



## **CORE Group Country Collaboration Model: Joint NGO Implementation of Community-Based Treatment of Malaria in Rwanda**

**CORE Objective:** To pilot-test the ability of community health workers (CHWs) to provide anti-malarial treatment for uncomplicated malaria in rural community settings through 1-year pilot funding to three NGOs

**Cost:** \$26,000 (CORE Group Pilot Phase) + CORE staff time  
\$94,500 (IRC match funds from Canadian International Development Agency (CIDA) for 2005-06 fiscal year)  
\$200,000 (US Agency for International Development (USAID) Rwanda Mission/Implementation Phase)

The Belgian Government and Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM) donated money and supplies for program expansion (specific amount not available).

### **Timeframe:**

CORE negotiation of pilot program with NGOs: 4-6 months  
CORE-funded pilot program: 1 year  
USAID Mission-funded expansion of pilot: 2 years  
Belgian Government and GFATM-funded scale up: Ongoing

**NGO Partners:** Concern Worldwide, International Rescue Committee (IRC), and World Relief

**Other Partners:** USAID and USAID Mission Rwanda, Rwanda Ministry of Health and National Malaria Control Program (PNILP), UNICEF, CIDA, GFATM, Belgian Government, Quality Assurance Project, Population Services International (PSI), and Rwandan districts.

**Result:** Rwanda's PNILP has adopted the community-based approach to distribution of anti-malarial medications as its national strategy and is working to expand the program to 12 of its 30 health districts. This represents a significant scaling-up of activities in a relatively short time frame. The collaborative process brought together multiple partners to achieve greater program impact, with the result of successfully training community health workers, implementation of community-based treatment of malaria, and ultimately, increased treatment of children under 5 years for fever. As of July 2006, more than 100,000 children had been treated with Amodiaquine + S/P, at a cost of \$1 per treatment.\*

*\* The Rwandan government is currently making arrangements to switch to artemisinin-based combination therapies at the community level using a blister pack design, likely by late 2006 or early 2007.*

### ***Malaria in Rwanda***

Malaria is a common feature of Rwandan life, and has increased in severity over the last 10 years. Fifty-seven percent of Rwandans live in areas where malaria is endemic, another 21% reside in areas at-risk for epidemics. Malaria ranks as the number one cause of morbidity and mortality in all age groups, responsible for between 40% - 50% of health center visits, and 43% of deaths. It is one of the five leading causes of death for children under five, and the main cause of death for children at health facilities.

According to Millennium Development Goal Statistics compiled in 2003, only 5% of Rwandan children under five were sleeping under insecticide-treated bed nets, and just 12.6% of under fives with fever were treated with antimalarial medication. The World Health Organization (WHO) recommends treatment within 24 hours after onset of fever, and the Abuja targets call for 60% of children to receive treatment within that timeframe. However, a survey conducted in two health districts by the Rwandan National Malaria Integrated Control Program revealed that children under 5 years got appropriate treatment for malaria an average of three days after the onset of fever. Additional surveys conducted in 2004 by Concern Worldwide, International Rescue Committee, and World Relief showed that of children included in the study only 16% in Kibilizi District, 9% in Kirehe District, and 20% in Kibogora District, received timely and appropriate treatment. About one-third of children received no treatment.

### **Program Rationale**

Given the magnitude of the malaria problem in Rwanda, the major potential benefit of a partnership was greatly expanded access to treatment and therefore improvement in child survival. In addition, the collaborative process would allow the three participating nongovernmental organizations (NGOs) to learn from each other, to develop new tools and experience in community management of disease, and to enhance their capacity to implement health activities in Rwanda. The pilot model also held the potential to inform scale-up activities in Rwanda.

The CORE Malaria Working Group promoted discussion on community-based treatment of malaria, based on the experiences of other pilot programs in Africa. The collaborative process began at headquarters level as a direct result of all three NGOs receiving USAID Child Survival and Health Grants for Rwanda. Under their grants, each of the three NGOs devoted partial effort to malaria interventions targeting children under 5 and women of child-bearing age. IRC received a USAID entry-category child survival grant in Rwanda in 1999, which was renewed in 2001. Concern Worldwide and World Relief were awarded USAID child survival grants in 2003. As part of grant oversight, USAID staff encouraged joint planning of activities to improve child survival in Rwanda. IRC was able to draw on its program experience in other African countries, and discussions began about creating a common model for community-based treatment of malaria. NGO headquarters staff were able to leverage strong personal relationships developed through the CORE Group to initiate this discussion.

Concurrently, the CORE Group expressed interest in supporting in-country collaboration among its NGO members to increase child survival program impact. At the Spring 2003 CORE membership meeting, CORE announced that seed money was available to members interested in pursuing joint child survival activities. This offer gave Concern Worldwide, IRC, and World

Relief the impetus to come together and discuss a potential partnership around malaria. From these discussions, all three NGO partners developed an initial proposal for CORE, which was vetted and refined with input from the CORE secretariat and its Malaria Working Group.

By 2003, the Rwandan Ministry of Health had worked with partners to create a well-funded malaria control program but was reluctant to consider a community-based disease management model. That year, however, the government began to show interest in implementing a national malaria strategy with support for community management. This change was assisted by:

- repeated visits by Concern Worldwide and IRC to the Ministry of Health to discuss implementing community-based treatment of malaria;
- exchange visits to Uganda and Kenya by Ministry of Health and NGO staff to observe community-based treatment programs;
- advocacy and support by the USAID Mission in Rwanda for the NGOs' approach and involvement in implementation;
- development and release of a national malaria strategic plan; and
- advocacy from entities such as UNICEF, GFATM and Roll Back Malaria to be more actively engaged in the fight against malaria, and to consider piloting community-based programming.

As these factors converged to open a new path for the NGOs, previous barriers in policy gave way to encouraging and action-oriented discussions.

## **Collaboration Process**

### *Roles & Responsibilities*

The CORE Group played a critical role in the collaboration's nascent stages. CORE's solicitation to NGO members for joint projects and its willingness to provide seed money were important catalysts for the three NGOs. In addition, CORE's Malaria Working Group and the CSTS+ Project assisted in technical development of a concept paper and championed the partnership process.

The three agencies shared two technical assistance consultations at the country level even before the involvement of CORE. Concern and the IRC brought William Vargas, an independent consultant, to train staff in LQAS, and later, World Relief brought Robb Davis of Freedom for Hunger to train on adult learning and health education facilitation (all agencies contributed to the consultant fees). CORE Spring and Fall Meetings offered opportunities for face-to-face planning among the three partner organizations and input from other members. CORE has also been an essential partner in the diffusion of results and lessons learned, with all three PVOs working with CORE on multiple occasions: World Relief to diffuse its Care Group methodology, for example; Concern to outline the results of its pioneering experience with sustainability assessments; and IRC to share its experience with community information systems. Finally, the NGOs benefited from the credibility of the CORE name to network with partners in Rwanda.

USAID's involvement at headquarters and country level became an essential source of political and financial support. From the outset, USAID Child Survival and Health Grants Program staff encouraged and provided opportunities for Concern, IRC, and World Relief to plan together. USAID asked Concern and World Relief to draft their Detailed Implementation Plan together and to look for concrete, collaborative activities to address the main causes of child mortality and morbidity.

In Rwanda, the USAID Mission's child survival point person, Jules Mihigo, was an unwavering advocate for increased malaria programming and a community-based treatment model. Mission staff assisted the NGOs to gain access to meetings with the PNILP, and Mission involvement lent legitimacy to the NGOs' proposed activities. The Mission took this support one step further by allocating \$200,000 for implementation.

While the CORE funds provided seed money to conduct planning and data collection, as well as implementation in one health center area, the USAID funds were necessary to launch the program in three full districts. The Mission also sponsored monthly meetings for field staff.

Concern Worldwide, IRC, and World Relief were responsible for the planning, implementation, and reporting of the program. This included drug distribution and monitoring. Headquarters staff administered overall financial management, as well as technical support and planning. Field staff participated in planning, established operational systems, and implemented activities.

USAID required that only one block grant be made for the entire program, leading to lengthy initial discussions of how money would be granted and proportioned. World Relief offered to be the fund manager, making the generous offer of not charging its own administrative costs for monies to be allocated to Concern Worldwide and IRC. IRC also offered to match CORE's seed funding.

Concern Worldwide and World Relief allowed IRC to receive a larger share of the funds to accommodate the fact that IRC's child survival grant funding would end a year before its partners. This flexibility in the financial administration proved key to removing what was seen by partners as a significant potential barrier. Funds were given to World Relief, which made sub-grants to Concern and the IRC. The system worked smoothly.

In Rwanda, each NGO identified one health district for program implementation, and each NGO headquarters office was responsible for providing technical support and supervision to its own field staff. When possible, concurrent visits by NGO HQ staff to the field were planned to maximize face-to-face collaboration. Implementation followed one model, and used common tools for data collection, monitoring, and reporting. The results were compiled by the National Integrated Malaria Control Program, which collaborated with PVOs to develop joint tools, and then developed a corresponding database. The National Integrated Malaria Control Program has a full-time data manager who enters all data related to the program.

Notably, Concern, IRC, and World Relief were each reluctant to pursue an exclusive leadership role. It was critical to the collaboration's success for all three partners to view themselves as having equal responsibility and ownership of the program. The level of staff involvement varied throughout the project, but each NGO was careful to value the contribution of its partners.

Among in-country partners, the PNILP became the overall program leader. PNILP staff began to take an active interest in the community-based model and in using NGOs as implementers in activities to fight malaria. Initially, the CORE-funded pilot program was limited to the three NGOs and three areas in three health districts. However, the PNILP sought expansion to additional areas within the health districts, and added three more districts under UNICEF soon afterwards.

Since 2005, the PNILP has been working to include another nine districts (totaling 12 of 30 nationwide). The PNILP oversaw data collection, including finalizing the design of registers and other tools, printing, and electronic data entry. The IRC contributed by offering tools from its community health information system as the starting point for the system.

The PNILP brought all partners and funding sources together, something the NGOs alone lacked authority to do. The PNILP was responsible for developing training materials and many of the tools used throughout the program. The Ministry of Health was responsible for overseeing its health staff who, in turn, monitored the activities of the CHWs.

USAID personnel in Rwanda supported the NGOs as key implementers and facilitated key meetings. Later, GFATM and the Belgian Government supported program expansion via funds and donated drugs and insecticide-treated mosquito nets. In 2004, UNICEF joined the program as an implementing partner; its involvement lent further credibility to the program. All of the additional partners were brought in at the initiative of the PNILP.

### Communication

To facilitate collaboration, the three NGOs and their partners utilized existing structures and processes rather than create new ones. For CORE, this meant discussions at regularly scheduled Malaria Working Group meetings and opportunities for sharing and input at CORE events. CORE staff asked the NGOs to present their work on several occasions for sharing of lessons learned and input from members. CORE support for the pilot project provided monies for travel to these meetings.

Throughout the program, HQ staff provide strong technical support to field sites, via e-mail, phone, and in-person communication as needs arose. The three NGOs stayed in touch via e-mail and phone conversations, but face-to-face meetings, especially concurrent HQ field visits, were the most productive opportunities for coordinating. In this way, USAID's focus on technical assistance and willingness to fund in-person HQ visits played a major role in the success of this program. In Rwanda, each NGO developed a focal team that attended meetings and served as a liaison for communication with other partners.

To facilitate in-country coordination and ensure regular communication, all stakeholders in Rwanda formed a National Technical Committee. The Committee was tasked with program oversight. In addition to the three NGOs, the Committee included PNILP, USAID, Quality Assurance Project, UNICEF, PSI, and representatives from each of the districts. Meetings were held monthly, and committee members visited the CHWs periodically during the pilot study to observe case management, follow-up home visits and review of drug availability and conditions. USAID also facilitated frequent meetings, usually held in Kigali, but occasionally at field sites.

Not surprisingly, NGO staff report that they would have benefited from more time to engage with their partners, but competing priorities and responsibilities were a challenge. NGO staff report that the collaboration required significant investment of time by those involved at HQ and field levels, though the exact amount is difficult to quantify.

## **Challenges & Solutions**

### Program Approach and Administration

Once the Rwandan government signaled its interest in pursuing community-based programming for malaria, Concern Worldwide, IRC, and World Relief were able to move from a concept to concrete activities. The three NGOs report that the government was supportive and played a key facilitation role.

One key challenge was how to establish a common program approach between Concern Worldwide, IRC, and World Relief. Each NGO brought its own institutional philosophy, capacity, administrative mechanisms (i.e. record keeping, reporting), and programming methodology to the project. Reconciling these factors took time and required flexibility not only by individual staff, but by the larger organization. In particular, differences in field staff capacity, recruitment, and allocation became significant issues because of their direct impact on implementation. Securing buy-in from each organization's headquarters staff helped to overcome these differences, as HQ staff were able to build on their relationship with field staff to promote collaboration. Cross-visits, initiated and organized at the country level, also played a major role in building trust.

NGO staff report that there was a cooperative attitude toward budgeting issues and relatively few roadblocks after initial negotiations were completed.

#### Communication and Reporting

NGO staff dedicated considerable time to phone and e-mail communication, but face-to-face contact was by far the most effective way to move the project forward. Finding the time to schedule in-person collaboration in a country with limited infrastructure and among partners with many competing priorities was an ongoing challenge.

Information sharing was another challenge. Although the PNILP developed common monitoring and reporting tools, the NGOs had separate reporting requirements internally and for donors. Harmonizing these requirements and ensuring that information was collected, analyzed, and submitted to the appropriate partners was difficult, given that implementation was subject to routine interruptions due to logistical, staffing, and other obstacles. Timely data collection and reporting have continued to be weak points in the collaboration both within and between organizations, although this has improved considerably with PNILP leadership.

#### Expanding the Partnership

The PNILP's adoption and expansion of the program added significant legitimacy to the program and potential for great impact. However, it also meant that NGOs yielded some of their control of the program. This did not turn out to be a major problem because the PNILP consulted its partners in all major decisions. As new partners came on board, roles, responsibilities, and strategies required some readjustment, but NGO staff report that the potential for greater impact made the partnership transition worthwhile.

#### Overcoming Obstacles

Conflicts were avoided and resolved through patience, dedication, and a strong belief in the collaborative process. NGO staff were willing to assume extra costs involved in the partnership because they believed in the project mission and rationale. The NGOs' careful attention to equal roles and responsibilities, and reliable support and follow-up from headquarters staff, helped minimize conflict. Headquarters staff visits as part of the USAID Child Survival Grants Program allowed more field visits than available with funds for malaria program alone, facilitating cooperation and resolution of problems. The PNILP's coordinating role and contribution of resources also enabled the program's success.

#### **Outcomes**

The program's major result is increased treatment of children for malaria, leading to decreased morbidity and mortality in program areas. The pilot began in 2003 targeting three areas in three health districts, and has since expanded district-wide and beyond. In the initiative's first five months, more than 85% of children treated in the intervention area were treated within 24 hours

of onset of fever. World Relief reported no deaths among children receiving treatment through these distributors. Distributors in the IRC areas reported 39 deaths over a 19-month period, out of over 73,000 children treated, a case-fatality ratio of 0.05%.

Furthermore, the case fatality ratio has steadily declined, from 0.15% the first quarter of the project to less than 0.04% for the most recent quarter. From November 2004 to February 2005 in Kibilizi District, Concern Worldwide reported that cases of children successfully treated for fever in the community rose from zero to 795. Due to the project's ongoing growth, the number of children served is increasing.

Data from 2005 report that:

- Concern Worldwide has trained 419 CHWs and is treating over 4,700 children under five per month;
- IRC has trained over 600 CHWs and is treating more than 8,000 children a month in two district; and
- World Relief has trained 473 CHWs and is treating 1000 children under 5 per month.

Other program outcomes in Rwanda include:

- The PNILP has adopted the pilot program's community-based approach as its national strategy and is working to expand the program to 12 of its 30 health districts. This represents a significant scaling-up of activities in a relatively short time frame.
- The three NGOs built individual and organizational capacity and confidence during the pilot program and its subsequent expansion.
- CHWs have assisted in educating community members about intermittent presumptive treatment in pregnant women (currently being rolled out nationwide) and promotion of insecticide-treated mosquito nets. Distributors may soon be directly involved in net distribution.
- IRC has begun integrating treatment of diarrhea into community-based management, and is petitioning the government to add pneumonia treatment.
- Concern Worldwide, IRC, and World Relief have received a \$4 million, joint USAID expanded impact child survival extension grant to continue their community treatment work in Rwanda.
- Relationships between NGOs, government and other partners have been strengthened.
- The Rwandan government and its partners submitted and were awarded 3<sup>rd</sup> and 5<sup>th</sup> Round GFATM malaria proposals to increase malaria activities such as mosquito net distribution and a transition to ACTs to treat malaria.

Additional benefits to CORE and the three NGO partners include:

- CIDA accepted an IRC four-country, three-disease, community-based disease management bundled proposal, and is funding it for \$2.4 million.
- IRC conducted a small pilot program for community treatment of diarrhea in the Democratic Republic of Congo, which has been expanded to cover two districts.
- Institutional knowledge from the three participating NGOs has been transferred to other CORE members via meetings and documents.
- Project experiences have informed CORE in its development of a Community Case Management best practices manual.

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