

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

***NATIONAL COMMUNITY BASED NUTRITION
PROTOCOL (NCBNP)***

Kigali, Rwanda

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PREFACE

Survival, development as well as Child and woman protection are all part of human rights. These rights are adopted through international conventions voted by several countries, of which Rwanda is a member.

Good nutrition is an integral part of these rights. However, malnutrition constitutes one of the major causes of child morbidity as well as mortality among developing countries.

In Rwanda, malnutrition is a public health problem and it is one of the serious obstacles to the country's development. It contributes to the increase in morbidity and mortality rates.

The fight against malnutrition constitutes one of the priorities of the Rwandan Government. In order to carry out this fight properly, the country developed several strategies and implemented various programs among which include the Community Based Nutrition Program.

The Community Based Nutrition Program or NCBNP constitutes an approach to promote equity and efficiency in the fight against malnutrition in a participative way. In addition, it allows the population to access nutrition services and activities as a gate way to child survival activities at the community level.

This document is a national document and provides major guidelines for the implementation of the whole Community Based Nutrition Program.

This Community Based Nutrition program strategy is within the political will of the government to implement its National and Multi-sector strategy for the purpose of eliminating malnutrition in Rwanda.


Dr. Richard SEZIBERA
Minister of Health



ACRONYMS

IGA	: Income-generating activity
CHW	: Community Health worker
MHW	: Maternal Health worker
CRC	: Children Rights Convention
WRC	: Women's rights Convention
NWC	: National Women's council
NYC	: National Youth council
S	: Sector
PHSR	: Population and Health Survey in Rwanda
FAO	: Funds for agricultural Organization
BMI	: Body Mass Index
JAF	: Joint Action Forum
MIGEPROF	: Ministry of Gender and Family Promotion
MINAGRI	: Ministry of Agriculture
MINALOC	: Ministry of Local government
MINEDUC	: Minister of education
MUAC	: Mid Upper ARM Circumference
NTWG	: Nutrition Team Work Group
NGO	: Non Governmental organization
DDP	: District Development Plan
PNBC	: Community Base Nutrition Program
PTA	: Parent - Teacher Association
AIDS	: Acquired Immune Deficiency syndrome
FPG	: Follow-up and Promotion of Growth
IDD	: Iodine Deficiency Disorders
UNICEF	: United Nations Fund for Childhood
USAID	: United States International Agency for Development
HIV	: Human Immune Virus

WHO

: World Health Organization

INTRODUCTION

In Rwanda, malnutrition remains a public health problem and it is one of the major hindrances to the country's development. It contributes to the increase of morbidity and mortality rates. It is also partly the cause of intellectual deficiencies, mental retardation, blindness as well as the health deterioration and poor aptitude at work

There are multiple causes of such problems among which a combination of them can be identified in the agricultural sector, vast population movement, erratic climatic mode, insecurity, diseases, inadequate care of women and children, unsuitable nutritional habits and other more fundamental factors which made many Rwandans, women and children in particular vulnerable to hunger and malnutrition. It is also important to underline the general poverty as well HIV/AIDS pandemic. A thorough analysis that was made on these causes facilitates their classification in the following three categories: immediate, subjacent and fundamental causes.

During the crisis that occurred after 1994 period, nutritional activities were primarily curative and centered on the installation of "nutrition services" within health centers. This approach is valid only for curative care of malnutrition cases during emergency periods.

Since 1996, the Ministry of Health in collaboration with its partners (UNICEF, PSS/FIDA, NGO) supported the Community Based Nutrition services while emphasizing on the participation of local and women organizations to find a preventive and durable solution to malnutrition problems. Some simple actions, easy to be implemented by the Community workers, have a very positive impact on nutritional state and survival of the population.

This document will be used as guide to different interveners and try to define the role of each party from the preliminary stage of planning until the implementation of CBNP activities. It finally gives a suggestion on the mechanisms and tools designed for follow-up/evaluation at all levels of intervention.

The general objective of this CBNP protocol is to give interveners a clear orientation in matters related to Community Based Nutrition so as to enable them contribute to the elimination of malnutrition in children of 0-5 years old and expectant as well as breast feeding mothers.

Specific objectives are as follow:

- To harmonize community nutrition interventions;
- To furnish the Ministry of Health and other interveners with a guiding national document for planning and implementation of the Community Based Nutrition Program.

CBNP PROTOCOL

1. Context

The nutritional situation in Rwanda remains at an alarming proportion, considering the extent of different types of malnutrition identified in the country for many years.

For the last two decades, Energetic Proteino malnutrition and deficiencies in micro-nutriments remains an important public health problem in Rwanda, thus contributing to high mortality in infant, juvenile infants and maternal cases . Indeed the prevalence of excessive insufficiency fell from 29% to 23% between 1992 and 2005, whereas the delay in growth or chronic malnutrition during the same period slightly increased by 42% and 45% in the country. This situation indicates the persistence of difficult socio-economic conditions of the population during the last 20 years as worsened by the war and the 1994 genocide together with the HIV/AIDS pandemic.

1.1. Energetic Proteino Malnutrition

According to the population and Health Survey in Rwanda (PHSR 2005), the chronic malnutrition induces the delay of growth (size ratio compared to age), affect 45% of the children who are 0 to 5 years old. The excessive insufficiency affects 23% of the children who are 0 to 5 years old, which presents much lower weight for their age. The acute malnutrition (much lower weight for their height), which is associated to a high death rate, affects 4% of the children, that is to say more than double within the health population of the same age.

Energetic Proteino Malnutrition does not only affect the children. According to the PHS 2005,9,8% of women who are between 15 to 49 years old present a malnutrition with a body mass index less than 18.5 showing almost no difference between rural (9.9) and urban (9.8) areas respectively.

The Ministry of Health's 2003 annual report classifies Energetic Proteino malnutrition as a devastating case among the first 10 causes of morbidity among children between 0 and 59 months old in Health centers, the 4th cause of mortality among children between 0 and 1 year old as well as

the 2nd cause of mortality among children between 1 and 14 years old in Hospitals. Energetic Proteino malnutrition cases reported by the hospitals are only related to serious and visible cases (kwashiorkor, emaciation, kwashiorkor, emaciation), which are only the tip of iceberg. Whereas the least visible case situations (moderate and light) contribute to more than 50% of not reported deaths among children.

This alarming situation is partly due to food crisis caused by economic situation that prevails in the country and the chronic food deficits at the household level. This situation therefore requires, in a concomitant way, an immediate effective system of finding a solution and durable joint actions in order to improve nutrition and food safety.

1.2. Micro-nutrients deficiencies

Anemia, which is the major demonstration of iron deficiency, is the main cause of maternal death, low weight at birth, reduction of attention and the children's performance at school. Anemia is highly widespread in Rwanda, and it affects 56.3 of the children that are less than 5 years old (PHSR 2005). It is also common in expectant mothers and at the age of procreation according to (56%, PHSR 2005) mainly owing to the fact that the type of food for the majority of people contains cereals and tubers, whose iron ratio is low or made up of limited absorbed iron.

Apart from its known virtues in the prevention and treatment of nutritional blindness, vitamin A supports the resistance to infections thus reducing the death risks among children. In addition, it reduces the seriousness of infectious diseases illness (constant diarrhea, measles, dysentery and malaria).

Vitamin A therefore improves the child survival. Juvenile death rate that is above 70 per 1000 is considered as an indicator of vitamin A deficiency. In 2005, the death rate among children who are below 5 years of age in Rwanda is 152 per 1000, (PHSR 2005).

Disorders Due to Iodine Deficiency (DDID) affect the physical and mental development of a human being. According to the findings carried out in 2007-2008 by the School of Public health in micro-nutrients among primary school children in Rwanda, the goiter prevalence rate is relatively weak. It is 0.7 for visible goiter and 5.1 for palpable goiter. Analysis on urinary iodine showed that only 0.15

of the population present less than 50 µg/J iodide and the median was estimated at 761.35 µg/J with a scale of 36 µg/J and 7843 µg/J respectively. As for the Iodine content in cooking salt, 99.9% of the households consume iodized salt, taken that the fight against iodine deficiency program is satisfying.

These data show that deficiencies in Iron and Vitamin A are still a serious public health problem in Rwanda. In addition, data on other major micro-nutrients such as zinc, selenium, B1 vitamin are not available in order to determine whether their deficiencies also constitute a public health problem more particularly in HIV /AIDS context.

In addition, the Rwandan population is not only affected by the deficiency diseases. According to the PHSR 2000, 12.5% of women between 15 and 49 years old have excess weight (IMC > 25), particularly in urban area (24.5%) against 9.9% in rural area. Excess weight or obesity is a big risk factor of diseases such as diabetes, gout, cardiovascular diseases, etc

2. Community Based Nutrition Program (CBNP)

An International Conference on Nutrition organized by FAO/WHO in 1992 recommended that each country develops and implements a National Action plan on Nutrition including the Follow-up and Promotion of Growth or FPG as one of the priority actions while stressing on the participative approach.

The Follow-up and Promotion of Growth (FPG) are all the genesis of CBNP. It is defined as an intervention to nutrition in measuring the weight of children. The results of this weighing are used as advices to parents to take necessary actions in order to improve the growth of their children. A child's healthy growth is influenced by their nutrition hence their survival.

In 1998, at the end of Genocide and emergency period in Rwanda, the Ministry of Health, in collaboration with UNICEF initiated the installation of CBNP in Nyanza district as a strategy of preventing malnutrition. With time and UNICEF support to hospitals in the district, the CBNP moved with other integrated interventions towards community based nutrition. Currently, CBNP has

already been set up in 13/30 districts in the country (list on appendix 1) with following main objective:

3. CBNP objectives

3.1. General objective

The general objective of CBNP is to support and in close cooperation with the local communities, the implementation of a minimum package of progressive and adjustable community based activities, particularly in the field of health, nutrition, hygiene and sanitation in order to contribute to the reduction of death rate among younger children as well as the fall in the rate of malnutrition (P/A) among children who are 0 to 5 years old within project sites.

3.2. Specific objectives

Specific objectives are as follow:

- Preventing malnutrition and contributing to the reduction of high rates of malnutrition at the sites of intervention;
- Increasing the size rate of weighing children who are 0-5 years old at the community level;
- Providing information on good practice as well as the lesson learnt for the improvement of nutritional condition of children and their mothers;

Contributing to the participation and adaptation of the local community for the program's sustainability.

4. Strategies

CBNP main strategic axes of are as follow:

- Community participation and the adaptation: The objective is to promote Community participation within the framework of development activities while focusing on the survival,

protection, child development as well as the wellbeing of a woman so that communities may adapt them and become the actors of their development;

- Building capacity of the community in matters related to nutrition: The capacity of the community in matters related to will be strengthened through regular trainings either by the trainers or health service providers. The availability of all the tools, materials and equipments necessary for effective implementation of the Community Based Nutrition must be ensured so that the protocol objectives are achieved. Training supervisions will be made on a quarterly basis (Appendix 6);
- Integrating services: Other interventions can be grafted with the monthly weighing exercise of the children who are below 5 years old as a supplement to micro- nutrients and de-parasite, follow-up of malnourished children, household food security and pre-school nutrition program.
- social mobilization and behavioral change communication;
- Triple A approach (Appreciation - Analysis - Action);
- partnership with the other sectors of development;
- Promoting gender approach: It is necessary to support and facilitate women and men participation in the same equal footing within the mechanism of decision making (nutrition committees, tap water management, give a sense of responsibility to maternity health workers, organizing community health insurance etc ...), women access to development activities in Umutugudu (involvement in decision making, AGR/Cooperatives, education, etc) all allow improvement of family nutritional situation;
- Synergy/convergence with the other interventions in the same sites: health centers, water project, agricultural project etc.... interventions on the health of children, nutrition, hygiene and sanitation will be convergent and synergistic at the community and household level;

5. Activities

5.1. Follow-Up and Growth Promotion as well as identifying malnutrition cases at community level

5.1.1. Follow-Up and Child Growth Promotion

All children aged between 0 and 59 months are weighed monthly at the level of each UMUDUGUDU by the Community Health Workers (CHW).

During the weighing exercise, the following services are provided:

- weigh all children who are below 5 years old by using Salter balance;
- recording children weight on individual record sheets (appendix 2) according to age and filling the growth curve, interpreting it and checking on vaccination calendar; providing individual counseling service and orientation depending on the child's nutritional state;
- recording children weight within the Community register (appendix 3) and marking it on the Community form (appendix 4).

Note:

- The age- weight index expressed in Z-score will be used according to the current growth filling form on which the child nutritional state is indicated: green color for a good nutritional state; yellow for a moderate state and red for severe malnutrition.
- The curve shape of the balance growth for each child will be interpreted by CHW and will be explained to the relative or another person who deals with the child.
- MHW must give both pregnant or breastfeeding mothers enough advice on their nutrition in general and their nutritional state in particular.

5.1.2. Identifying malnutrition cases

Identifying cases of malnutrition among 0-59 month old children will be done according to the national protocol for malnutrition management within the community.

- For children who are less than six months: any child presenting at least one of the criteria of malnutrition at this particular age must be referred to a HC.
- For children who are between 6 and 56 months:
 - ✓ use MUAC and P/A (colors) according to the current protocol.
 - ✓ Any child whose P/A is lower or equal to -2 Z-score or the MUAC being lower than 125 mm must be referred to a health center.
- Any child presenting at least one of the danger signs (see national protocol for malnutrition management) must be referred to a HC (appendix 5);
- Any expectant or breastfeeding mother whose MUAC is lower than 210 mm (see national protocol for malnutrition management) must be referred to a HC.

5.2. Education for behavioral change

One of the major roles of a CHW is to exempt medical and nutritional education for behavior change in a positive sense. This education can either be done in group (talks) or individually during the time of weighing or during home visits.

5.2.1. Mothers' Educative talk

Before each weighing period, a CHW gives an educational talk by using nutritional education booklets on health, nutrition and hygiene topics.

These varied topics usually include exclusive breast-feeding; complementary food; meal planning; emaciation and kwashiorkor; importance of father's role in preventing malnutrition; nutritional safety; childbirth preparation; hygiene and household sanitation; family planning; prevention and

awareness of diarrhea, malaria, and respiratory infection symptoms (where and how one can access sanitary services, mutual health insurance).

5.2.1. Individual Counseling

During child growth follow-up: While filling in the growth curve, a CHW interprets and uses such occasion to give advice according to the child's nutritional state.

During home visit: After the child growth follow-up, a CHW must pay home visits particularly in targeting families that have children who do not gain some weights or who were admitted at OTP.

During individual counseling, a CHW uses counseling cards on food provision and young child feeding.

5.3. Culinary demonstration

A culinary demonstration is carried out on a monthly basis at Umudugudu level. For that reason:

- locally available food is identified;
- a list of identified food is drawn up according to its nutrient contents;
- balanced diet as well as elaborate collations;

Before conducting culinary demonstrations, each mother's contribution is identified.

5.4. Care of malnutrition at the community level

During monthly weighing, a CHW is responsible for:

- Detecting children who have a moderate or severe malnutrition by using 2 indicators:
 - MUAC and P/A report;
 - And other alarming signs of malnutrition such as problems in breast feeding; lack of breast milk; loss of weight during 2 consecutive weighing; a child in yellow or red band; edema; acute diarrhea; vomiting.
- Detecting any expecting or breastfeeding mother whose MUAC is lower than 210 mm (refer to the national malnutrition management protocol).

Children as well as women detected to be moderately or severely malnourished are referred for care at a nearest health centre.

A CHW is responsible for:

- Making a follow-up of children who are admitted in outpatient therapy treatment program (OTP) and in Nutrition Supplement program (NSP) through home visits by using Checklist for home visits (appendix 7);
- Carry out nutritional education on behavioral change in order to give individual advice to the parents or other people who take care of children.

5.5. Promoting Community participation by Triple A

Triple A approach consists of:

Appreciation of the problem

Analysis on causes related to the problem

Action: setting in motion solutions related to the identified problems, by rationally using the resources available.

On the level of each village there should be a Community based nutrition committee which is composed of different community health workers: MHW, binomial CHW (2), and CHW in charge of social affairs including the village chief “Umudugudu”. The Community Based Nutrition Program is an integral part of the Community health package.

After each weighing session, an analysis of a child nutritional state in each same “Umudugudu” is made while basing on the children’s weight as indicated on the village Community card and according to the Triple A approach.

Through discussions, solutions in connection with the causes of nutrition state in Umudugudu are proposed by the community.

The triple A approach allows the support of Community initiatives that lead to bigger joint efforts by other interventions and through harmonizing the vision of nutrition problems as a development challenge. It also ensures participation of beneficiaries in determining their needs, implementing, following-up and evaluating the activities.

5.6. Supplement in micro-nutrients and de-worming

Supplement in vitamin A for children between 6-59 months as well as post partum women (in 8 weeks which follows childbirth), de-parasite of children who are 12-59 month old, and those at school age are systematically done during mass campaigns (Mother and Child Health Week or other campaigns). During the child weighing by Community workers, supplement in vitamin A and de-parasite is carried out in children as well as in post partum women having escaped mass distribution or health training after childbirth.

For the sick children, the supplement and de-parasite are made through the integrated community child care diseases (ICCCD).

For children who are detected as malnourished, supplement and de-parasite are according to the protocol carried out at FOSA level.

Food dressing at the households level (ex: Sprinkles) can also be encouraged.

5.7. Food security within Households

To ensure food and nutrition security at the household level, the following activities will have to be undertaken:

- Promoting kitchen garden (Akarima k' Igikoni) and fruit trees, breeding of large and smaller live-stock (cows, goats, pig, sheep, rabbits, hens and fish, bees ...);
- promoting dairy consumption;
- production and consumption of a balanced diet (vegetables, fruits, meats) in order to ensure food that is rich in micronutrients (bio-dressed food, orange sweet potatoes), animal proteins, and other nutrients;
- promoting modern agricultural techniques such as bio-intensive agriculture, land consolidation, seeds selection, use of the suitable inputs...;
- promoting income-generating activities (IGA).

- Offering nutritional support to children who are under five years old, expecting and breastfeeding mothers with a special attention to children and mothers who infected and affected by HIV/AIDS as per the national care protocol (can be inserted into the Malnutrition Management paragraph).

5.8. Integration of pre-school Nutrition Program in the Community

At Community level, nutrition of children who are under 5 years old and are in nursery schools or in other Childhood training Community centers require special attention and the following activities will need to be promoted:

- consumption of a nutritionally balanced food (while insisting on milk consumption, fruits and vegetables, etc); this in will have to be in collaboration with the parents;
- growth monitoring;
- training of basic concepts of good nutrition;
- promoting school gardens;
- supplementing micronutrients and the de-parasite according to the protocol;
- promoting best practices of hygiene such as washing-up hands, drinking portable water.

6. Stages carried out at the sites

1. Analyzing the state of nutrition and all its determinants in collaboration with the community (multi-sector Analysis);
2. Sensitizing and mobilizing all Community actors (including local authorities) basing on the nutritional state results analysis;
3. Establishing management organs and follow-up of program at all levels;
4. Identifying priorities in the community on each level of intervention;
5. Community Participation in planning and developing a community plan of action ;
6. Implementation of plan of action;
7. Training of health workers;
8. Availing necessary materials;
9. Training of CHW (according to the training module and management tools);

10. Starting activities of promoting and following -up child growth in the community (weighed, filling of cards and other tools,...);

11. Initiating and implementing other Nutrition and Health activities:

- ✓ IEC
- ✓ Supplementing micro-nutrients,
- ✓ De-parasite,
- ✓ Home visit,
- ✓ vaccination,
- ✓ FP,
- ✓ Food Supplement (FSP).
- ✓ Promoting the use of impregnated mosquito nets
- ✓ Creation of homes with culinary demonstration
- ✓ AGR (Agriculture, breeding, etc....)
- ✓ Promoting hygiene
- ✓ Promoting vegetable gardens (Akarima k' igikoni) and garden school
- ✓ Promoting ANJE, including Agakono k' umwana
- ✓ Etc (Refer to 3 years strategic plan)

12. Supervision, Follow-up and Evaluation

7. Follow-up and Evaluation

The follow-up and the evaluation allow to:

- Check if the activities carried out correspond well with objectives of the project;
- Identifying problems and finding suitable solutions. For example, long waiting during weighing sessions constitutes one of the causes of mothers' unwillingness. Provision of material support (various contributions) could be one of the solutions.
- Evaluating the project performance.

The follow-up of CBN sites activities is done by the management tools that are relevant to all levels. This follow-up includes analysis, processing and information broadcast as well as periodic

exchange of information and experience among various interveners at each level. Each level must ensure the feedback in applying pre-established filling forms.

Standard filling forms used as a monthly report (appendices 8, 9, 10) adapted at each level will be filled in and sent to the levels concerned:

- Umudugudu, cell and sector: monthly
- District: monthly, quarterly and annually

In addition, monitoring of activities is focused at village level and is done on the basis of six month using monitoring forms (appendices 11, 12, 13). The following indicators are subject to this monitoring:

- % of time without lack of follow-up materials and the presence of CHW;
- % of target population being able to profit CBNP in their own village;
- % of 0-59 month old children living in a village where the program visited at least once during monitoring period;
- % of 0-59 month old children who presented themselves to CBNP without any single absence during monitoring period;
- % of children having adequate coverage and a required quality standard follow-up;
- Availability of materials and inputs.

8. Management of CBNP activities

8.1. Coordination and Program Management Organs (Refer to table 1)

Management Organs	Level
Multi-sector village committee for Eliminating Malnutrition	Umudugudu
Multi-sector Cell committee for Eliminating Malnutrition	Cell
Multi-sector Sector committee for Eliminating Malnutrition	Sector (SC)
Multi-sector District committee for Eliminating Malnutrition	District
Central multi-sector Central committee for Eliminating Malnutrition	Central level

8.2 Composition, Roles and Responsibility for various Coordination and Management Organs

8.2.1. Multi-sector village committee for eliminating malnutrition

Composition:

- Village Chief,
- 2 binomials CHW,
- 1 MHW,
- 1 CHW in charge of social affairs

Roles and Responsibilities

- Participating in analysis from the starting state
- Planning and making a follow-up of activities: analyzing monthly data and giving the reports at the cell
- Organizing and presiding over monthly meetings for the purpose of sharing information that is relevant to the situation
- Evaluating the program
- Ensure sustainability of CBNP.

8.2.2. Multi-sector cell committee for eliminating malnutrition

Composition:

- Executive secretary,
- CHW representative,
- NCW representative ,
- NYC representative,
- Responsible for economic development,
- Person in charge social,

Roles and Responsibilities

- Ensuring coordination of CBNP activities at cell level
- Identifying the population needs in matters related to nutrition at cell level

- Compiling and analyzing report from the villages and sending them to SC;
- Convening and presiding over monthly meetings of representatives of Multi-sector village Committee for Eliminating Malnutrition;
- Playing the part of an intermediary between the village and SC.

8.2.3. Multi-sector of sector committee for eliminating malnutrition

Composition:

- Executive secretary,
- Head of Health Centre,
- Chairman of community health workers' cooperative,
- Community health workers' trainer,
- NCW representative,
- NYC Representative,
- Agriculture officer,
- Veterinary officer,
- Chairman of PTA (Parent Teacher Association),
- Cooperative representatives,
- Civil society representative,

Roles and Responsibilities

- Ensuring coordination of CBNP activities at sector level,
- Analyzing reports from the cells and defining priorities of intervention in matters related to eliminating malnutrition at sector level,
- Convening and presiding over quarterly meetings of representatives of the Multi-sector Committee for Eliminating Malnutrition at cell level,
- Advocating and mobilizing resources,
- Playing the part of an intermediary between cells and the district

8.2.4. Multi-sector committee for eliminating malnutrition at district level

Composition:

- V/Mayor in charge of social Affairs
- Doctor head of a hospital
- Hospital nutritionist
- In charge of co-operatives
- In charge of health
- In charge of education
- Supervisor of community health activities
- Representatives of Multi-sector Committees for of Eliminating Malnutrition at sector level
- NCW representative,
- NYC representative ,
- Agriculture officer
- Veterinary officer
- Representative of Joint Action Forum (JAF)
- Rwanda Nutrition Society

Roles and Responsibilities

- Ensuring coordination of CBNP activities at district level
- Assuring integration of activities for eliminating malnutrition within the district development plan(DDP)
- Analyzing reports from sectors and to the direct and directing priorities of intervention in matters related to eliminating malnutrition all around the district
- Advocating and mobilizing resources
- Convening and presiding over semester meetings of representatives of Multi-sector Committees for Eliminating Malnutrition at sector level.

8.2.5. Multi-sector committee for eliminating malnutrition at central level

Composition:

- Nutrition Desk /MOH
- Technical Working Group on Nutrition (TWGN)
- MINEDUC, MINAGRI, MINALOC, MIGEPROF
- UNICEF, WHO, USAID
- Rwanda Nutrition Society (RNS) etc.

Roles and Responsibilities

- Availing the national policy on nutrition to all levels
- Preparing CBNP standard working documents and distributing them to all levels
- Ensuring technical, material and financial support of the program
- Ensure coordination, follow-up and evaluation of the program
- Advocating for the program at all levels
- Supporting nutrition state analysis at the level of each district.

Table 1: Coordination and Program management Organs

Level	Attributions	Interventions	Composition	Supports
Central	Standardization	<ul style="list-style-type: none"> - Availing national documents - Advocacy - Strategic planning -Financial and technical support - Coordination - Follow-up /supervision, Evaluation 	<ul style="list-style-type: none"> - Administration (MINISANTE, MINAGRI, MINALOC, MIGEPROF...) - International Parteners (UNICEF, WHO, USAID,...) - RNS - NGOs 	<ul style="list-style-type: none"> - Monthly meeting - supervizing mission - Mission report - Semester report -Annual income
District	Coordination	<ul style="list-style-type: none"> - Assuring integration of nutrition activities - Analyzing sectors' reports and identifying priorities - Advocacy and mobilisation of resources - Convening and presiding over semmister meetings of integrated multi-sectorial committees of sectors 	<ul style="list-style-type: none"> -Vice Mayor in charge of social affairs - District Hospital - In charge of cooperatives, health, education - Community health supervisor - Multi-sectorial committees representatives in sectors - NCW and NCY representatives - Agriculture officer, Veterinary officer - JAF representative - RNS 	<ul style="list-style-type: none"> -Semester meeting of integrated multi-sectorial committees in sectors - Sectors' reports -Report to the central level
Sector	Coordination and follow-up at sector level	<ul style="list-style-type: none"> -Analyzing cell reports and identifying priorities - Convening and pre siding over quarterly meetings of integrated multi-sectorial committees of cells - Advocacy and mobilization of resources - Intermediary between cells and the district 	<ul style="list-style-type: none"> - Executive Secretary - Head of health center - Chairman, Trainer of CHW - NCW and NCY representatives - Agriculture officer, Veterinary officer - PTA Chairman - Cooperatives representatives - Civil Society representative - In charge of social affairs 	<ul style="list-style-type: none"> - Quarterly meeting of integrated multi-sectorial committees in cells - Cell reports -Report to the District

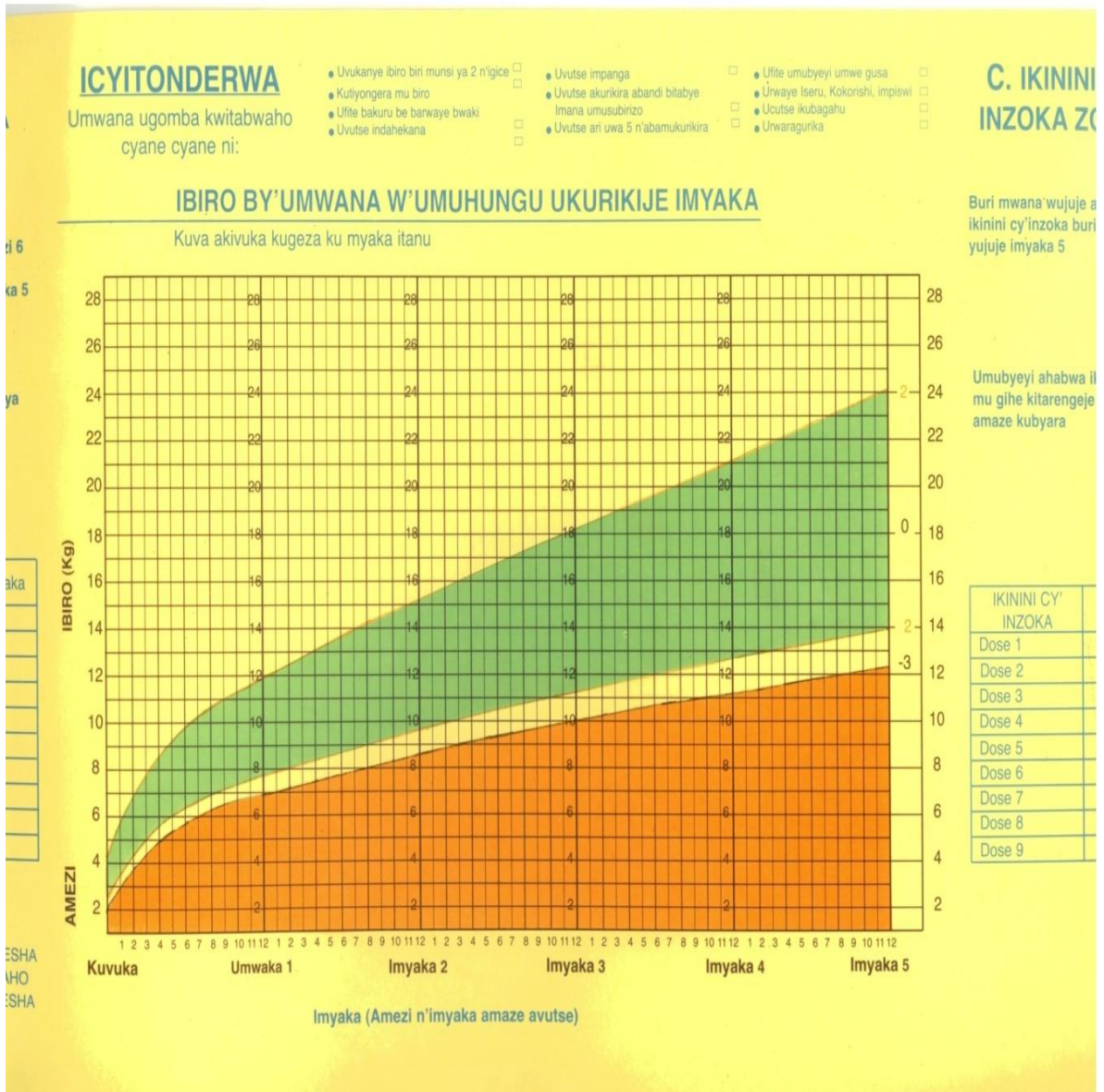
<i>Level</i>	Attributions	Interventions	Composition	Supports
Cell	Coordination and follow-up at cell level	<ul style="list-style-type: none"> - Identifying community needs - Convening and presiding over monthly meetings of integrated multi-sectorial committees of villages - Intermediary between villages and sectors 	<ul style="list-style-type: none"> - Executive Secretary - CHW representative - NCW and NCY representatives - In charge of social affairs - In charge of economic development 	<ul style="list-style-type: none"> - supervizing mission - Village reports - Report to the sector
Umutugudu	Implementation	<ul style="list-style-type: none"> - Activities - Analyzing the situation - Planning, implementation, training and evaluation of activities - Monthly meeting for information sharing - Evaluation of activities - Assuring CBNP sustainability 	<ul style="list-style-type: none"> - Village chief - 2CHW binomials - 1MHW - 1CHW in charge of social affairs 	<ul style="list-style-type: none"> - Activities 3A - Monthly data

APPENDICES

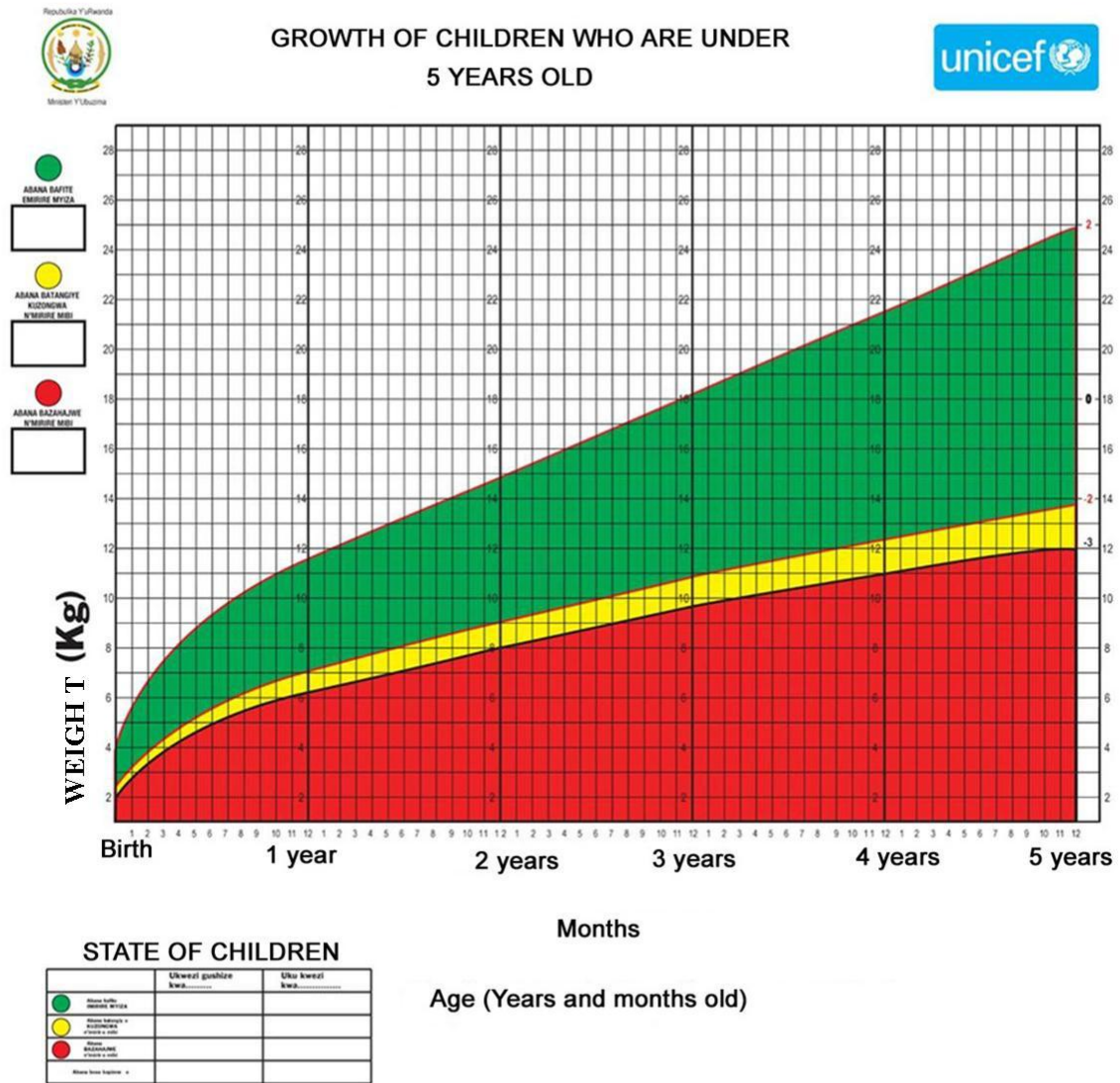
APPENDIX 1: List of 13 districts with CBNP

Provinces	District	Hospital
<i>SOUTHERN</i>	NYANZA	Nyanza
	GISAGARA	Gakoma
	HUYE	Kabutare
Sub Total	3	3
<i>NORTHERN</i>	BURERA	Butaro
	MUSANZE	Ruhengeri
	GAKENKE	Ruli
	RULINDO	Rutongo
	GICUMBI	Byumba
Sub Total	5	5
<i>WESTERN</i>	RUBAVU	Gisenyi
	NGORORERO	Kabaya
		Muhororo
	NYABIHU	Shyira
RUSIZI	Mibilizi	
Sub Total	4	5
<i>EASTERN</i>	NYAMATA	Bugesera
Sub Total	1	1
TOTAL	13	14

Appendix 2 : Individual chart



Appendix 3 : Community chart



Appendix 4 : Community register

Census registry of under five children in every village

Sector:

Health Center:

Cell:

Village:

Date:

No.	Name	Date of birth	Age (In months)	Sex	Father's names/male guardian	Mather's names /female guardian	Observation
Total							

Appendix 5 : Census form

REGISTRY OF FOLLOW-UP, GROWTH AND FEEDING IMPROVEMENT OF UNDR FIVE CHILDREN IN A VILLAGE

PROVINCE:

HOSPITAL:

Child number:

District:

Child names:

Health Center:

Sex: MALE/FEMALE

Sector

Date Date of birth (Month/Year):

cell

Father's name:

Village:

Mather's name:

Area concerned by the health center: YES/NO

Year	Child weighing month	CHILD GROWTH (Kg/Months)					MID UPPER ARM CIRCUMFERENCE (MUAC)			9	10	11	12	13	14	15	16	17	18
		1	2	3	4	5	6	7	8										
	January																		
	February																		
	March																		
	April																		
	May																		
	June																		
	July																		
	August																		
	September																		
	October																		
	November																		
	December																		

Records

1. Names of the child after birth
2. Weight (Kg)
3. GREENI
4. YELLOW
5. RED
6. GREEN
7. YELLOW
8. RED
9. SWELLING(Œdema)
10. Breastfeeding only
11. Received Vitamin A
12. Received worm tablet
13. Observed vaccination program (yes/no)
14. Was visited at the residence?
15. Was sent to see the doctor
16. No longer under the program/state the reason
17. Resume the village program
18. Explanation(the child's sickness or any other comment)

Appendix 6: Reference and counter reference forms

Sending and reply message forms

CHILD GROWTH AND FEEDING PROGRAM AT THE VILLAGE LEVEL (CBNP)

Ministry of health

a) **A DOCUMENT FOR SENDING A CHILD TO A HEALTH CENTER**

District

Sector.....

Child's namesFather's name.....,

Mother's nameCellvillage

Date of birth/...../..... Weighing (Kg) MUAC: red or .. yellow

Was sent tohealth center

Reasons:

The child is in red colourthe child is in yellow colour the child is swelling †

Other reasons

Date :/...../.....

Names and signature of a health counselor.....

b) **MESSAGE RESPONSE**

Child's names:

Date of arriving at the health center:/...../.....Time (hours):

Diagnosed disease:

Drug administered:

Final results(to be treated and discharged/recovery/referred to hospital/death /Disappearance:

.....

Comments;

Doctor's name:

Signature:

Date/...../.....

AT THE HEALTH CENTER

Appendix 7: Quarterly supervision of CBNP activities form

Site Identification: to be filled

Activities	Supervision №1	Supervision №2	Supervision №3	Supervision №4	Observation
	Date :.....	Date :.....	Date :.....	Date :.....	
I. Planning of activities					
1. Planned CBNP meetings					
2. Respective Planning					
3. weighing days chosen correctly					
II. Receiving participants					
4. Acceptable waiting Conditions					
5. Disciplined waiting line					

6. Clean and attractive CBNP site					
7. Acceptable duration of CBNP meeting(2 hours)					
III. Products and materials available					
8. Registration materials available					
9. Complete and good conditioned working materials					
10. Micro- nutrients (vit A and Mebendazole) available					
IV. Registration					
11. Registration on the correct individual form					
12. Correct filling of individual form					
13. Correct filling in the register					
V. diagnosis exercise					
14. Complete and well done interrogation					
15. Systematic and correct weight taking					
16. Systematic and correct research on anemia signs					

17. Research on the signs of Vitamin A deficiency					
18. Systematic control of vaccination state					
19. Research on malnutrition signs					
20. Correct interpretation of a child's growth curve					
VI. Care					
21. Systematic and correct administration of vitamin A					
22. Systematic and correct administration of mebendazole					
23. Criteria of transfer to a known and respected health center					
24. Planned talk meeting					
25. Relevant planning					
26. Acceptable and available scholastic materials					
27. Accepted methodology					
28. Respective talk duration					

29. Practical research on non accompanied children					
VIII. Auto-evaluation					
30. Correctly calculated target population					
31. Nutrition State of weighed children is categorized					
32. Existence of data analysis with the community					
33. Existence of decisions correcting identified problems					
Global Total Score					

Activity

1 – Done correctly

2 – Done but need improvement

3 – Not done or done incorrectly

AT VILLAGE LEVEL

Appendix 8 : Check-list for home visit

CHW Name: _____

Date of Visit: _____

Child's Name: _____

Feeding		
Is the ration of RUTF present in the home?	Yes	No
If not, where is the ration?		
Is the available RUTF enough to last until the next OTP session?	Yes	No
Is the RUTF being shared or eaten only by the sick child?	Shared	Sick child only
Is food other than RUTF given to the sick child?	Yes	No
If yes, what type of food?		
How many times per day is the sick child given food/RUTF to eat?		
Does someone help/encourage the sick child to eat?	Yes	No
What does the caregiver do if the sick child does not want to eat?		
Is the child currently breastfeeding? (for children < 2yrs)	Yes	No
Is clean water available?	Yes	No
Is water given to the child when eating RUTF?	Yes	No

Caring		
Are both parents alive and healthy?	Yes	No
Who cares for the sick child during the day?		
Is the sick child clean?	Yes	No
Health		
What is the household's main source of water?		
Is there soap for washing in the house?	Yes	No
Do the caregiver and child wash hands and face before the child is fed?	Yes	No
Is food/RUTF covered and free from flies?	Yes	No
What action does the caregiver take when the child has diarrhea?		
Food Security		
Does the household currently have food available?	Yes	No
What is the most important source of income for the household?		

If problems are identified please list any health education or advice given in the space below or on the other side of the page. Return this information to the health facility.

Appendix 9 : Monthly report form at the village level

Monthly village report

How children were censured	Months					
	0-6	7-11	12-23	24-35	36-59	Total
Number of censured children						
Number of weighed children						
Number of children in green color						
Number of children in yellow color						
Number of children in red color						
Number of children who were transferred to the health center						
Number of children who were swollen						
Number of children who died						
Number of children who were absent for three times						
Number of children who received vitamin A tablet						
Number of children who were given worm drug/mebendezole						
Number of children who underfed (in yellow color) and followed at village level						
Number of children were most underfed (in red color) being followed at the village level						
Number of children who were visited at home						
Number of weighed children in nursery school						
Number of children who were recovered						

How children were censured	Months					
	0-6	7-11	12-23	24-35	36-59	Total
Number of breastfeeding women						
Number of pregnant women						
Number of breastfeeding women whose MUAC was measured:						
Number of pregnant women whose MUAC was measured:						
Number of breastfeeding women whose MUAC was above 21cm:						
Number of pregnant women whose MUAC was above 21cm:						
Number of breastfeeding women whose MUAC were below 21cm :						
Number of pregnant women whose MUAC was below 21cm :						
Number of breastfeeding women who are not more than 6 week after giving birth and have been censured						
Number of breastfeeding women who are not more than 6 weeks after giving birth and have received vitamin A tablet						
Number of breast feeding women who are not more than 6 weeks after birth and have received worm tablet						
Given lesson: <ul style="list-style-type: none"> • • 						
Number of prepared balanced diet						

Appendix 10: Monthly report of activities at the health center

Health Center :

Month :.....

Year :.....

Total population:.....

Target population:

- Children between 0-59 months:.....

-Pregnant women :.....

- Breastfeeding women :.....

Level		Nutritional state of children by age group												Nutritional state of women					
Cell	Village	0-11 months			12-23 months			24-36 months			37-59 months			Pregnant women			Breastfeeding women		
		V	J	R	V	J	R	V	J	R	V	J	R	V	J	R	V	J	R

Appendix 11: Monthly report of activities at the district level

Appendix 12: Monitoring form of activities at community level

Rate of determinants

Determinant	Indicator	Source of information	Mode of calculation	Calculation
<i>Target population</i>	Children between 0-59 months	Census of CHW	Children from operational area who are registered by the CHW	Total children between 0-59 months registered within the area of influence
Availability	% of time without lack of the follow-up materials and with the presence CHW	- CHW report - Available spreadsheet for the CBNP - Stock sheet	Number of months without stock out of individual form, register, report book, community form, presence of CHW /divided the total number of months x all considered issues (9) during the period (6) of follow-up and multiplied by 100.	$\frac{6 \times 9 - \text{number stock out months}}{6 \times 9} \times 100$ = -----%
Accessibility	% of the target population to benefit for the CBNP within their own village	CHW and HC workers' information	Population to benefit for the CBNP in their own village/divided by the total population	$\frac{\text{Population having access to CBNP in their village} \times 100}{\text{Total population}}$ = -----%

Determinants	Indicator	Source of information	Mode of calculation	Calculation
<i>Usage</i>	% of children between 0-59 months from a village having frequented the program at least once during monitoring period	CBNP register	Number of children between 0-59 months who have frequented the CBNP during monitoring period/divide by the target population.	Children between 0-59 CBNP X100 / Target Population = ----- %
Adequate coverage	% of children between 0-59 months that showed up at the CBNP without any absence during monitoring period	CBNP register	Among children who attended the program, remove those who do not have any absence during the monitoring period	Children without any absence x 100 divide by the target population = ----%
Effective coverage	% of children having adequate coverage and follow-up with the required quality standards	Form of quality score	- Consider obtained max during supervision in the monitoring period - Divide by the maximum number of quality issues - Multiply by the number of supervisions carried out during the semester -Multiply these reports by the obtained EC above	E.C = A X E.C= -----%

Appendix 13: Spreadsheet for availability at CBNP

N°	Materials and workers	Month: 1	Month: 2	Month: 3	Month: 4	Month : 5	Month: 6	Total A = 6
1	Register							
2	Census book							
3	Individual form							
4	Community form							
5	Weihging							
6	Pair shorts							
7	CHW report							
8	At least 2 CHW							
9	Vitamin A							
	Total							B=

$$\text{Availability} = \frac{[(6 \times 9) - \text{Number of break off months}] \times 100}{[6 \times 9] \times A} = \frac{A-B}{A} \times 100 = \text{-----}\%$$

A = Number of months of monitoring period, multiplied by the number of issues whose availability we look for

B = Total of months of stock out during monitoring period

Appendix 14 : CBNP monitoring form at the health center

DISTRICT:.....
HOPITAL :
HEALTH CENTRE :

Period
Target population.....

Nº	Determinant	Cell							
		Site							
1	Target population								
2	Availability								

3	Accessibility										
4	Usage										
5	Adequate coverage										
6	Effective Coverage										