen gardens.” (Nyamasenga village –Ruyigi)*

4. What changes/differences did you observe on children due to project’s intervention? (Write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, and note whether there is Improvement or not.)

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - Children had malnutrition related diseases. 	<ul style="list-style-type: none"> - Children don’t have the problems related to malnutrition and are in

<ul style="list-style-type: none"> - There were many deaths due to malnutrition. - There were many children who were not vaccinated and whose child growth monitoring was not well done. 	<p>good health.</p> <ul style="list-style-type: none"> - The malnutrition cases sensibly diminished. - Many children are vaccinated, and there is a good child growth monitoring.
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5. What changes/differences did you observe at health and nutritional status of women due to your participation in the project’s program? (Write down all the answers, ask the participants to illustrate, give examples if there are any, look for personal examples to be deeply explored, and note whether there is Improvement or not.)

Before Tubaramure	After Tubaramure
<ul style="list-style-type: none"> - “Most of women didn’t go to health facilities for pre and post natal consultations.” (Nyarubabi village – Ruyigi) - “Women didn’t know how to feed their children and at what point they should start to give them food.” - “Women didn’t deliver at the health facilities and consequently there were many cases of fistulas due to the deliver at home.” (Nyamasenga villlage-Ruyigi) - “Women were not part of the groups” (VNyamasenga village-Ruyigi) - “ Women consulted witch doctors in case of miscarriage (Muhene village-Ruyigi) - “ There were many anemia cases.” (Muhene village-Ruyigi) - “There were no good hygiene practices.” (Muhene village-Ruyigi) 	<ul style="list-style-type: none"> - “ Most of the women attend the health facilities for pre and post natal consultations.” (Nyarubabi village-Ruyigi) - “ Women know how to feed their children and at what point they can start to give them food to their children.” - “Women deliver at the health facilities and consequently the fistula cases diminished.” (Nyamasenga villlage-Ruyigi) - “Women are members of groups ” (Nyamasenga village-Ruyigi) - “ Women visit the health facilities in case of miscarriage menace” (Muhene village-Ruyigi) - “ Anemia cases during pregnancy sensibly diminished.” (Muhene village-Ruyigi) - “Good hygiene practices learned

	<p>during the program are applied.” (Muhene village- Ruyigi)</p>
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6. According to you, what were the strengths of Tubaramure?

- *“The program through the setting up of groups and SILC groups allowed gathering people who, in turn, accomplished activities together, and this strengthened the social cohesion and mutual assistance.” (Kirasira village-Ruyigi)*
- *“The program prevented and efficiently fought against malnutrition.” (Nombe village-Ruyigi)*
- *“Because of the trainings provided by the program, women who attended have good health.” (Rusange village-Ruyigi)*
- *“Hygiene improved because of the sensitization carried out by the program.” (Kirasira village-Ruyigi)*
- *“Women awoke and can express themselves in the public,” (Nyamasenga village-Ruyigi)*
- *“Leader mothers sensitize other women who are not part of the program on food and hygiene good practices,” (Nyamasenga village-Ruyigi)*
- *“Groups strengthen the social cohesion” (Nyamasenga village-Ruyigi)*

7. What were the weaknesses of Tubaramure project?

- *“Tubaramure project covered a small number of population whereas many people are in case of assistance need.” (Nombe village-Ruyigi)*
- *“During the sensitization, it was forecasted to dig 12-meter-deep latrines. However, it is not easy to dig until this depth since it is dangerous for the digging person. Also, because the program didn’t distribute latrine covers, isn’t there a high risk to the person using the latrine because of the enormous depth? (Rusange village-Ruyigi)*
- *“The program didn’t consider that most of the households have only one bucket. This becomes a problem if there is a need to set up the hand washing station because some of the households are not able to get a second bucket. (Kirasira village-Ruyigi).*
- *“Another concern is related to the fact that Tubaramure bucket is only used for food packing only. If a woman or someone else is seen using the bucket for other purposes, he was automatically removed from the list of the beneficiaries of Tubaramure Program.” (Kirasira village-Ruyigi)*

- *“A pregnant woman who received food automatically lost the beneficiary qualities once she miscarries.” (Kirasira village-Ruyigi)*
- *“The program distributed goats and chickens; however, considering the number of people in case of need, the number of distributed animals was not sufficient.” (Muhene village-Ruyigi)*

8. What are the current challenges in Tubaramure project’s villages?

- *“Although the program provided an important support, the major challenge is poverty, which is a general phenomenon in our village as well as at the national level.” (Nombe village-Ruyigi).*
- *“Due to the climate change, a balanced feeding will be difficult to keep since food is not available, and consequently mothers and children’s health will be affected.” (Kirasira village-Ruyigi)*
- *“The villagers cannot get chemical fertilizers, and there is no livestock to produce organic fertilizers.” (Nyamasenga Village-Ruyigi)*
- *“There is a lack of some vegetables, epinards, carrots, paper,... which are very important in nutrition.” (Muhene village-Ruyigi)*
- *“There were some cases of injustice where pregnant women who would have benefitted from the food didn’t get it.” (Rusange - Ruyigi)*
- *“Children of the graduated mothers relapse.”*

9. What do you suggest or recommend for reinforcing the project acquisitions in different zones?

- *“Trainings and refreshments should continue as well as food distribution.” (village-Ruyigi)*
- *“There should be cattle distribution.” (Nombe village-Ruyigi)*
- *“Once the project continues, there should be new supervisor as well as stock managers” (Kirasira village-Ruyigi)*
- *“There should be toilet covers distribution in order to avoid accidents”*
- *“Supplying watering cans kitchen gardens ”*
- *“Distribution of buckets and jerry cans for household hygiene” (Village –Ruyigi)*
- *“There should be agronomists and veterinarians for supporting breeding and agricultures activities.” (Rusange villabe –Ruyigi)*

- *“The program should provide transportation means to leader mothers and fathers in order to facilitate household sensitization”*
- *“The program should support us by giving us Five millions or more in order to invest in big project. Otherwise, we cannot get the means for investment”*

10. Learned lessons/testimony/proverbs. (Note: Pay attention to relevant stories related to success, failures, stories of change, if these aspects are expressed during the focus group, after the interview get closer to the person and deepen his/her story by giving the name, sex, age, period, and summary.)

- *“Instead of giving fish to a child, you teach him how to fish”. Before, we didn’t know how to set up kitchen gardens, but with the program, we learned how to grow easily vegetables, there is birth limitation due to family planning” (Rusange-village)*

Annex IV.I. Summary Comments from Local Authorities

1. What local activities of the Tubaramure project are you aware of ?

- *The program has distributed food to pregnant women and children under 2 years of age.*
- *The program provided training on hygiene. It has taught us us latrine construction and the installation of hand washing stations around the toilet as well as the importance of digging a garbage pit, building a platform for kitchen utensils, cleaning utensils and keeping a jerry can to keep water to drink*
- *The program introduced vegetable harvesting system in a kitchen garden*
- *Distribution of small livestock (goats, chickens)*
- *Sensitization on family planning (Nombe village-Ruyigi)*
- *Sensitization on pre and post natal consultations for women (Nyamasenga village-Ruyigi)*
- *Creation of groups and groups SILC*

2. What was your involvement level in the program's activities?

- *"We encourage the population to responding positively to meetings organized by the program." Nyamaenga*
- *"We encourage women to join the groups." (Nyamasenga village-Ruyigi)*
- *"We sensitize non-beneficiary population to emulate good examples of the changes in behavior taught by Tubaramure program." (Nyamasenga Village-Ruyigi)*
- *Through meetings we hold with the population, we call upon men to participate in the program so that they can be trained on food practices.*
- *We educate people about hygiene.*
- *I work with the Health and Nutrition Promoters. (Rubanga village-Ruyigi)*
- *From a neighbor, I could copy the good eating habits from my neighbor and I set up a vegetable garden. (Rubanga village-Ruyigi)*

3. What activities had relatively greater impacts on the beneficiaries?

- *Sensitization on hygiene and as impact; diseases of dirty hands decreased significantly.*
- *Sensitization on food practices had more impact because malnutrition cases significantly decreased.*
- *Sensitization on prenatal and postnatal consultations for women had a positive impact because women now go to the health center or hospital for these consultations. Before, women delivered at home, but now they deliver in health facilities*
- *Food distribution to pregnant women and children under 2 years has allowed the children to have a good health.*
- *The SILC groups and Groups*
- *The kitchen garden supplies vegetables even during the dry season.*

4. What changes/differences did you observe at health and nutritional status of children due to your participation in the project’s program? (Write down all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, and note whether there is Improvement or not.)

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - The children had malnutrition related problems. - There were many death cases due to malnutrition. - There were many children who were not vaccinated and growth monitoring was not well done. - When a child was sick, the parents took him to the witch doctors. 	<ul style="list-style-type: none"> - Children do not have malnutrition related problems and are in good health. - Malnutrition cases have decreased significantly. - Many children are vaccinated and there is good growth monitoring. - When a child is sick, the parents take him to health facilities.

5. What changes/differences did you observe on women due to the program’s intervention (Note all the answers, ask the participants illustrate, give examples if there are any, look for personal examples to be deeply explored, and note whether there is improvement or not.)

Before Tubaramure	With Tubaramure
<ul style="list-style-type: none"> - Most of pregnant women did not go to the health center or hospital for the pre and post natal consultations - They did not know how to feed their children and from what month they must give them food. They give them food before 6 months. - Women were not more concerned with hygiene - Few women brought their children to the health facilities for vaccination Women did not deliver at the hospital 	<ul style="list-style-type: none"> - Most of pregnant women go to the health center or hospital for the pre and post natal consultations - They know how to feed their children and for what period they should give them food. They give them food after 6 months. - Women are more concerned by hygiene - Many women have their children vaccinated - The women deliver in hospital - Active participation in income generating activities

6. What are the strengths of Tubaramure?

- *The program, through the established groups and SILC groups, allowed people to come together and carry out activities together, thereby strengthening social cohesion and mutual assistance.*
- *The program has been able to prevent and fight effectively against malnutrition by distributing food. (Nombe village Ruyigi)*
- *The introduction of kitchen garden for the production of vegetables even during the dry season.*
- *In the area of health, as a result of training provided by the program, mothers who participated have a good health.*

- *The program has taught women the importance of pre and post natal consultations.*
- *Hygiene has improved due to the awareness building workshops conducted by the program.*
- *Groups set up by the program represent one element that will allow the sustainability of the program's acquisitions.*

7. What are the weaknesses of Tubaramure project?

- *Tubaramure covered a small part of the population while many people are in situation of need. (Nombe village Ruyigi)*
- *Towards the end, the program reduced the number of beneficiaries. (Munazi village-Ruyigi)*

8. What are the current challenges in Tubaramure project's villages

- *The current challenges are related to the risk of famine due to climate fluctuations. (Nombe village Ruyigi)*
- *No small livestock for organic manure*
- *No challenges (Rubanga village Ruyigi)*

9. What do you recommend or recommend for reinforcing the project's acquisitions in different area?

- *The program could give chemical fertilizer and seeds in order to increase production. Once the program closes, it will be necessary to have another project working in the same context. (Nombe village Ruyigi)*
- *Distribution of small livestock for organic manure*
- *Capacity building of the population on agriculture and livestock (Nyamasenga village Ruyigi)*
- *Support groups (Munazi village Ruyigi)*
- *The Government should look for other donors to support the program Tubaramure. (Nyamasenga village –Ruyigi)*

10. How many women are members of village development committee? What is their role?

Number of leader mothers members of Village Development Committee:

- *Nombe village 5*
- *Munazi village 2*
- *Nyamasenga village 3*
- *Rubanga village 1*
- *“Tubaramure leader mothers play an important role in the peaceful resolution of conflicts. They participate in various meetings, they play the role of counselors in households, and they sensitize other women to respond positively to development works. Compared to other women, Tubaramure leader mothers are respected and appreciated because of their leadership qualities (Nombe village- Ruyigi).*
- *In addition, they also participate in the defense of women and children’s rights (Munazi village- Ruyigi). Since they are directly connected with the administration, they transmit the orders from the authorities to the rest of the village population.” (Nombe village-Ruyigi)*

Annex V. Testimonials from Program Beneficiaries

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Annex V.A. Testimony 1: SILC Group Member

Date: 15/07/2014

Location: Nyagutoha Colline, Ruyigi Commune, Province of Ruyigi

My name is Jeanne Marie Bukyuru; I am 61 years old. I live in Nyagutoha village. I warmly thank Tubaramure project. Before the latter, women in general and I, myself, in particular, who is aging, had trouble providing ourselves with money to cover some of our basic needs, such as seeds. We were even ashamed to go to a sister colleague to borrow money from her. With the project, SILC was implemented in our village. For the moment, we contribute BIF2,000 per member, and this enables me to have a loan. I respect hygiene rules. Before, I did not know anything about hand washing stations and drying racks for kitchen utensils. Today, I have them at home and you can come and see for yourself!

As far as nutrition is concerned, I can now prepare a balanced diet as instructed by the project. If there is a mother in my neighborhood who has a malnourished child, I show her how to prepare porridge to give to her child according to instructions received when we were sensitized on good nutrition for good health. For the moment, with other SILC members, we have enough food and clothing, but we must not content ourselves with that because we need to be able to buy small livestock such as goats. For that purpose, we must first make an effort on our part in saving a slightly higher amount. Also, until now, we used the funds we save ourselves. *Ntawusimbiza uwutisimbije*—you cannot help someone against his will.

With the willingness of each member, and if we reach a certain level of development, Tubaramure project will probably support us financially before its withdrawal. Thus, with our savings and the financial support, we can provide ourselves with goats, say 5 goats, in order to receive organic manure. At that moment, our development will be visible and we can brag on the airwaves what the project will have done for us. Please, come back and visit us to see our level of development. Thus, we will tell you a proverb concerning the context in which we are, compared to the development that we will have achieved.

Thank you.

Annex V.B. Testimony 2: Leader Mother

Date: 07/16/2014

Location: Ruhwago Colline, Ruyigi Commune, Province of Ruyigi

I am Pelouse Nibaruta. I live in Ruhwago Village, in Ruyigi Commune and Province. I am married with 5 children. I am a leader mother. When the Health and Nutrition Promoter came to sensitize us on Tubaramure project, I was chosen by women's Care Group, to which I belong. Indeed, we were a group of 10 women, and, among us, they chose a leader mother. My selection was then motivated by my dynamism; as a matter of fact, the group saw in me a person who can be useful for them by going to trainings and meetings and in my turn by training them on the project. Note that the training by Tubaramure project was mainly focused on hygiene first.

Before Tubaramure, there were many things that I did not know particularly in hygiene, nutrition and health.

Hygiene

Hand washing station

Before the project, I did not know that when someone leaves the restrooms, he had to wash his/her hands. When I came back from there, I found it normal to feed the children, to cook without washing my hands. However, with Tubaramure project, we have been taught that it is absolutely necessary to wash our hands after leaving the restrooms. Thus, the hand washing station was built. Now my whole family (my husband and children) have got the good habit of washing hands. You know, you cannot help washing your hands because on your way from the latrine, you can already see the hanging jerry can containing water. I put my foot on a piece of wood, which is connected to the container with a rope. The jerry can, with a hole at a certain level, slopes and the water begins to flow; I wash my hands with soap. I also learned that if, for instance, I have no soap at my disposal, I can use the ash, as it is a disinfectant.

Water Conservation

Before the project, I did not know that water should be stored carefully in a closed container. When I needed water to drink, I took a mug that I picked anywhere, and I drew water in a bucket without a lid. Sometimes, there were flies that fell into the bucket of water, but I drank it without concern. With Tubaramure, I learned that I must keep water to drink in a sealed container, and I put it today on the dining table. Now, flies can no longer fall into the water.

Drying rack for kitchen utensils

Before the project, I cannot say that I washed utensils. Indeed, I did so without using soap; I put them anywhere and anyhow, without worrying about the flies that could lay their eggs on them. With Tubaramure, I learned that we must build a drying rack for kitchen utensils, use soap to wash them and dry them on the rack face down to prevent flies or other dirt that may drop on them.

Latrine construction

Before Tubaramure, we neglected to construct latrines. We did it anywhere. However, today, it has been improved—the standards have been met.

Health

With the training by Tubaramure project on hygiene, the health of my family has improved significantly; diarrheal diseases were reduced and have become increasingly rare. Today, I go to the health center for antenatal and postnatal consultations, and I vaccinate my children more regularly than I did before.

Nutrition

Before the project, I thought it was sufficient to give children any food to eat; I never cared to give them a balanced diet. For instance, for a malnourished child under six months, I gave the porridge and thought that this type of food was adequate for my child. Fortunately I learned how to prepare a balanced diet from the project. I take the cooked amaranth, and I combine it with the porridge. I add the tomato puree and peanut flour. If I do not have sugar, I add to the mixture the crushed fruit banana, and then I give it to a baby under six months. To children, I can give them, for instance, beans, bananas, amaranths (vegetables) and fish, or I can prepare them dough that is eaten with tomato, peanut flour (which replaces the oil) with meat. So I do not see any illnesses related to malnutrition in my household. In short, the changes from Tubaramure in our village remain positive. As the project has given us the soybean seeds, I would like for it to support us financially for growing the soybean. We are in the dry season, so we need support in growing soybeans and peanuts. This would allow us to continue to provide nutritious food. We are poor families. With this support, there is no doubt that we can develop.

Thank you for your coming to visit me.

Annex V.C. Testimony 3: Graduated Beneficiary Mother

Date: 07/16/2014.

Location: Nyarubabi Colline, Butaganzwa Commune, Province of Ruyigi

I am Madame Faustine Nkengurutse, from Nyarubabi Colline in Butaganzwa Commune. I am 27 years old. I have spent 5 years in Tubaramure program, and I learned many things that helped me to improve hygiene in my household and health of my children. I say this because, before this program, I did not know the value of digging a latrine; we were hiding behind the banana trees for our toileting needs. Before eating, everyone washed their hands one after another turn in only one casserole or basin with the same water that had become dirty. My children fell ill so often that I went to the hospital almost every day. It is because of the Tubaramure program that we have been educated on the use of clean latrines, hand washing stations and drying racks. In this program, I learned a lot of hygiene practices that have significantly reduced dirty hands related illnesses. Currently, I can say that I regularly go to the Health Center for child growth monitoring and immunization. Even my husband was finally convinced that I have not wasted my time by participating in this program.

I warmly thank Tubaramure. If the opportunity arises, I will certainly role-play a sketch to show my joy and to thank again Tubaramure for everything it has done for us.

Annex V.D. Testimony 4: SILC Group Member

Date: 07/16/2014.

Location: Nyarurambi Colline, Butaganzwa Commune, Province of Ruyigi

My name is Delphine Ndikumana. I am 35 years old. I live in Nyarurambi in Butaganzwa commune in Ruyigi province.

Since October 2013, I am a member of SILC. In earlier times, I couldn't pay the school fees for my children, and I could not buy goats and chickens. Today, with SILC, I have already purchased 4 goats and 2 hens. After the dividends, I expect to buy a piece of land because I need it. I intend to improve my family's clothing in general, and clothing for my children, in particular. I contribute BIF1,600 (BIF1,500 + BIF100) and I have on my account 68,000 Burundian Francs. Today, I am happy because poverty in my family decreases gradually.

If it would be possible, we would ask you to provide us with supplementary training sessions that will guide us for income-generating activities in order to increase the monthly contributions. I can now say that *unity is strength*, as the members of my group can grant loans outside the group, and we have strong social cohesion.

Annex V.E.. Testimony 5: Care Group and Focus Group Member

Date: 07/16/2014

Location: Ruhwago Colline, Ruyigi Commune, Ruyigi Province

My name is Euphémie Njejimana, 30 years old and mother of 5 children, among whom two were not in Tubaramure program while the last three were part of the program.

Before the program, I gave water to my first born at the age of 4 months and to the second, at the age of 5 months and half because I thought that they could be thirsty. In addition, I gave them poor-nutrient foods (beans + sweet potatoes or cassava) for several consecutive days.

With Tubaramure training sessions, I managed to change my old food practices. Thus, I exclusively breastfed my last three children for 6 months without giving them a single drop of water. At the age of 6 months, I started giving them porridge and fruits, whereas the first ate only sweet potatoes or cassava.

I started to give rich-nutrients foods to the first children; that means containing the three food groups (carbohydrates, lipids and proteins). I have completely changed the way of feeding them, and I am more considerate of the timing of their meals.

Annex V.F. Testimony 6: Focus Group and Care Group Member

Date: 07/16/2014,

Location: Ruhwago Colline, Ruyigi Commune, Ruyigi Province

My name is Médiatrice Miburo; I live in Ruhwago village, in Ruyigi commune and province. I married and am the mother of 4 children: among them is 1 daughter and 3 boys. I am in the Tubaramure program of CRS.

Before taking part in this program, I did not go to the HC for the antenatal consultations for all of my pregnancies. I often fell sick, but I ignored the reason. I was so thin. I ate any food, poor-nutrient foods. Sometimes, I went to work without having my breakfast. Very often, I fainted when I was alone in the fields because of hunger. I suffered from anemia. The children I bore had a weight ranging between 2 and 2.3 kilograms.

When I joined Tubaramure program, I first learned to do prenatal consultations every three months and postnatal consultations to remain healthy. Then, I learned how to prepare a very balanced diet with available foods. For instance, I had to eat the porridge preparation in the morning and at 4 o'clock when I was hungry.

Lastly, I learned the good practices of body and family hygiene. Examples: the hand washing before preparing meals, the construction of drying rack for kitchen utensils and latrine construction, etc...

With the implementation of trainings and pieces of advice on prenatal consultations and on rich-nutrient foods for the health of mothers and children got from Tubaramure program, the child I gave birth to had 4.5 kilograms of weight.

In addition, the foods Tubaramure gave me were very useful for my health.

Annex V.G . Testimony 7: Agro-pastoral Group Member

Date: 07/16/2014

Location: Ruhwago Colline, Ruyigi Commune, Ruyigi Province

My name is Patricie Niyonzima; I am 34 years old. I live in Ruhwago village in Ruyigi Commune and Province.

Before the project came in our village, I ignored how to grow vegetables during the dry season and set up a garbage pit/kitchen garden near my compound. Additionally, my children often fell ill during the dry season while they were scattering dirt everywhere, and I did not know why. One day, I brought one of my sick children to the hospital for tests. The day after, I got the results, and the doctors told me that my child was suffering from malnutrition. I asked for their advice; they suggested me to give him vegetables, and eggs although I had no money.

Indeed, when the project came in our village, Health and Nutrition Promoters began to educate us on growing vegetables, both during the dry season and the rainy season, as well as on digging garbage pits. Two months later, I saw a group of 20 people who cultivated vegetables during the dry season at home. I asked them if I could be part of their team, and they accepted.

I started to set up a vegetable garden around my house during the dry season. After two months, I started to give the child meals that contain vegetables and his weight increased.

I thank Tubaramure project and I can say this proverb in Kirundi “*umutwe w’umwe ntiwigira inama*” (Two heads are better than one).

Annex V.H . Testimony 8: Tubaramure Graduate

Date: July 2014

Location: Nyamasenga Colline, Nyabitsinda Commune, Ruyigi Province

My name is Marie Mbonihankuye; I'm 31. I live in Nyamasenga Village in Nyabitsinda Commune in Ruyigi province.

Before I joined the Tubaramure project, I went for prenatal consultations only once. After sensitization, I went for four as expected.

Regarding nutrition, I did not eat porridge; I bore children weighing 2 kilograms, but, after sensitization, I gave birth to two children, weighing 3 and 4 kilograms, respectively. In addition, I didn't know the 3 food groups, lipids, carbohydrates and proteins. Now, I know how to prepare our meals with porridge [flour] and how to combine the three food groups with local products. I also know how to prepare soy milk, whereas, before, I only ate the products of the current season. My household has become the model in our community for these nutritional practices. For the child nutrition, I gave him food for adults at the age of 3 months, but, today, I give her breast milk exclusively for 6 months and I give him food from 9 months on. Also, in order to improve the nutrition and with the program acquisitions, I learned how to build a vegetable garden where I can pick vegetables even during the dry season. Before, I thought that vegetables grew only in the marshes and shallows.

As far as hygiene is concerned, hand washing and development of proper latrines were not my concern. Today I wash my hands after leaving the lavatories, before and after meals as well as before feeding children. Previously I was using the river water to wash myself. However, today, I use two local or artisanal water taps *ibikarabo* for hand washing and bathing. The family has better health; children no longer suffer from intestinal worms. To drink clean water, the program has taught us to prepare drinking water, that is to say, boiling it while formerly I drank it like that without worrying about germs.

For latrines, we used pits / open and uncovered holes. Today, our household latrine is well built and as well maintained as our dwelling house.

Annex V.I. Testimony 9: Pregnant Mother

Date: July 2014

Location: Munazi Colline, Kinyinya Commune, Ruyigi Province

I'm Jocelyne Bigirimana from Munazi village in Kinyinya commune of the province of Ruyigi; I'm 30 and mother of 4 children.

I was pregnant with my first child when we were refugees in Tanzania. UNHCR (United Nations High Commission on Refugees) provided us with corn flour, peas and oil. I had to work to earn money for buying vegetables. I ate just to fill my stomach. The baby was born weighing 3 kilograms. The UNHCR (United Nations High Commission on Refugees) gave us porridge.

The second child was born in Burundi, weighing 2.8 kilograms. When I was pregnant with him, I did not have breakfast or lunch; I ate, for instance, only rice, beans or cassava and more beans.

Tubaramure program came when I was pregnant with my 3rd child. I was given flour for porridge and oil, and I was taught that I must eat food containing carbohydrates, lipids and proteins as well as eat a meal each of three times a day. For breakfast, I took porridge; for lunch, I ate cassava, beans and *lengalenga* (amaranth); for dinner, I ate sweet potatoes, beans, and cabbage mixed with oil. Thus, the child was born weighing 3.2 kilograms

As a graduated woman, I was pregnant with my 4th child, and I continued to eat whole foods like porridge for breakfast [maize and soy], for lunch, I ate, for instance, cassava, beans and cabbage and, for dinner, bananas, beans and cassava leaves. The child's weight was 2.9 kilograms at birth. I thank Tubaramure project for helping me to know good food practices for pregnant women. From now on, I know that sorghum is not only used for making local beer but also is used for preparing porridge once mixed with other cereals.

Annex V.J. Testimony 10: SILC Activities

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

I'm Nsavyimana Gaspard; I'm 42 years old. I'm married with 6 children, 3 sons and 3 daughters. Before the Tubaramure project settled down in our community to teach us SILC activities, I was not saving, and I was the first in our community when it came to poorly managing the family resources. Example: I often drank beer forgetting that I had to save money for the family needs. I was using all the money available. I didn't get school fees for my children. I did not have livestock without forgetting the clothes, and I walked barefoot.

With Tubaramure program, I approached the Tubaramure Health Promoter, and I heard the lessons they taught to the people of our community on the importance of SILC activities. I asked them if I could become a member of this group, and they accepted. They explained to me the activities they do in the SILCs (savings and internal lending committees) in addition to mutual help.

By joining a SILC, I followed their program through monthly contributions. I contracted a loan, which was intended to buy seeds and chemical fertilizers for my fields [a loan of BIF 20,000 and I paid back BIF 22,000]. For the second loan of BIF 50,000, that I asked later was intended to buy school materials for my children, and I paid back BIF 55,000 FBU within 2 months. I continued to save until we share dividends. My share of dividends was used for the purchase of a rooster and a hen; now I have six chicks. I am waiting for their growth and for the stage of laying eggs, and I want to sell them to earn money and meet family needs.

In closing, I thank Tubaramure program for these training and guidance. If it had not come into our community to teach us about SILC activities, I would have been a scoundrel for my family. I give the program a thousand thanks.

Annex V.K. Testimony 11: Tubaramure Father Leader: Survey Agent Ndagijimana Andre

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

I'm Damas; I live in Kirasira Colline in Butezi Commune. I'm 22; I'm married with one child aged 3 years 7 months.

When Tubaramure project was set up here in Butezi commune, I was already married. Through the teachings of the project, my wife, who was pregnant, went to the health center for antenatal care. She received food like porridge at 3 months of pregnancy and increased weight. The baby, to whom she gave birth, was 3.500 kilograms. [Note here that most women here gave birth to babies who were underweight]. My wife continued to benefit from the slurry until the child was 2 years of age. The latter was graduated when he had the weight of 16 kilograms.

In addition, with the teachings on family planning, my wife who is 4 months pregnant will give birth when my first child will be more than 4 years! As the project is almost closing, I still continue and will continue to ensure a balanced diet for the mother and child thanks to the advice given by Tubaramure. My wife and child are healthy. If you look at my child, you can easily think that he is 5 years.

I thank Tubaramure for bringing many positive changes into our community. I wish it could continue to support us.

Annex V.L. Testimony 12: SILC Activities

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

I'm Josephine Ntahondereye, age 50. I spent two years in the SILC group. Before, I was in other associations where I received no benefit. The members of this association bickered/quarreled all the time, so I joined the SILC group.

My husband is paralyzed. He cannot help me at all. I'm only looking for what the family needs to survive.

For example, when the new school year approaches, SILC lends me money and I pay school fees for my children; I buy their uniforms and notebooks. Recently, my son was married, and my colleagues gave me BIF50,000 that he needed for the dowry.

In addition, I asked for a loan from SILC to buy chemical fertilizers for my field. If I had not had the loan, the harvest would have been bad.

Prior to being in a SILC, I had a straw house, and, after having dividends, I bought corrugated sheets for my house and we are now safe from the rain.

I also bought a goat, and I currently have two goats and a pig.

Before I did not have slippers, but, for the moment, I have them, and if my loin cloth is torn, I can buy myself another one, and I can buy clothes for my children. I can also buy myself beauty products; I could not do so before joining SILC group.

Annex V.M. Testimony 13: Agro-pastoral Group Member

Date: July 2014

Location: Nyamasenga Colline, Nyabitsinda Commune, Ruyigi Province

My name is Goreth Nyandwi, I'm 25 years old. I live in Nyamasenga Colline in Nyabitsinda commune, which is in Ruyigi province. I don't know how to describe Tubaramure.

Honestly, this is a project that helped us a lot in our village. I do not know if you, yourself, have not heard of Tubaramure on the radio. Tubaramure fought against malnutrition for our children.

For instance, for me, when I was pregnant for the first time, I learned that I had to go for prenatal consultations at least 4 times, and after delivery, I had to go for postnatal consultations and for my baby's immunization. In addition, I had to eat for me and for my baby. The program has supported me by giving me porridge and everything I needed.

When my child reached the age of 2 years, the project guided, educated and encouraged me to continue to raise my baby. It showed me the benefit of joining an association, and that it is easier to help a group than an individual. Tubaramure supported us by giving us two goats and seeds. We worked together, and we purchased another goat.

As far as seeds are concerned, if I do not have any, I request for a credit in the association, and I pay it back after harvest, whereas before I could leave some of my land in fallow because of lack of seeds.

Before I was alone, but for the moment, I have many friends. My husband did not help me to work in the fields, but, when he joined our association, he has changed his behavior because, there, they give us advice. We purchase seeds in the association; when one is a member, if for example 1 kilogram costs 1000 BIF, a member buys for 500fbu kilogram; it is an advantage of the association. At the end of the season, when we harvest, we share the surplus and we keep the rest as seed for the new season.

Annex V.N. Testimony 14: Non-direct Beneficiary

Date: July 2014

Location: Butezi Colline, Butezi Commune, Ruyigi Province

My name is Josephine Butoyi, 52 years old. I live in Nombe Village, in Butezi commune, in Ruyigi province. I am not a part of the Tubaramure project beneficiary, but I would like to give a testimonial of my sister beneficiary of Tubaramure. She had two children who were suffering from kwashiorkor and she, herself, suffered from malnutrition when she was pregnant. After she went to participate in Tubaramure's seminar, she brought home booklets or brochures where there were pieces of advice for her husband.

After consulting the book, which also contained pieces of advice on nutrition and health for a pregnant woman regarding her diet and prenatal consultations, he liked them and changed his behavior. The husband in question was an irresponsible man and a drunkard; he contributed nothing in the family. With his wife, they used to fight all the time. Now he helps his wife with the housework, and he cares for his children in good nutrition. It is him who advises his wife to go for prenatal care.

Before the program, they did not space births, but, for the moment, they practice what is called "family planning".

With respect to hygiene, their home was very dirty before Tubaramure. On top of that, they had no latrine, garbage pit or hand washing station. Now, with the project awareness, their home has become very clean; they have built the latrine and set up the hand washing. All household members are healthy.

Tubaramure helped us a lot. It contributed to change positively the behavior of men in our community. Today, men help their wives in field work and participate in associations.

Annex V.O. Testimony 15: Community-based Growth Monitoring Program

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

My name is Beatrice NIBIGIRA, I'm 30, I live in Kirasira Village, Butezi Commune in Ruyigi Province, and I am a mother of 3 daughters. I would like to give a testimony on the growth monitoring of my children.

My first child was born before Tubaramure project. He weighed 2.1 kilograms at birth, at one month, 2.5 kilograms, after 2-months: 3 kilograms, 3 months later: 3.5 kilograms. After one year, the child was 8 kilograms. I gave up monitoring the weight of the child after one year six months, because I did not know its significance.

After Tubaramure implantation, I was pregnant with the second child who weighed 3.7 kilograms at birth, 4 kilograms after a month, 5 kilograms after 2 months, 6 kilograms after 3 months, 7 kilograms after 4 months. A year after the birth, he had reached 10 kilograms.

When I became a graduated woman, I gave birth to the third child who weighed 3.6 kilograms at birth, 4.5 kilograms after one month, and 5.5 kilograms after 3 months. The child reached 8 kilograms after one year. The child did not increase in weight because of malaria. I continue to monitor my children's growth today because the second child who is 4 years old weighs 15 kilograms.

I thank Tubaramure project for its training on children growth monitoring because the weighing is a real indicator of children growth.

Annex V.P. Testimony 16: Man and Wife Group Members

Date: July 2014

Location: Nombe Colline, Butezi Commune, Ruyigi Province

I'm Leonidas Nkwirikiye, age 34. I live in Nombe Village, in Butezi Commune in Ruyigi province. Before joining the group, during the growing season, we could not finish fieldwork. There were delays in planting some seeds, hence the production was bad. In addition, we were closed to each other; we didn't exchange information on the benefits of groups. Today with Tubaramure project, we are aware of the possibility of joining groups where we learn a lot in hygiene, health and nutrition without forgetting social cohesion.

Thus, Tubaramure trainings, joint work in my community has increased; that is the reason why fieldwork is progressing normally. Indeed, group members help one another in this work. In my case, my household agricultural production has increased thanks to this collaboration. My wife is now awake. This is the same for other women in my community. I would point out that even men have changed their behavior thanks to the advice given within groups. If there is a member who falls ill, other members are mobilized to take him to the hospital for health care.

Annex V.Q. Testimony 17: A Leader Mother Member of a Group

Date: July 2014

Location: Nombe Colline, Butezi Commune, Ruyigi Province

My name is Leonie Bigirimana, age 33.

Before Tubaramure had begun its activities, there was no group here in our community. With Tubaramure program, we received sensitization on the benefits of groups. I saw no importance to join because I thought it was a waste of time. Gradually, with some of my sisters, I realized that there was a great interest in groups. Thus, we gathered with others; we had 25 members when we started the group.

My husband, who was unaware of the importance of groups, did not want me to participate in meetings and activities. I will never forget when the members of my group came to help me to plow our field. My husband was amazed; he did not know what to say because this field was cultivated for only BIF3,600 instead of BIF20,000; the difference is there. In the evening, he spoke with me about the group; he then realized that membership in a group provides many benefits, including joint work, savings and loans. Since that day, my husband told me that, even if it happened that I participate in successive meetings, he would take care of housework.

God save the group that enabled my husband to change positively! Other people appreciate our activities and want to create groups. In short, I would say that we members of the group have become the model in our community.

I thank all Tubaramure program. I want our group to go ahead and Tubaramure to continue to build our capacities before its withdrawal. That's a pity. I would like to say this saying in Kirundi, '*akaryoshe ntigahora mw'itama,*' that is to say, "good things do not last long."

Annex V.R. Testimony 18: Children's Health

Date: 21/7/2014

Location: Nombe Colline, Butezi Commune, Ruyigi Province

I'm Cornalie Nahimana; I'm 41, and I have been in the Tubaramure project for 4 years and 7 months. In our household, we frequently suffered from diarrheal illnesses. We could not spend two months without a person, especially a child, suffering from diarrhea. We did not have this habit of going to the health center for care. One day, one of my children suffered from the illness for a week. When I went to the HC for the child care, I received only tablets that were not effective at all because diarrhea persisted. After three weeks, I went back to the HC because my child was so weak and very thin. At the HC, I was given porridge to help my child recover weight. Then, I was told that the diarrhea was due to poor hygiene, and malnutrition.

With Tubaramure project, we learned how take care of children with diarrhea before going to the HC and even while under treatment, (give plenty of liquids, especially water with a little salt). For me, I also think that even the HC did not care for these cases properly, because they did not raise my awareness of how to keep my child well after going home.

Today, not only do they give tablets, but they also explain what food a child or adult with diarrhea should be eating, thanks to Tubaramure. Since the latter educates us on hygiene, health and how to prepare meals, we noticed that if we give the example of my household, dirty hand related illnesses are no longer frequent as before. Children grow undisturbed because we know how to prevent these illnesses.

To conclude, I would say it was high time Tubaramure came to our community to teach us. To thank Tubaramure, I do not have words to use to express my thanks, but I will share what I learned with others who did not have the chance to participate in the project.

Annex V.S. Testimony 19: SILC Group Member

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

My name is Josephine Nitereka; I'm 35 years old; I live in Kirasira Village, Butezi Commune in Ruyigi province. Before Tubaramure project begins to work in our community, we did not do SILC activities: namely, savings, and credit. We asked our neighbors for credit and we were not sure we were going to have it.

Thus, with Tubaramure project, we were taught to make income-generating activities to earn money and satisfy our needs. In January, we took the initiative to create a small SILC group of 10 women living in the same community. In this SILC group, our contributions totaled BIF500 per month. After six months, we had BIF300,000. In August, we withdrew BIF200,000 for our children's schooling reasons and we did a fair share. However, we continued to contribute and it is in January 2012, that we withdrew BIF 120,000 to buy two goats (one male and a female). We benefited from manure to fertilize our fields.

After one year, the goat gave birth to two kids. Two members of the group received both kids. We intend to make a chain of solidarity until every member receives a goat.

Note, also, that for a member who had lost a family member; we gave him a total amount of BIF20,000 for comfort.

I cannot end without saying a word of thanks to Tubaramure project for advice and lessons he continued to give us. We will continue to apply them.

Annex V.T. Testimony 20: Cooking Demonstration

Date: July 2014

Location: Kirasira Colline, Butezi Commune, Ruyigi Province

My name is Valerie Kadende. I'm 29. I live in Kirasira Village in Butezi commune in province Ruyigi. As a housewife, I prepare food for my family. Before Tubaramure program, I prepared anything. I could not prepare them a balanced diet, that is to say, one, which contains carbohydrates, lipids and proteins. For instance, I prepared beans and cassava without vegetables or rice with beans without sauce, and, when I was pregnant, I ate anything because I didn't know that pregnant a mother needed a proper diet, such as porridge, vegetables and fruits. I thought that I cultivated vegetables to sell them and earned money to purchase what I needed.

With Tubaramure program, I learned a lot in the field of cooking, that is to say, the cooking demonstration. We learned how to prepare porridge with flour that we were given with vegetable oil, and how to prepare other local foods. Example:

To prepare porridge for the whole family, there is a measure to be followed:

Little flour + 3 table spoons of oil + sugar or banana to replace sugar

To prepare porridge for children:

Little flour + ¼ table spoon of oil + sugar or banana to replace sugar + vegetables prepared separately.

When we don't have this flour, we use our own flour + peanut + sugar and we mix the two. To prepare other foods, Tubaramure program taught us how to mix other foods for a balanced diet. Example: Beans + Sweet potatoes + vegetables

Rice + Beans + Meat

Milk + Maize bread

Rice + Potatoes + Meat

Note that a lactating woman who drinks milk with maize bread will have her breast milk increased, and a pregnant woman who eats porridge for breakfast, and who eats rice together with potatoes and meat, will have her weight increased, and her baby's weight will increase at birth as well.

I thank Tubaramure program for this demonstration that it taught us. I would ask the program to train us more in cooking demonstration if there are other recipes that we are ready to buy ingredients.

Annex V.U. Testimony 21: Community Health Worker

Date: July 2014

Location: Itahe Colline, Gisuru Commune, Ruyigi Province

I'm Damas Nzoya from Itahe Village, in Gisuru Commune in Ruyigi Province. I'm 45. I'm a health worker and have been for many years. I can give a testimony that Tubaramure PM2A brought positive changes at home. Before the program, hygiene was deplorable. Children had kwashiorkor, and there was no person in general mobilization teaching hygiene practices, nutrition and health for some illnesses prevention.

Today, following project activities, malnutrition related illnesses were reduced after learning practices in balanced nutrition for pregnant and lactating women as well as for children. Dirty related illnesses decreased because of new prevention practices including, the establishment of hand-washing stations, use of latrines with lids and good management of household waste by putting in place garbage pits. Pregnant women went to health facilities for prenatal consultations. We learned to set up kitchen gardens for vegetables that promoted self-sufficiency at any season. Following project sensitization, the population understood the importance that groups played in the start of their development. A very important acquisition was also the discovery of soymilk. Note that personal hygiene and that of households is appreciable.

Annex V.V. Testimony 22: Child Growth Monitoring

Date: July 2014

Location: Itahe Colline, Gisuru Commune, Ruyigi Province

I'm Gloriose Niyonkuru, age 42. I live in Itahe Village, in Gisuru Commune of Ruyigi Province. I'm married with 5 children, 4 sons and 1 daughter. However, among the five children, I lost one. Before Tubaramure, children growth was not at all good in our community starting with that of my children. Further to malnutrition, I gave birth to underweight children. Example: My first child was born with 2 kilograms; they told me that I had given birth to a mouse. The nurse told me to breastfeed the child for 6 months without giving him any other food. However, with housework that I had to do, I didn't follow the advice. I started to feed him at the age of 4 months with foods for adults but his weight didn't increase. Every time I went for his immunization, I noticed that the increase in weight ranged between 500 grams and 1 kilogram.

My second child was born with 2 kilograms, 100 grams. At one year, he had kwashiorkor due to malnutrition. I saw his belly swelling and I thought he was suffering from intestinal worms. Unfortunately, he died at the age of one year and three months.

The third child and fourth child were born with the same weight of 2 kilograms 200. I followed medical advice, but, at five months, I had given them poor-nutrient foods. They were growing underweight. Their weights ranged between 1 kilogram and 2 kilograms.

My fifth child is a girl who was born when I was in Tubaramure program. The program began when I was two months pregnant. I was put in the program at six months. I followed the training program on good nutrition and health practices

I went for prenatal consultations and postnatal consultations; I ate three or four times a day. I was really fat, and my health had improved. I then gave birth to a child of 4 kilograms. I breastfed her for 6 months without giving her any other food or drink. I practiced growth monitoring every month. At six months, I began to give her porridge and some fruits. She weighed 7 kilograms and 900 grams. At seven months, I began to give her food for adults; for example bean puree + potato. When I weighed her, she weighed eight kilograms and 500 grams. I continued to vary her diet until now, when she is 1 year, 6 months; she now weighs 13 kilograms.

I appreciate the growth of my child through Tubaramure program. If I had not participated in this program, my last child would not have undergone this good growth.

Annex V.W. Testimony 23: Graduated Mother

Date: July 2014

Location: Busyana Colline, Cankuzo Commune, Cankuzo Province

I'm Priscilla Niyonkuru, I'm 26 years and mother of two children. I have 3 years experience with Tubaramure program. I can testify that the project has changed many things in attitudes and practices in our community. Indeed, before the project, household hygiene was deplorable: hygiene awareness was virtually non-existent; there were no latrines with lids; personal hygiene was neglected; balanced diet was a dream; and we thought it was only for the rich people.

Today, our community has a new image with the project activities. In hygiene, all the households have latrines with lids and garbage pits around their homes. In terms of health, lactating and pregnant women attended health facilities for prenatal and postnatal consultation. We have Leader Mothers who have the equipment for detection of malnutrition case and refer children in cases of severe malnutrition CDS relatives.

In terms of nutrition, I always eat vegetables even in the dry season following the development of the gardens. I learned something new in soy production. Now I know the three food groups including carbohydrates, lipids, and proteins. In preparing my meals, I care about the three food groups. As for the porridge that we eat, we use whole meal flours. Hygiene has improved following the development of hand-washing stations.

I warmly thank Tubaramure that taught us so much about hygiene, health and nutrition. Thanks to its program, the health of our households in general and our children in particular has improved.

Annex V.X. Testimony 24: Leader Mother

Date: July 2014

Location: Busyana Colline, Cankuzo Commune, Cankuzo Province

My name is Marie Rose Nzungu; I am 32 years old. It was time Tubaramure came in Busyana. In terms of hygiene, it was catastrophic. At home, we had a very poorly arranged latrine covered with banana leaves. My neighbors on the other had no latrines and they defecated behind their homes, or in the fields. You could even go in the street, by day, and meet a man or woman squatting in his/her field or near his/her home. It goes without saying that the dirty hands related illnesses were rampant in our community. Children and even adults were suffering from diarrhea.

With regard to medical consultations, women did not go to health facilities for prenatal and postnatal consultations and did not vaccinate their children. If a woman told her husband that she was going to the health center, he scolded her. One day, I ran into the same problem. When I spoken to him, he replied, "You want to go for prenatal consultation? What for? A woman who does not go for prenatal consultations cannot deliver? You just want to run away from housework." I kept quiet and I dropped the conversation. This was the first pregnancy.

Currently, I thank Tubaramure program that has done a lot for us and especially raised our husbands awareness because, today, they have quit the stage of ignorance; they care for the housework, the health of their children and wives. Even at the HC level, we noticed that Tubaramure program changed things because it always begins with lessons on prenatal and postnatal consultations, family planning, AIDS, and child immunization before providing other services.

Annex V.Y. Testimony 25: Agro-pastoral Group Member

Date: July 2014

Location: Muyaga Colline, Cankuzo Commune, Cankuzo Province

I'm Consolata Nahishakiye, and I'm 37 and divorced with two children. I live in Muyaga Village in Cankuzo Province.

Before Tubaramure activities, I didn't know how to prepare our local foods. I prepared cassava and beans, and I gave to my children. I ate without washing my hands and my children did the same as well. They often fell ill.

With the project, I know how to prepare a balanced diet containing three food groups; carbohydrates, lipids and proteins. I also know to prepare porridge from local foods. For instance, I take soy flour, I mix with maize flour and sorghum flour with sugar, and I give to the children. I'm aware of the moments to wash my hands, and I sensitize my children to do the same. Today, the children are healthy; they no longer fall ill like before. There is no kwashiorkor at my home; all of this is thanks to Tubaramure program.

In addition, before the program, I was not aware of the importance of joining associations. There were no groups in my community. Today, there are many of them. I would mention, for instance, a group of agriculture and livestock and a SILC group.

Annex V.Z. Testimony 26: Delivery at the Home and Delivery at the Hospital

Date: July 2014

Location: Muyaga Colline, Cankuzo Commune, Cankuzo Province

My name is Pascasie Ndabita of Muyaga Village in Cankuzo Commune in Cankuzo Province. I'm 50 years old and am mother of 9 children. I would like to talk about the difference in hygiene level between delivery at home and delivery at hospital.

I gave birth to my second child at home. There were two midwives who helped me, and my husband was observing. I was sitting on an old matt on which they had put old and dirty clothes. One of the midwives was giving me knee strikes at the level of the back to help me to push the baby. Those strikes were hurting me. When my child was born, the second midwife, who was in front of me, took my baby without washing her hands and wrapped it in the dirty clothes. I spent two days without washing myself, as I had no energy for that. The following day, my friend came home and washed me as I had started to release bad smell.

With Tubaramure sensitization on prenatal and postnatal consultations, I went to the HC for that purpose. I then took a decision to go and delivery at the hospital where there is hygiene. The nurses are clean, the delivery table and the tablecloth are also clean. The nurses really cared for me; they did not give me knee strikes. When the baby was born, they washed him first and wrapped him in clean clothes. Then, they washed me and gave me care that I needed.

I thank God for having protected me against illnesses such as tetanus during my home delivery. I thank Tubaramure project for being concerned with mothers and children's health. To help other women, I will continue to raise awareness to give birth in a hospital setting.

Annex V.AA. Testimony 27: Tubaramure Father: Employee of Gitanga Health Center

Date: July 2014

Location: Gitanga Colline, Gitanga Commune, Cankuzo Province

I'm Laurent Bavumiragiye, aged 42 and married with 5 children. I work in Gitanga health center.

Before Tubaramure program started to work in our village, I worked in that health center where we received a lot of children, ranging between 100 and 120, suffering from kwashiorkor, and 80% suffered from intestinal worms; out of 10 children who came for stool testing, we found 8 cases of children with worms.

In addition, women didn't know about good food practices. They didn't know how to prepare a balanced diet, that is, containing lipids, carbohydrates and proteins. There were no kitchen gardens in our community.

Hygiene was deplorable. Children defecated in the yard, and stools could stay there the whole day. There were neither hand washing stations nor were there drying racks for kitchen utensils. With Tubaramure program, here at Gitanga health center, the number of children suffering from kwashiorkor reduced. Up until now, we've counted 6 children who are under kwashiorkor treatment, and they receive appropriate nutrition.

We've also noticed that there has been a decrease in the number of children suffering from intestinal worms.

Thanks to the program, households learned good food practices, such as the set up kitchen gardens to improve nutrition. As far as hygiene is concerned, households learned how to build appropriate latrines, hand washing stations and drying racks for kitchen utensils. Thus, there has been a behavior change in hygiene. Even a child of less than five can claim to be washing his hands before meals. As for health, and further to training by the program, most women who delivered at home regularly go to health centers for the prenatal and postnatal consultations; hence, there has been a decrease in maternal and childhood mortality. I thank Tubaramure Program for the activities carried out in our community.

Annex VI. Chapter Annexes

Annex VI.A. Chapter 2 Annexes

Annex VI.A.1. How Tubaramure IR1 Courses on Ministry Protocols Were Adjusted to Different Target Audiences, 2009-2014

Protocol Training was Designed to Support and Target Audiences	Content
Clinical-Level Trainings	
IMCI	This course on the integrated management of newborn and childhood illnesses comes with a set of algorithms for the observation and clinical examination of a child and questions for the mother to quickly recognize danger signs when a child comes with cough, diarrhea, fever, etc. The training is at a fairly high level and requires previous medical schooling.
CMAM	For the nurses, doctors, and clinical assistants, the training covered the management of malnutrition and how to conduct therapeutic feeding serves for several malnourished children. For the public health technicians, the community health workers and the Tubaramure health promoters, the emphasis on training has been on identifying malnourished children in the community and referring them to the health center. All groups were also taught the basics of good nutrition practices and how to teach mothers to provide wholesome nutrition with the foods that are available locally.

GM	<p>In this course health workers not only learned how to interpret the anthropometric measures of a child. Community health workers learned how to measure the MUAC, while health center staff and public health technicians learned to use the scales and measuring boards. They were also taught the basics of nutrition and signs of malnutrition. Trainees learned to check whether children had been vaccinated and dewormed and if they had received any micronutrient supplements. They were also taught how to give a presentation in the community. For the Tubaramure health promoters, there was an additional class for community cooking demonstrations.</p>
CPN	<p>For the nurses this was a clinical training, focused on the danger signs and risks in pregnancy and childbirth. For the Tubaramure health promoters and community health workers it was more basic, aimed at getting pregnant women to know the importance of regular checkups and why they needed to get their vaccinations and supplements during pregnancy and after childbirth.</p>
CPoN	<p>For the nurses this was a clinical training, focused on the danger signs and risks in childbirth and postnatal period. For the Tubaramure health promoters and community health workers it was more basic, aimed at getting pregnant women to know the importance of regular checkups and why they needed to get their vaccinations and supplements after childbirth.</p>
Community-Level Trainings	
<p>Integrated manual for community health workers including</p>	<p>Manual in French that summarizes the MoH strategy for community-level activities to support the major nutritional protocols. Started in 2012, this program for community health workers and public health technicians teaches simple and basic messages such as how to cool a child with a fever, how and when to give oral rehydration, and when to refer a child to the health center.</p>
<p>IMCI/CMAM/GM/CPN/CPoN (<i>community based</i>)</p>	

Management Trainings	
Data management and reporting	Manual in French that summarizes the major data management and reporting tasks that the newly appointed head doctors in the newly created health districts were expected to support.

Source: Kathy Tilford, Ange Tingbo, and Vera Bensmann. 2012. *Mid-Term Evaluation Report for the Tubaramure PM2A Program*. Bujumbura: CRS for Tubaramure and personal interviews with IMC Country Director Basile Ndumbi; IMC Program Manager Hervé Ketsobou; IMC Site Manager Jean Paul Cubaka; August 2, 2014.

Annex VI.A.2. List of MoH Protocols the Tubaramure PM2A Programs Supported Through Its IR1 Training, Supervision, and Coordination Activities, 2009-2014

List of MoH Protocols	Dates that Protocols the IR1 Activities Supported Were Validated by the MoH and/or Revised²¹⁷	Target Audiences
IMCI clinical	Initial date of validation: 2009; Revised and revalidated: 2012	Doctors and nurses
IMCI at the community level (IMCI/CMAM/GM/CPN/CPoN) <i>community based</i> . This protocol was eventually outlined in the Integrated Manual for Community Health Workers	Validated: August 2012	Doctors, nursing supervisors, Community Health Workers, Public Health Technicians, and Tubaramure Health Promoters
CPN	Validated: November 2011	Nurses
CPoN	Validated: November 2012	Nurses

²¹⁷ A major strength of the Tubaramure Program’s IR1 activities was that they built on and reinforced the MoH protocols that were most important for reducing the country’s high malnutrition rates. The dates in this column indicate the dates that the protocols that Tubaramure supported were first validated and revalidated after a revision. One of the major policy impacts of the Tubaramure Program was to provide some technical and logistical support for completing the validation process and/or revising the protocols to better address current thinking on treating and preventing malnutrition. The term ‘validation’ means that the MoH has officially approved the protocol for use.

CMAM	Initial date of validation: December 2009; Revised and revalidated: April 2010	Doctors, nurses, and medical assistants
Integrated Manual for Community Health Workers	Initial date of validation: August 2012	Nurses, Community Health Workers, and Public Health Technicians
GM	Drafted but not yet validated by the MoH	Nurses and medical aids
Data management and reporting: PRONIANUT manual on management and reporting		Medical information agents
Supervision: PRONIANUT manual on management and reporting		Doctor and nursing supervisors

Source: IMC Country Director Basile Ndumbi; IMC Program Manager Hervé Ketsebou; IMC Site Manager Jean Paul Cubaka; August 5, 2014.

Annex VI.A.3. Model Used to Train Health Center Staff and Cycles of MoH Trainings Supported by the Tubaramure Program, 2009-2014

Major MoH Protocols to Which the Tubaramure Staff Contributed	Persons From Each Health Center Trained in Each Cycle (Two Sessions Per Cycle)					
	Cycle 1 2010-11		Cycle 2 2012-13		Cycle 3 2014	
Clinical-Level Trainings	Session	Session	Session	Session	Session	Session
IMCI clinical	1	1	1	1		
CMAM	1	1	1	1	1	1
GM	1	1	1			
CPN/CPoN	1	1	1			
Community-Level Trainings						
IMCI/CMAM/GM/CPN/CPoN (community based)		1	1			
Integrated Manual for Community Health Workers ²¹⁸						1
Management Trainings						
Data entry and management		1				

²¹⁸ MoH. 2012. *Manuel Intégré des Agents de Santé Communautaire*. Bujumbura: IMC for Tubaramure

Source: IMC Country Director Basile Ndumbi; IMC Program Manager Hervé Ketsebou; IMC Site Manager Jean Paul Cubaka; August 5, 2014.

Annex VI.A.4. Principal Categories of MoH Personnel Involved in Tubaramure Training Missions and Types of Center Support Provided, 2009-2014

Types of Training	Types of Participants	Frequency and Timing of the Supervision Missions		Areas Where Supervision Missions Helped Improve Service Quality
		# of Joint Supervision Missions with the MoH ²¹⁹	# Supportive Supervision Missions by the MoH and the Tubaramure IR 1 Specialists	
IMCI clinical	Doctors, nurses	1 supervision/quarter/CDS	1 supervision/month/each CDS	Enabled supervisors to see if staff were using the new protocol (in general) and the new IMCI algorithm (in particular) correctly ²²⁰
CMAM	Doctors, nurses, aides	1 supervision/quarter/CDS	1 supervision/month/each CDS	Enabled supervisors to see if the protocol is being applied correctly
GM	Nurses, aides	1 supervision/quarter/CDS	1 supervision/month/each CDS	
CPN/CPoN	Nurses	1 supervision/quarter/CDS	1 supervision/month/each CDS	
IMCI/CMAM/G	Doctors,	N/A	N/A	Helped supervisors

²¹⁹ These missions included supervisors from the district (BDS), provincial (BPS), and national level (MSPLS) health departments.

²²⁰ This algorithm outlined a series of signs that the health worker should follow to determine what was wrong with a child and what actions should be taken to treat the child.

M /CPN/CPoN (<i>community based</i>)	Public Health Technicians, Tubaramure Health Promoters, Community Health Workers	1 supervision/ quarter/CDS	1 supervision/ month/public health technician	to determine whether or not the Public Health Technicians and Community Health Workers were conducting the community-based activities correctly
Data management and reporting	Nurses	No regular schedule since missions are need-based	No regular schedule since missions are need- based	Helped supervisors to determine if the collection and analysis of the nutritional data was being done correctly

Source: IMC Program Manager Hervé Ketsebou and IMC Site Manager Jean Paul Cubaka; August 5, 2014.

5. Three Types of Ministry of Health Coordination Meetings Supported by the Tubaramure Program, 2009-2014 Annex VI. A.

Type of Meeting	Unit	Participants	Frequency	Support Provided	2009	2010	2011	2012	2013	2014	Sustainability Challenges
Partner Coordination Meeting (<i>Reunion de coordination des partenaires dans la domaine de sant�</i>)	Province	-Provincial and district MoH administrators and technical staff -Hospital staff -NGOs working in health and nutrition -CDS managers -The governor and his advisors -The head administrator for each commune	Quarter	The concept existed and was reinforced by logistical and financial support (gas, per diem, food for participants)		X	X	X	X	X	During the last year, these meetings have been co-supported by other NGOs that intervene in both areas ²²¹
Partner Coordination Meeting for Community-Based Initiatives (<i>Reunion trimestrielle communautaire</i>)	Province	-Provincial and district MoH administrators and technical staff -Public Health Technicians -President of community health committees -Tubaramure staff ²²²	Quarter	New concept reinforced by logistical and financial support				X	X	X	Provincial offices are still seeking outside funding
Commune-Level Monthly Meetings (<i>Reunions communales mensuelle</i>)	Commune	-Public Health Technician with the Community Health Workers that he/she supervises -Sometimes attended by the <i>colline</i> chiefs, commune administrators -1 IMC staff member -Commune Tubaramure Health Promoters	Monthly	Limited financial and logistical support for the first meetings only				X	X	X	Few, if any, meetings since January 2014

²²¹ To address this issue, Tubaramure signed a new memorandum of understanding with the two provincial ministry offices in June 2013, which specified that they would only support one out of every two meetings. This provision pushed the ministry to identify other NGO actors to support the meetings, which it has done successfully.

²²² In contrast to the partner meeting, this meeting focused on community based health and nutrition initiatives. To date, it has not found a partner to replace Tubaramure, thus it is unclear whether the agenda of this group will be merged with the first meeting or continue as a separate forum.

Annex VI. A.6. Stakeholder Feedback on How the Program Increased the Rate of Prenatal Consultation in the Health Centers

The results found by the quantitative survey overlap with the observations made by the team final evaluation in the various health facilities visited and the interviews with the beneficiaries. According beneficiaries and partners met, the program has had a significant impact on increasing attendance at the health center, resulting in an increase in prenatal consultation and the number of women who give birth in health facilities.

“Before Tubaramure the rate of prenatal consultation rate in our health center NYAGUTOHA was less than 20%. Most women consulted especially the Abapfumu (traditional healers) and only a few cases of women who were having difficulty were referred to the health centers. Currently the number of women coming in for prenatal consultation has increased to almost 60%. This is a direct result of the Tubaramure Program—especially the distribution of food to the women.”

“The pregnant women are now are aware of the importance of antenatal care (four visits) and postnatal consultations. They visit health facilities for prenatal consultations; something that hardly existed before the program (Village Nyagutoha and Nyamasenga).”

“Even after stopping the distribution of food, attendance at the (health center) remains high because the recipients have understood the importance of the prenatal consultation for them and for their future child. They always stay motivated and go massively in the center. During the prenatal counseling session, the women receive information on the benefits of giving birth in health facilities, exclusively breastfeeding, immunization, and family planning.”

“To date, the rate of postnatal consultation is still very low, and lower than the 20% of women giving birth in health facilities. More public awareness building is needed to increase the rate of postnatal consultation at our center as well as others.”

Source: Final Evaluation focus groups; July 2014.

Annex VI. A.7. Links Between the Burundi Government’s National Protocols and MoH Indicators and the Program Outputs that Increased Program Efficiency

Tubaramure IR1 Outputs	National Protocols These Activities Supported ²²²	Number of Indicators the Provincial Health Service Was Required to Track to Monitor Its Performance on These Protocols	
		MoH	PBF

²²² The first year in parenthesis indicates the date of the first validated protocol; the second year it was revised.

Output 1.1. Pregnant and lactating women access pre and postnatal care services	CPN (2011) /CPoN (2012)	CPN: Yes CPoN: No	CPN: # of women that have participated in prenatal consultation # of women who came for VIH/SIDA testing CPoN: # of women who participated in postnatal consultation in the first 42 days after birth
Output 1.2. Implementation of national IMCI plan is supported	IMCI (2009, 2012)	Yes	1 indicator (# of consultations of children less than 5 years of age)
Output 1.3 Health facilities supported in providing growth monitoring (GM)	Growth Monitoring (under draft since 2009)	Yes	# of children completely vaccinated
Output 1.4. Severe and acute malnutrition (SAM)	CMAN (2009, 2010)	Yes	0 (no indicators currently being tracked)
Cross-Cutting: Strengthening the capacity of the MoH's community-level activities with the Community Health Workers	The Integrated Manual for Community Health Workers (2013)	Yes	The MoH is currently pilot testing some indicators that could be used to tract community-level initiatives for the PBF in two provinces (Makamba and Mwaro) ²²³
	PNDS (<i>Plan National pour le Developpement Sanitaire</i>): 2011-2015	Yes	

Source: Jean Paul Cubaka, IMC, Burundi; August 1, 2014.

²²³ The MoH is currently in the process of lobbying the PBF administrators to include various community-level indicators for nutrition and health systems in the PBF indicator list.

Annex VI. A.8. Tubaramure IR1 Exit Strategy

Activity to Be Sustained	Which Part?	How?	Who?	Pre-Existent Capacity	Resources Needed	Timeframe
IMCI, ANC/PNC, GM, CMAM	Equipment	Provide non-existent material (Sheet of GM, CMAM, IMCI)	MoH	Material provided by Tubaramure Program (medical and non medical material), sample of sheet of health activity	Yes, to replace the unfunctional tools	August 2014
	Training & Refresher Training	Train trainers	BPS, BDS	Team of trainers	No	Done
		Train nurses	BPS, BDS	Team of trainers	No	Done
		Train Community Health Workers	BPS, BDS, and nurses	Team of trainers	No	Done
		Train COSA	BPS, BDS, and nurses	Team of trainers	No	November 2013
	Train Paramedics	BPS, BDS, and nurses	Team of trainers	No	Done	
Supervision	Incorporate IMCI, ANC/PNC, GM, CMAM in routine supervision items	MoH (level and peripheric level)	PHA and DHA trained	No	Done	
Quarterly Meeting	Incorporate IMCI, ANC/PNC, GM, CMAM in meeting items, space out meetings organized by the program	MoH (level and peripheric level)	PHA and DHA trained	No	Done	
SPC communautaire	Equipment (see above)	Provide material (sheet of referral activity and report, children card), scales	BDS	Materials provided by Tubaramure Program, sample of sheet of children card	Yes, to replace the unfunctional tools and to produce sufficient quantity of children card	Done
	Training & Refresher Training	Training for nurses and para medical	BDS	PHA and DHA trained	No	Done, but in need of manual from MoH
	Supervision	Integrate local authorities and the community in this activity	BPS, BDS, Public Health Technicians, Community Health Workers	PHA and DHA trained	No	still running
ML/ASC (Home visit, sensitization, screening in the community)	Equipment (see above)	Provide material (Sheet of referral activity and report), Kit of Community Health Workers	BDS	Kit provided by Tubaramure Program, sample of sheet of Community Health Workers' health activity	Yes, to produce a important quantity of sheet	Done and to be distributed in August
	Training &	Make available pre-existent	BDS	Pre-existent manual of training and	No	Done in June
Activity to Be Sustained	Which Part?	How?	Who?	Pre-Existent Capacity	Resources Needed	Timeframe
	Refresher Training	manual communities activities		Public Health Technicians trained		
	Supervision	Integrate local authorities in this activity	BDS	PHA, HPT, and DHA trained	No	August 2014

Source: IMC, Burundi; July 2014.

Annex VI.B. Chapter 3 Annexes

Annex VI.B.1. Dates Different Training Modules Were Rolled Out to the Care Groups*

Cascade Training of Care Groups	2009	2010	2011	2012	2013	2014
Module 1	X	X	X			
Age-Specific Card (NEW)		X	X	X	X	X
Module 2			X			
Module 3			X	X		
Module 4					X	
Module 5					X	
Special Retraining Sessions ²²⁴						X

* X=Active Training Sessions

Source: Key informant interviews, FH, July 2012.

²²⁴ Since January 2014, the FH supervision and training activities have focused on retraining mixed care groups on the modules related to the EHA and ENA indicators that were lagging behind

Annex VI.B.2. Principal Recommendations of the 2012 Study on Sustaining Care Groups and Strengthening the Consideration of Gender in Tubaramure Programs

Activities to Strengthen the Care Groups

1. Gain access to seeds and goats and distribute them to the beneficiary mothers as a complementary activity that is part of a more broad-based strategy to keep them active in the program.
2. Initiate activities that are likely to motivate the Leader Mothers and provide them with the material and logistical support they need to transmit their information as well as other motivations (e.g. *pagnes*, tee shirts, brief cases, badges, umbrellas, per diems, transportation reimbursement, exchange visits, seeds, etc.).²²⁵
3. Select substitute Leader Mothers to shadow the LMs as they execute their tasks so that they can replace them should they be absent for any reason or resign.
4. Train Leader Fathers, who are at the same level of the Leader Mothers on the remaining modules.
5. Support the Leader Mothers and their husbands in creating mixed economic groups (*groupements*) for seed multiplication and the goat production using a *chaine de solidarit * approach in which the Leader Mother receives a male and female goat, keeps the progeny once the goat reproduces then passes on the animals to another member of the *groupement*.
6. Training the beneficiary mothers and their husbands on the “organization and functioning of associations” and “program design, execution, and monitoring and evaluation” in order to build the capacity of the associations to execute many of the core activities of the programs.
7. Contact the provincial coordinators for health about using the Leader Mother as community-level change agents.
8. Involve all local development actors in the Tubaramure PM2A Program’s activities in order to build local ownership for the activities. In conjunction with this, facilitate the organization of quarterly meetings with local development actors to strengthen their partnership and assistance with harmonizing the activities.

Activities to More Effectively Involve Men

1. Transmit at every opportunity public awareness messages that promote gender equity and paternal responsibilities in order to promote more equitable general relations in all program activities.
2. Train men as Leader Fathers at the same time that the women leaders are trained on the modules that have not yet been taught.

²²⁵ The NGO Food for the Hungry (FH) used to provide work-related items to LMs until they found that these incentives caused more problems and divisions than help. Many FH staff feel that the Tubaramure Leader Mothers’ persistent requests for additional support/incentives comes from the inclusion of food into the Care Groups. Once food became a condition for belonging to a beneficiary group and becoming a Leader Mother (who was elected by a beneficiary group), it affected the reasons that the Leader Mothers and beneficiaries participated in the BCC activities (Source: Feedback on draft Tubaramure Final Evaluation Report; September 22, 2014).

3. Involve the Leader Fathers—in collaboration with the Leader Mothers—in teaching the beneficiary mothers and their husbands.
4. Associate men in all activities that the program is involved, especially those like seed multiplication and goat production that are likely to encourage them to stay active in the program and/or to support their wives.

Source: Leonie Niyonkuru; 2012. *Etude sur la Pérennisation des Care Groups et les Activités Genre dans le Program Tubaramure*. Bujumbura: Tubaramure. (November 2012). Pp. 22-23.

Annex VI. B.3. Principal Recommendations of the 2012 Study on Obstacles to the Adoption of Good Practices on Health, Nutrition, and Hygiene

1. *Improve and revamp some of the different BCC messages by:*

- Clarifying and reinforce the BCC training messages;
- Ensuring that the Tubaramure Health Promoters have understand the content of the message and are able to teach this to the Leader Mothers;
- Testing the capacity of the Tubaramure Health Promoters to deliver the message and offer additional training if he or she needs it in order to deliver the BCC training correctly;²²⁶
- Retraining all LMs on all of the modules, in order to clarify the messages, so that they are better able to deliver these messages correctly to the beneficiary mothers;
- Adding a small section to all modules that emphasizes that the communities should not adopt the practices just to satisfy the program. This section is needed to support the long-term sustainability of the innovations.

2. *Build BCC public awareness programs focused on men:* These activities should be separate from the main cascade training programs. This is because one cannot count on women to execute these activities, especially since the communication between spouses is often not easy. Men's participation is critical and they must be systematically trained at the same level as the women.

3. *Strengthen BCC public awareness programs at the food distribution sites:* This activity—which is already being discussed by the program—needs to be realized, because it provides an opportunity for more consistent public awareness programs. These activities should address all of the BCC themes, even those relative to the modules that have been taught or a long time. This is also an occasion to clarify some of the misconceptions about Prenatal consultations.

4. *Simplify the norms for latrines:* The field realities in most *collines* are such that there is a high risk that the communities will simply not construct latrines. More discussion with the beneficiaries and key resource people is needed to reach a consensus on latrine models that the communities can support.

5. *Consider using alternative communication channels, like the churches, for public awareness programs that target husbands.*

6. *Support innovative ways of building more widespread public awareness of the BCC messages:* The Tubaramure leadership recently decided to summarize the key program messages into a series of posters that can be displayed in different offices of the communes, diffused on radio, in in song, as well as in the organization of a series of multi- disciplinary field teams with the collaboration of the communal administration. If this decision is executed, it will contribute to improving the impact of the BCC messages in the communities.

Source: Tubaramure PM2A Program M&E Team. 2012. *Etude sur les Obstacles a l'Adoption des Bonnes Pratiques en Matière de Santé, Nutrition et Hygiène, dans les*

²²⁶ Note: Post-tests were conducted at every module training to test the promoter's understanding of the key messages. If a promoter scored below a 75%, the Care Group supervisor followed up with additional training (Source: Feedback on draft Tubaramure Final Evaluation Report; September 22, 2014).

provinces de Ruyigi et Cankuxo. Bujumbura: M&E office of the Tubaramure Program for Tubaramure.

Annex VI.B.4. Categories of Data in the Tubaramure Groupement Database

1. Nom Du Groupement
2. Interview faite Par
3. Date d'Interview
4. Date de Naissance du Groupement
5. Age du Groupement en Mois (La durée d'existence de ce Groupement)
6. Province
7. Commune
8. Colline
9. Sous Colline
10. Nom et Prénom du Président du Groupement
11. Nombre d'Hommes à la Naissance du Groupement
12. Nombre de Femmes à la Naissance du Groupement
13. Effectif Total des Membres à la Naissance du Groupement
14. Nombre Actuel d'Hommes
15. Nombre Actuel de femmes
16. Nombre Total de Membres (Actuels)
17. Nombre d'Hommes qui sont dans le Comité Exécutif
18. Nombre de femmes qui sont dans le Comité Exécutif2
19. Effectif Total de ceux qui sont au Comité Exécutif
20. Principales Activités du Groupement
21. Groupements Agréés ou Non Agréés Localement
22. % de Participation aux Activités du Groupement
23. Textes Disponibles Régissant le Groupement
24. Ces Textes Sont-ils toujours Respectés?
25. Thèmes Déjà Discutés Au Groupement
26. Bailleurs Qui ont déjà Appuyé le Groupement
27. Autres Sources de Revenus pour faire fonctionner le Groupement
28. Difficultés Du Groupement
29. Besoin En Formation du Groupement (Formations dont le Groupement a besoin)
30. Y a-t-il SILC propre à votre Groupement?
31. Hommes qui sont Membres de ce SILC
32. Femmes qui sont Membres de ce SILC
33. Membres total de ce SILC
34. Nom et Prénom du PSN qui encadre de Groupement

Source: Tubaramure M&E Office; August 28, 2014.

Annex VI.B.5.
Sample Work Plan for a *Tubaramure* Promoter

Promoter Work Plan Assumptions:

Every Two Weeks

- Teaches all 12 Care Groups one at a time, each teaching takes approximately a half day;
- Supervises eight or more LMs, each supervision visit takes approximately a half day;
- Attends a bi-monthly meeting with his/her supervisor, this meeting lasts for half of a day; and
- Receives a supervision visit during normal activities (no additional time required).

Once a Month

- Spends at least a half day preparing the promoter's monthly report;
- Attends the community development committee meeting, this takes approximately a half day; and
- Visits the health facility at least once a month, this takes approximately a half day.

In order to teach all the Care Groups, visit the MoH one time per month, visit a CDC one time per month, attend the bi-monthly meetings, and prepare their reports, each promoter would only have time to supervise 11 LMs each month.

As each promoter has 12 Care Groups that are made up of 12 LMs; only supervising 11 LM per month would mean that it would take 13 months for the promoter to see each LM. Normally, the goal is for the promoter to supervise enough LMs so that each LM is visited every six months. Moreover, this list does not include the Promoter's additional responsibilities outside of the Care Groups.

Annex VI. B.6. Original Plan for Tubaramure Health Promoter’s Monthly BCC Schedul

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	Teach CG#1 ----- Supervise a LM (1)	Teach CG#2 ----- Supervise a LM (2)	Teach CG#3 ----- Supervise a LM (3)	Teach CG#4 ----- Teach CG#5	Teach CG#6 ----- Teach CG#7
Week 2	Teach CG#8 ----- Teach CG#9	Teach CG#10 ----- Teach CG#11	Prepares Monthly Promoter Report ----- Teach CG#12	Bi-Monthly Meeting (With Reporting) ----- Supervise a LM (4)	Supervise a LM (5) ----- Supervise a LM (6)
Week 3	Teach CG#1 ----- Supervise a LM (1)	Teach CG#2 ----- Supervise a LM (2)	Teach CG#3 ----- Visit the MoH	Teach CG#4 ----- Teach CG#5	Teach CG#6 ----- Teach CG#7
Week 4	Teach CG#8 ----- Teach CG#9	Teach CG#10 ----- Teach CG#11	Visit a CDC ----- Teach CG#12	Bi-Monthly Meeting ----- Supervise a LM (3)	Supervise a LM (4) ----- Supervise a LM (5)

Source: FH, Burundi; October 2012.

Annex VI.C. Chapter 4 Annex

Annex VI.C.1. Evolution of the Tubaramure Program's Support for Seed and Animals to the *Groupements*, 2010-Present

Type of Input	2010	2011	2012	2013	2014	Total
Amaranth (sachet of 5 g)	2000	0	3045	1440	0	6485
Leeks (sachets of 5g)	2000	0	0	0	0	2000
Onions (sachets of 5 g)	2000	0	0	1440	0	3440
Cabbage (sachet of 5 g)	0	465	3045	1440	0	4950
Eggplant (sachet of 5)	0	0	2172	0	0	2172
Carrots (sachet of 5 g)	0	0	673	1440	0	2113
Tomatoes (sachets of 5 g)	0	465	0	0	0	465
Papaya (plants)	573	1423	606	0	0	2602
Passion fruit (plants)	0	2000	0	0	0	2000
Mangos (plant)	0	0	600	0	0	600
Avocados (plant)	0	0	2439	0	0	2439
Soy (kg)	0	0	0	1920	4340	6260
Maize (kg)	0	0	0	720	0	710
Chickens (number)	0	4500	2000	0	0	6500
Fodder (kg)	0	500	250	0	0	750
Goats	0	0	0	523	2046	2569

Source: Tubaramure IR3 National Coordinator Regine Pacis Nohoreho, based on the distribution reports; July and September 2014.