Community Health and Improved Nutrition (CHAIN)

Project Appraisal Document (PAD)

Public Version of the PAD as Amended through Amendment 2, January 15, 2016

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I. INTRODUCTION AND OVERVIEW

This project appraisal document (PAD) informs the design of activities supported by USAID/Rwanda to increase the utilization of quality health services and products by target populations and communities. These mechanisms and activities constitute the Community Health and Improved Nutrition (CHAIN) Project, a five-year (FY2014-FY2018), $122 million project.

USAID/Rwanda's Country Development Cooperation Strategy (CDCS)[1] aims to accelerate Rwanda's progress to middle income status and better quality of life through sustained growth and reduction of poverty by realizing four development objectives (DO). DO3—*Health and well-being of Rwandans improved*—acknowledges the links between the health of Rwandans and the country's economic growth as well as the role of human development in breaking intergenerational cycles of poverty. USAID's contribution to DO3 is further broken down into two intermediate results (IR): IR 3.1, focused on strengthening the capacity of the health sector to deliver high quality services, and IR 3.2, focused on increasing utilization of quality health services/products by target populations and communities. CHAIN will address IR 3.2. The CDCS prioritizes gender-sensitive approaches and institutional capacity building as key foundations of both achieving and sustaining all of USAID's objectives in Rwanda.

Adopting an integrated approach to health and human development, CHAIN will include health promotion, water, sanitation and hygiene (WASH); social marketing and HIV prevention interventions; strengthening of social services to vulnerable populations, especially women during pregnancy and lactation, children, and people living with HIV (PLHIV); and interventions addressing the nutrition challenges confronting Rwanda at this time. In addition to strengthening the capacity of individuals, households, and community structures to improve their health, nutritional, and socioeconomic status, the project will support activities strengthening the Government of Rwanda (GOR) capacity and the capacity of civil society organizations (CSOs).

Acknowledging that nutrition and comprehensive human development depends on several factors that are inter-sectoral in nature, the CHAIN project will link to and take advantage of mechanisms and activities supported across the Mission, to create efficiencies and optimize the achievement of Mission goals and objectives.

The CHAIN project will align with and contribute to the following USAID priorities:

- Global Health Initiative
- President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint: Creating an AIDS-Free Generation
- United States Government (USG) Action Plan on Children in Adversity
- Ending Preventable Child and Maternal Deaths (EPCMD)
- USAID Forward
- The USG Feed the Future Multi-Year Strategy for Rwanda[2]
- USAID Water and Development Strategy
- USAID Gender Equality and Female Empowerment Policy,[3] operationalized for CHAIN via the CHAIN Project Gender Analysis[4]

[1] USAID/Rwanda. *Country Development Cooperation Strategy: 2014-2018.* September 2014. https://www.usaid.gov/sites/default/files/documents/1860/Rwanda-CDCS-Approved-Public-Version.pdf

[2] USG. *Feed the Future Rwanda FY 2011–2015 Multi-Year Strategy*. 2011. feedthefuture.gov/resource/rwanda-feed-future-multi-year-strategy

[3] USAID. *Gender Equality and Female Empowerment Policy*. March 2012. https://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf

[4] USAID/Rwanda. Gender Analysis for USAID/Rwanda Community Health and Improved Nutrition (CHAIN) Project. July 2014. https://www.usaid.gov/sites/default/files/documents/1860/GA%20-%20CHAIN%20project%20-%20FINAL%20Aug%2011%202014%20-%20Public%20Version.pdf

CHAIN will also collaborate with several related USAID/Rwanda projects and activities:

- Strengthening Capacity of Health Sector to Deliver Quality Health Services in Rwanda (SCHS) Project
- Feed the Future Project
- Youth Sustainable Partnerships for Education and Economic Development Project
- Human and Institutional Capacity Development Activity
- Akazi Kanoze Youth Livelihoods Activity

Key partners for CHAIN include:

Key Partner Country Institutions	**Key Partner Donors and Multilateral Organizations**	**Key Partner NGOs Not Currently Receiving USAID Funs**
Ministry of Health and Rwanda Biomedical Center	World Health Organization	Clinton Health Access Initiative (CHAI)
Ministry of Local Government	United Nations Children's Fund	Project Healthy Children (PHC)
Ministry of Gender and Family Promotion	Global Fund	
Ministry of Agriculture	United Kingdom, European Union, Belgium, Denmark, Luxembourg, Germany, the Netherlands, and Switzerland	
Ministry of Infrastructure	Japan International Cooperation Agency (JICA)	
University of Rwanda College of Medicine and Health Sciences, School of Public Health	Other USG agencies working in Rwanda: Centers for Disease Control and Prevention, Department of Defense, and Department of Agriculture	
District governments		

II. PROJECT DESCRIPTION

Problem statement

Inequality in health and nutrition outcomes, often driven by inadequate utilization of quality health services/products and behaviors among vulnerable populations, limits human development and the ability of Rwandans to break intergenerational cycles of poverty. Moreover, economic, health, and nutrition inequality are mutually reinforcing and need to be addressed concurrently if the development challenge they represent is to be resolved. In order to achieve the Mission Goal of accelerating Rwanda's progress to middle income status and better quality of life through sustained growth and reduction of poverty, we must address health and nutrition inequality in Rwandan society.

Development hypothesis

If 1) priority populations improve their socioeconomic status and food security and adopt positive parenting, feeding, and hygiene practices; 2) awareness of, access to, and demand for high-impact health practices among these populations is increased; and 3) the performance of and engagement by civil society organizations in the health sector is improved, ***then*** the utilization of quality health services and products by target populations and communities will increase and they will be able to improve and sustain the health of themselves and the vulnerable individuals in their care.

End-of-project outcome

By the end of the CHAIN project, households and individuals will have improved access to health, nutrition, and WASH products and services and will have adopted healthy behaviors and improved health seeking behaviors, resulting in an improved health and nutrition status, including reduced stunting, for target populations. These results will be especially apparent among the most vulnerable individuals including pregnant and lactating women, young children, orphans and vulnerable children (OVC), and key populations (female sex workers and men who have sex with men), contributing to reduced health inequalities. It is expected that local CSOs will have improved links with local government programs providing health and social services, and there will also be increased capacity and engagement of the private sector in delivering specific health and nutritional products. Mechanisms that link and coordinate Rwandan CSO efforts with those of GOR health system and social services, such as community health workers (CHWs), one-stop centers for gender-based violence (GBV), Vision Umurenge Program (VUP), and community health insurance, will be forged and strengthened.

These outcomes will be measured through five project purpose-level indicators:

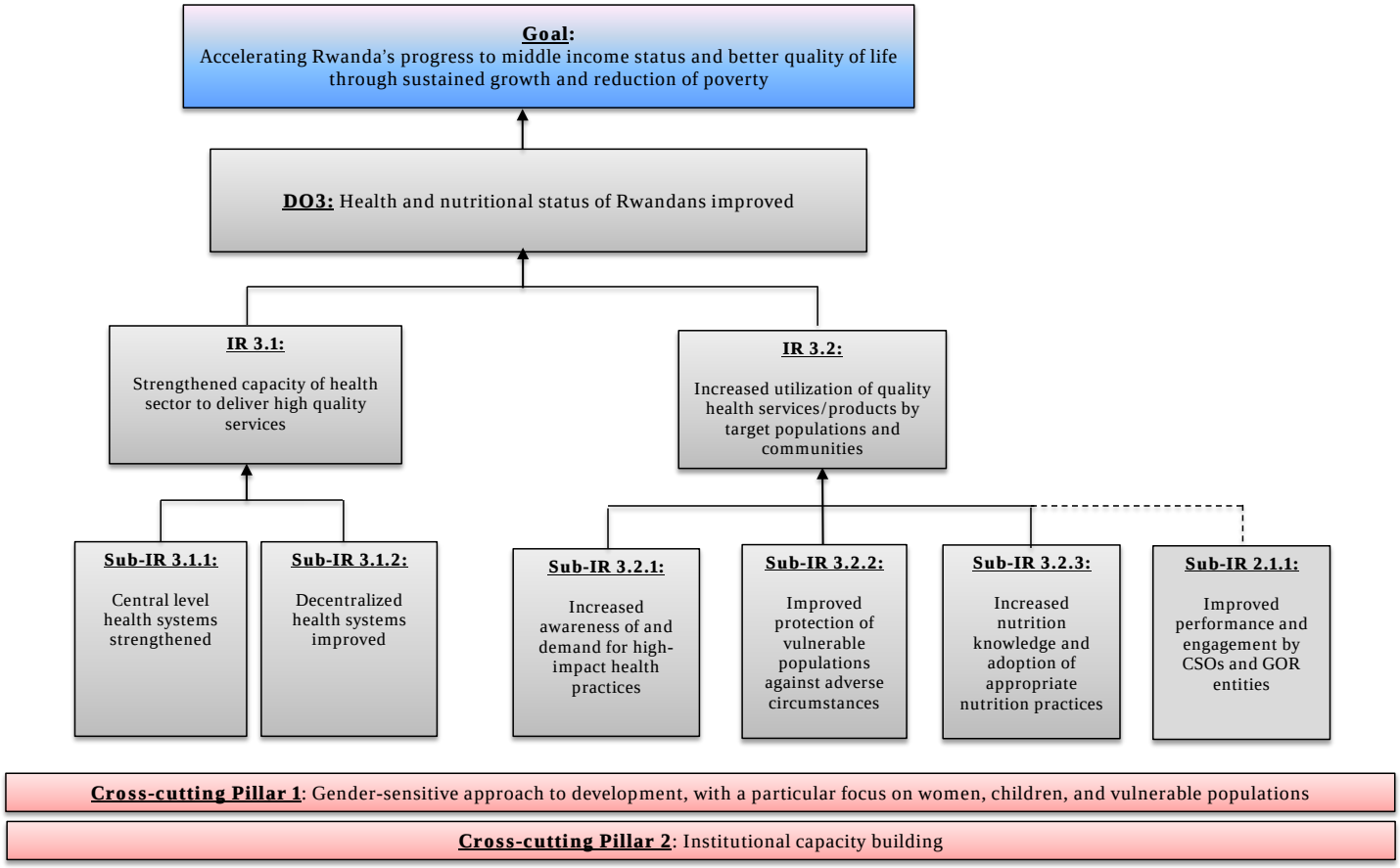
Indicator	Target for 2018
Proportion of children under 5 years old who slept under an insecticide-treated net the previous night	82%
Number of individuals served through USAID directly-funded CSOs	370,000
Percentage of currently married women aged 15-49 with unmet need for family planning	6%
Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	620,000
Percentage of women age 15-49 with anemia	10%

Geographic focus and coverage

The geographic focus of each activity under the CHAIN project will be determined based on a number of factors including geographic analyses of the development problem(s) to be addressed, coverage of relevant interventions by other donors and partners, and the geographic focus of complementary USAID-funded activities under CHAIN and other relevant projects.

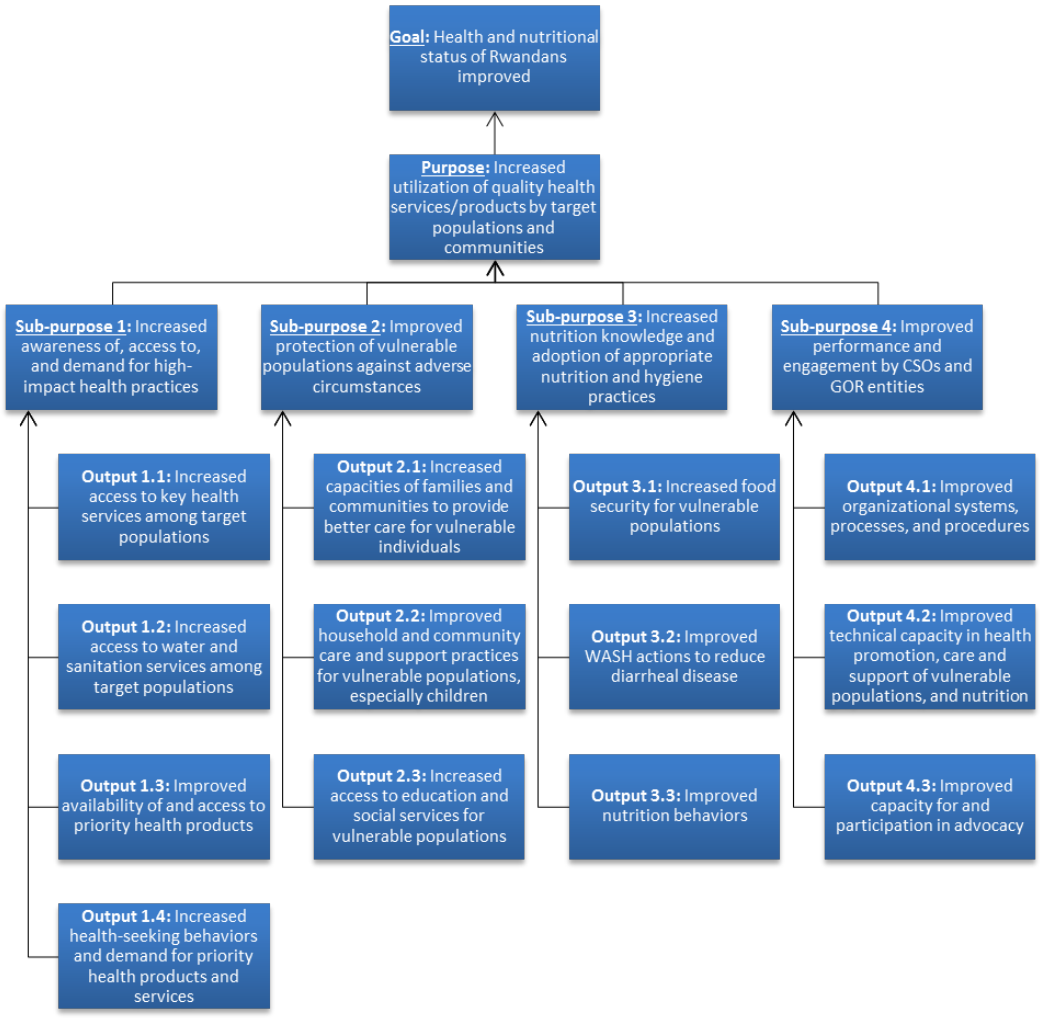
Results Framework

The USAID/Rwanda Health Office contributes to the following portion of the mission's results framework:



The results framework for CHAIN builds on IR 3.2 and expands its sub IRs (named sub-purposes in this PAD) into the outputs and activities described in the following results framework and the text.

CHAIN Results Framework:



Sub-Purpose 1: Increased awareness of, demand for, and access to high-impact health practices

Development Logic: Well-recognized bottlenecks to achieving coverage of life-saving interventions in community settings are lack of knowledge, poor utilization and poor quality of services. The underlying premise of Sub-purpose 1 is that households and communities have tremendous incentive to improve their health; however, they often lack awareness of and capacity to demand and access quality health services and products.[5] Empowered to become active actors in their health care, families are expected to adopt more effective health practices and behaviors, and seek/demand proper care from CHW and health facilities.

Output 1.1: Increased access to key health services among target populations

The Modes of Transmission study carried out in Rwanda by the Rwanda Biomedical Center identified the top four groups that will contribute to new HIV infection in the coming years:

1. Stable heterosexual relationships (65%).
2. Female sex worker (FSW) networks composed of FSWs, their clients, and their non-paying partners (20%).
3. Those participating in casual heterosexual sex (10%), interpreted as youth aged 15-24, as they compose the majority of sexually active individuals out of union.
4. Men who have sex with men (MSM) (5%).

[5] Ensor, Tim and Stephanie Cooper. "Overcoming barriers to health service access: influencing the demand side." Health Policy and Planning. (2004) 19 (2): 69-79 http://heapol.oxfordjournals.org/content/19/2/69.full.pdf+html

These priority groups are identified in the National Strategic Plan (NSP) for HIV as key populations.[6] Among these priority groups, female youth have a significantly higher HIV prevalence rate than males of the same age, especially among 20-24 year olds, with an HIV prevalence rate of 2.4% among females and 0.5% among males.

Community-based organizations (CBOs) will link target populations and those who may otherwise be hard to reach (e.g., PLHIV and mobile populations) with clinical services. The partners will also provide key and vulnerable populations with HIV and sexually-transmitted infections (STI) prevention packages and reproductive health services. The project will continue to build the capacity of local organizations to do this work.

A key activity under this output will be to provide key populations—female sex workers, their clients, and MSM—with integrated prevention packages. Innovative ways of reaching key populations and target populations, such as Safe-T-Stop centers, have been developed and will be continued.

Output 1.2: Increased access to water and sanitation services among target populations
Water, sanitation, and hygiene are highlighted in Rwanda's Economic Development and Poverty Reduction Strategy 2 (EDPRS 2), and the Rwandan government has committed to attaining 100% coverage of water and sanitation by 2018.[7] To support this goal, CHAIN will work with district governments in developing district water and sanitation plans explicitly considering gender and equity. The project will also support expanding access to drinking water supply using public-private partnerships, while building technical and managerial capacity within the district government and private operators.

In consultation with other sector stakeholders, CHAIN will map and assess existing sanitation supply chains, products, and services, and seek to catalyze the sanitation market. CHAIN will work with both existing and potential new supply chain actors and entrepreneurs, potentially through Global Development Alliance (GDA) partnerships.

These investments will be supported by policy and regulatory level interventions addressing issues related to sustainability, cost, financing, and quality. In the private sector, CHAIN will encourage entrepreneurship, especially among women, for provision of water and sanitation products and services. These activities will be complemented by Output 3.2, Improved WASH actions to reduce diarrheal disease.

Output 1.3: Improved availability of and access to priority health products
Many health products, including contraceptives, are provided for free by public health facilities, and much of the Rwandan population is able to access priority health products through the public sector. Social marketing provides another source for health products, at a price point which is lower than private sector prices. This is key to increasing access, particularly among targeted populations such as FSWs and MSM, as social marketing activities can be targeted towards these distinct target groups and provided in locations frequented by these groups, rather than in public health facilities that are often not regularly utilized by these groups.

Under CHAIN, USAID will continue to support the social marketing of priority health products including condoms, contraceptives, and safe water products; while potentially expanding to new products including nutritional supplements. In addition, although access to improved sanitation is fairly high in rural Rwanda, there are some product design improvements that would make household sanitation both more aspirational and also more hygienic. Social and/or commercial marketing of low-cost latrine products and services may be explored to reduce exposure to feces from poorly designed

[6] National HIV and AIDS Strategic Plan 2013-2018
[7] Republic of Rwanda (n.d.). EDPRS 2 2013-2018.

and/or maintained latrines.

Output 1.4: Increased health-seeking behaviors and demand for priority health products and services

Health communication activities that both increase awareness of and demand for key health products and services, and enhance behavior change and promote health seeking behaviors on issues related to HIV/AIDS, malaria, reproductive health, family planning, maternal and child health, nutrition, hygiene, and safe water use at the community and household level will be developed and implemented under this output. There will be a focus on integrating messages across partners and between health products and services when appropriate.

A key issue for adolescents, according to the Rwandan Integrated Children's Rights Strategy, is reproductive health; young people's vulnerability in this area has also been highlighted in the Health Sector Strategic Plan III (HSSP III) and the Joint Assessment of National Strategies (JANS).[8] This output will develop activities for this target group using evidence-based approaches and messaging. This output will also focus on using innovative methods, including mobile technology, to provide health messages and to encourage behavior change.

Sub-Purpose 2: Improved protection of vulnerable populations against adverse circumstances

Development Logic: Effective responses to the needs of vulnerable populations increase people's resilience to respond to the impact of HIV and other health or economic threats. Under CHAIN, responses will focus on knowledge-based skills development, while resilience will include household level capacity (i.e., knowledge, opportunities, and resources). Vulnerable groups under this sub-purpose are defined as PLHIV; OVC; members of the household caring for OVC and/or PLHIV; very poor households, especially female- and widow-headed households; and out-of-school youth, especially girls. This vision is closely aligned with the GOR's EDPRS 2, the National Social Protection Strategy, the Rwanda National HIV and AIDS Strategic Plan, and the Rwanda National Policy on Orphans and Vulnerable Children.

Output 2.1: Increased capacity of families and communities to provide better care for vulnerable individuals

USAID/Rwanda hypothesizes that if families have an improved economic position, they will be in a position to access health and social services for their family members, particularly children. To this end, the project will address the vulnerabilities of HIV/AIDS affected households and communities by stabilizing household assets, improving nutrition and food security, generating income, and fostering market linkages. Economic strengthening activities such as savings and lending groups, cooperatives, and market-related agricultural improvements will be continued. These type of activities have been shown to have a positive effect on a family's economic position, and in turn, on the health of children in these families.[9]

Within this output, cooperatives and other existing structures will be assisted to engage with CHWs at suitable junctures and to build financial planning skills into their assistance to members, focusing on local health insurance, identifying and addressing health needs early, and innovative mechanisms for decreasing costs associated with health. Women and youth-friendly economic strengthening activities will be combined with skills training, life skills, and sexual and reproductive health information.

Output 2.2: Improved household and community care and support practices for vulnerable populations, especially children

In Rwanda, care-seeking behavior for children is low. Just 50.2% of children with symptoms of acute respiratory infections, 42.7% of those with fever, and 37% of those with diarrhea are taken to a health facility/provider (DHS 2010). Moreover, it is estimated in the Rwanda HIV and AIDS National

[8] Rwanda, MTR-JANS HSSP II, Final Report, 2011

[9] Associated Consultants for Consultancy Services, Household Economic Resilience Assessment Report for the USAID/Higa Ubeho Program, September 2003.

Strategic Plan that up to 50% of eligible children are not accessing antiretroviral therapy (ART). Many programs focused on OVC are uniquely poised to expand and extend health care knowledge, practices, and services to reach women, infants, and children who are less likely to present in clinics, resulting in greater protection from adverse circumstances (Guidance for Orphans and Vulnerable Children Programming, PEPFAR 2012[10]). In addition, there is opportunity for tracing patients who are lost to follow up for key health services.

Activities associated with this output will encourage better care practices in families for OVC and other vulnerable family members through home visits, training sessions, after-school programs, positive deviance approaches, and behavior change communication strategies. These activities will support communities to address barriers that limit healthy outcomes for vulnerable populations (e.g., attitudes around pregnancy and eating, early childhood development (ECD), WASH, harmful gender norms, alcohol use, etc.). Approaches to specifically address the special needs of infants and young children and their guardians, as well as interventions to address barriers to healthy practices faced by women and girls, will be developed. Male engagement in health behaviors, especially family planning, prevention of mother-to-child transmission (PMTCT), antenatal care (ANC), infant and childcare, and child health and nutrition will be encouraged.

In addition, this output will benefit CSOs and the GOR. Support to the work of the GOR's emergent community social workers and animators will be explored and developed. The technical capacity of CSOs to undertake effective home visits with appropriate frequency, quality, duration, and input will be strengthened.

Output 2.3: Increased access to education and social services for vulnerable populations
This output considers the capacity of local government institutions, local community groups, and local civil society organizations to deliver their mandated services to OVC and vulnerable people, according to the Social Protection Strategy of the GOR.[11] It will strengthen local community-based structures and organizations to address the needs of vulnerable populations sustainably, in part by linking them to GOR programs but also by building institutional and technical capacity so that local organizations can access and adopt international best practices. Best practices to be adopted will include innovative ways of ensuring that OVC attend and progress through school.

The project will also work with local leaders, including religious leaders and opinion leaders, to analyze and address gender issues. Approaches to sustainably increase the capacity of local government, community, and CSOs to support and respond to the psychosocial needs of vulnerable households, survivors of GBV, and children will be incorporated.

This output will complement the Mission's work under DO 4, Increased Opportunities for Rwandan Children and Youth to Succeed in Schooling and the Modern Workplace by1) improving the quality of basic education to which vulnerable children will be referred and 2) strengthening opportunities for youth transitioning into the workforce. Quality educational institutions need to be child-friendly and sensitive to needs of orphans and vulnerable children, and adolescent workforce programs should address any barriers to access related to gender including teenage pregnancy, the needs of young single mothers for day care, and any discrimination in the workplace.

Sub-Purpose 3: Increased nutrition knowledge and adoption of appropriate nutrition and hygiene practices
Development Logic: Stunting rates remain high in Rwanda, at 44% in 2010.[12] The persistent high rates of stunting are significant, as malnutrition during fetal development and early childhood is known to have long-lasting negative effects on the individual, including lower school achievement,

[10] PEPFAR Guidance for Orphans and Vulnerable Children, 2012. http://www.pepfar.gov/documents/organization/195702.pdf
[11] EDPRS 2, Social Protection Strategy, 2013.
http://www.minecofin.gov.rw/fileadmin/templates/documents/sector_strategic_plan/Social__Protection__Strategy__July_2013.pdf
[12] National Institute of Statistic of Rwanda (NISR), Ministry of Health (MOH), and ICF International (2012). Rwanda Demographic and Health Survey 2010. Calverton, Maryland, USA: NISR, MOH, and ICF International.

future health problems, lower income in adulthood, reduced resistance to diseases, and increased levels of mortality.[13,14,15] Adults are affected as well: the primary cause of maternal mortality in Rwanda is hemorrhaging, which is related to anemia, and another common cause is eclampsia/hypertensive disorders, which is related to calcium deficiency.[16] These negative effects cost Rwanda an estimated 503.6 billion Rwandan francs (equivalent to 11.5% of Rwanda's GDP) in 2012.[17]

As outlined in USAID's Multi-Sectoral Nutrition Strategy, malnutrition (including stunting) is caused by a variety of individual, household, community, national, and underlying factors that together determine whether the requisites for healthy growth (food, health, and care) will be met. Effective programming to address malnutrition requires a cross-cutting approach, and while all of CHAIN's sub-purposes contribute to improved nutritional status, a particular focus on nutrition and hygiene is required. This sub-purpose describes CHAIN's activities to ensure quality training and services in prenatal health, adequate dietary intake, access to health services and immunization, and adoption of hygienic practices and environments. In addition, CHAIN will support coordination and collaboration among local government, community leaders, civil society, and households. These activities will complement those described in the Feed the Future and SCHS projects.

Output 3.1: Increased food security for vulnerable populations

Access to diverse foods depends largely on household income and food availability. In the Rwandan context, calorie availability has paralleled population growth and is sufficient for the population to have 2,100 calories per day.[18] However, the supply of high quality protein and fats, and the bioavailability of certain vitamins (B12, B2, and A) and minerals (calcium, iron, and zinc) remains insufficient. One explanation is the limited availability and affordability of foods of animal origin, including milk, eggs, poultry, fish, and meat—even if available, the minimum-cost nutritious diet[19] costs 165% of the income of the very poor, 148% of the income of the poor, and 94% of the income of middle income Rwandans.[20]

CHAIN will work through agriculture and economic growth activities to increase yields of crops that are the main sources of energy and low-cost proteins. In addition, it will promote production, processing, distribution, and commercialization of animal source foods value chains to increase the availability and consumption of animal source protein. CHAIN will also target increased use of food supplements and complementary foods that provide micronutrients missing in the Rwandan diet and can improve maternal nutrition and complementary feeding. CHAIN will pursue partnerships to implement these activities and will collaborate closely with partners introducing and scaling up bio-fortified crops under the Feed the Future PAD amendment.

Behavior change communication and advocacy will remain a major activity under this output and will include promotion of animal source foods, biofortified crops, and the use of income-generation circles to promote use of funds to improve familial nutrition status.

[13] Martorell, R., Melgar, P., Maluccio, J.A., Stein, A.D., & Rivera, J.A. (2010). The nutrition intervention improved adult human capital and economic productivity. The American Institute of Nutrition, 140(2), 411-414.
[14] Grantham-McGregror, S., Cheung, Y.B., Glewwe, P., Richter, L., Strupp, B., & International Child Development Steering Group (2007). Development potential in the first 5 years for children in developing countries. The Lancet 369(9555), 60-70.
[15] Dewey, K.G. & Begum, K. (2011). Long-term consequences of stunting in early life. Maternal & Child Nutrition, 7(s3), 5-18.
[16] National Institute of Statistic of Rwanda (NISR), Ministry of Health (MOH), and ICF International (2012). Rwanda Demographic and Health Survey 2010. Calverton, Maryland, USA: NISR, MOH, and ICF International.
[17] UN Economic Commission for Africa & the World Food Programme (2013). The cost of hunger in Rwanda. The social and economic impact of child undernutrition in Rwanda. Implications on national development and vision 2020. (The study calculates the combined cost of undernutrition by considering the need for extra health care, school repetition and drop outs and diminished productive capacity and mortality.)
[18] MINAGRI Annual Report 2012
[19] For the study's purposes, the authors defined a minimum cost nutritious diet as a "lowest cost diet that meets the average energy and the recommended nutrient requirements of the household" (p.18).
[20] Save the Children (2011). A cost of diet analysis in a northern highland district of Rwanda.

Output 3.2: Improved WASH actions to reduce diarrheal disease

According to the Rwanda 2010 DHS, the prevalence of diarrheal disease in Rwanda is 13% for all children under five but over 20% for children aged 6-23 months, when children begin complementary feeding and start to come into contact with their environment through crawling. The diarrheal disease burden at this critical developmental time contributes to physical and cognitive stunting and was the cause of 17% of under-five child mortality in Rwanda in 2010.[21] Pit latrines, which are the largest category of latrine type used in Rwanda, may meet the Millennium Development Goal definition of "improved," but they do not prevent exposure to feces. Availability of clean water is also not assured as, sources may be contaminated despite 68% access in rural areas (JMP 2014), access may be complicated by Rwanda's challenging terrain, and safe transport and storage are not guaranteed.

CHAIN will promote the suite of evidence-based hygiene behaviors that have been shown to reduce diarrhea in children under five, through CHWs and CSOs/CBOs at community level, as well as through the private sector. Priority hygiene behaviors include hand washing with soap before handling food and after contact with feces, correct and consistent use of hygienic sanitation, and household water treatment and safe storage.[22] CHAIN will also promote clean containers and safe transport and storage of water in the household and also continue to promote correct and consistent adoption of water treatment, with SûrEau or other evidence-based water treatment products. In addition, CHAIN will work with CHWs and others to create demand for household investment in new or upgraded latrines, which are easy to clean and cover when not in use.

Finally, although hand washing with soap is the single most effective and inexpensive way to avert diarrhea-related child deaths and disease,[23] as measured by disability-adjusted life years (DALYs), a 2013 study by UNICEF indicates that only 28% of caregivers wash their hands with soap before feeding a child or preparing food, despite 100% knowing that they should. Likewise, 64% know they should wash their hands after using the latrine, but only 46% do so,[24] and 97% of caregivers do not wash their hands immediately after wiping a child's bottom. Opportunity for personal hygiene is limited by the fact that only 10% of households have a place for washing hands and 53% lack water, soap, or any other cleansing agent. There are a range of hand-washing station options available, including the "tippy tap," which is a container made of locally available materials that allows hand washing with a minimal amount of water. CHAIN will build on the work of other USAID partners in promoting a range of tippy taps adapted to the local context and will explore partnerships with soap manufacturer(s) to promote hand washing.

Output 3.3: Improved nutrition behaviors[25]

Data suggest that dietary diversity (particularly in the mother's diet and in the food being offered during the complementary feeding period), diarrheal illnesses, and the intake of micronutrients such as iron and zinc by mothers and children remain key areas of concern in addressing Rwanda's high levels of childhood stunting and anemia. Improved knowledge and practices will also be critical: only 24% of caregivers have knowledge of proper feeding practices for children,[26] and recent World Food Program analyses suggest that increased education, particularly completion of secondary school, is correlated with a sharp decline in the likelihood of having a stunted child.

Under this output, CHAIN will leverage the existing CHW structure to improve nutrition and WASH practices. It will strengthen the capacity of CHWs to deliver key nutrition and WASH messages,

[21] Child Health Epidemiology Reference Group, 2012. *Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000*. The Lancet.
[22] Cairncross et al. (2010). Water, sanitation and hygiene for the prevention of diarrhea. Int. J. Epidemiol. (2010) 39 (suppl 1).
[23] Cairncross and Valdmanis, (2006). Water Supply, Sanitation and Hygiene Promotion, in Disease Control Priorities in Developing Countries, 2nd edition. Jamison DT, Breman JG, Measham AR, et al., editors. Washington (DC): World Bank; 2006.
[24] UNICEF (2013)
[25] Data in this section is drawn for the DHS. However, UNICEF (2013) provides relevant and more alarming data such as 38% of caregivers introducing complementary foods at 6 months and only 41% of caregivers knowing that this is the appropriate time to introduce complementary foods. However, the report's author instructed that the data was not applicable at the national level and recommended relying on the DHS.
[26] UNICEF (2013) p.49

counseling, and services through ongoing training and support of the CHWs. Critical to improving nutrition and WASH behaviors is ensuring counseling is high quality, reinforced in a timely manner, and supported by the expanded household decision makers and community. CHAIN will also reinforce linkages between CHWs and health facilities to ensure appropriate care and treatment when necessary.

Social and behavior change is critical to decreasing malnutrition. Communication activities will promote demand for key nutrition and WASH products and services and increase optimal nutrition and WASH practices. This output's activities will include the establishment and support of women's groups and hygiene clubs and integrate nutrition and WASH messaging into income generation activities, savings and credit groups, farmers groups, and other community networks. Nutrition will also be expanded in the education curriculum.

The project will also build institutional capacity and enable local organizations to access international best practices and technical support in order to decrease malnutrition. The project will also support the GOR via Rwanda's National Multi-sectoral Strategy to Eliminate Malnutrition, the District Plans to Eliminate Malnutrition (DPEMs), and MINAGRI's Nutrition Action Plan.

Finally, CHAIN will contribute to the introduction of the GOR's fortification strategy and monitor its influence in select rural communities. CHAIN will also test the feasibility of fortifying rice, sorghum, and milk, as well as potentially food supplements and/or pharmaceutical products. CHAIN will stimulate the work of national researchers such as those in the College of Science and Technology of the University of Rwanda on relevant topics.

Sub-Purpose 4: Improved performance and engagement by CSOs and GOR entities

Development Logic: Amplifying the voice and strengthening the advocacy skills of communities and CSOs can have positive outcomes for health service delivery. CSOs also have an important role in promoting demand creation and health seeking behaviors. A review in Nigeria in 2008 found that involving clients and community representatives in the assessment and monitoring of health service delivery not only gave citizens a voice in the health sector, but also strengthened the formal health system response. The same study also found that the engagement of CSOs was a positive contributing factor.[27]

This sub-purpose is concerned with strengthening the institutional systems in the GOR, private sector, and civil society that promote access to health products and services, as well as other critical social services that support health outcomes in vulnerable populations. Targeted CSOs will be in an improved position to help the community articulate their health needs and share concerns through existing or emerging formal and non-formal mechanisms. Realization of this result will depend substantially on a successful collaboration between CHAIN and the Democracy and Governance Office's Human Institutional Capacity Development (HICD) activities and will complement and indirectly support the SCHS project.

Output 4.1: Improved organizational systems, processes, and procedures

The establishment and reinforcement of sound organizational systems is critical to the development of local organizations and contributes to their sustainability. Currently, the USAID/Rwanda Health Office provides direct cooperative agreements to four local CSOs and has indirect relationships with many others.

As part of local capacity development objectives under USAID Forward, each of the four direct grantee organizations has already undergone an assessment by the Democracy and Governance Office's HICD activity, which USAID has invested heavily to strengthen the organizational systems of its direct grant recipients. Under this output, capacity building activities of these four CSOs will

[27] Technical Brief: Strengthening Voice and Accountability in the Health Sector, Cathy Green, PATHS, DFID 2013

continue through tailored capacity building plans HICD developed for each CSO. Areas for development may include strategic planning, monitoring and evaluation systems, or financial planning. In the event that new local CSO awards are made later in the CHAIN project, additional capacity building activities will be developed to support the new local partners.

In addition, many of USAID's CHAIN implementing partners provide sub-grants to local CSOs and/or CBOs and often provide significant capacity building support for these organizations to improve their operations, and in some cases, support them to become direct recipients of USAID funding.

Output 4.2: Improved technical capacity in health promotion, care and support of vulnerable populations, and nutrition

In order to maximize the role of CSOs within the health and nutrition sectors, it is essential that they have strong technical capacity. Under this output, a number of strategies will be used to increase the capacity of CSO staff and organizations as a whole. For example, this may include support for trainings, study tours, and/or other learning opportunities for technical staff of CSOs. Activities may also include support for the development of technical tools and guidelines that can be used by CSOs and CBOs in health promotion, care and support, and nutrition activities. In addition, CSOs will engage in national technical working groups to improve coordination and alignment with wider health and nutrition sector strategies and activities.

Output 4.3: Improved capacity for and participation in advocacy

Local CSOs working with vulnerable populations have a unique role to play in advocacy at the local level. Given their work and long-standing relationships with the community, they are well placed to work with local leaders to ensure that the needs of the most vulnerable are met. For example, the local CSOs can advocate with local leaders for inclusion of identified vulnerable households in social programs or advocate for programs to target specific districts or sectors with identified needs.

Under this output, local CSOs and other partners will receive technical support to increase their capacity to engage in advocacy on behalf of their target populations and to encourage communities to advocate for their own needs. This support will aim to further the other three sub-purposes by helping CSOs to, for example:

- Create space for voice and advocacy between providers, policy makers, and communities, and to raise communities' awareness of their rights and entitlements to quality health services;
- Engage in formal and non-formal mechanisms through which clients and community members can express their views to reach WASH and health service providers and policy makers;
- Ensure that the voices represent the wider community—including women, youth, and the most vulnerable—and find ways to improve the quality of women's participation in these processes; and
- Emphasize community participation in health as an entry point and strengthen public participation on health issues.

III. PROJECT IMPLEMENTATION MECHANISMS

Overview of Project Activities

The CHAIN Project will be implemented through approximately 20 activities authorized under this and other USAID/Rwanda PADs, reflecting contributions from across the entire spectrum of USAID/Rwanda DOs. The activities currently awarded or already listed on the USAID Business Forecast are catalogued in the table below.

Current CHAIN Implementing Partners

ACTIVITY NAME	IMPLEMENTING PARTNER	START DATE	END DATE	TECHNICAL OFFICE
Ubaka Ejo	AEE/Rwanda	9/12/2012	9/11/2020	Health
Turengere Abana	Association François-Xavier Bagnoud (FXB)/Rwanda	9/12/2012	9/11/2020	Health
Gimbuka	Caritas/Rwanda	9/12/2012	9/11/2020	Health
Rwanda Social Marketing Program	Society for Family Health	10/25/2012	10/24/2017	Health
ROADS III	FHI 360	10/1/2013	9/30/2016	Health
Twiyubake	Global Communities	2/1/2015	1/31/2020	Health
Global Alliance for Improved Nutrition (GAIN)	GAIN	3/1/2015	2/28/2018	Economic Growth
Early Childhood Development Curriculum Evaluation GDA	TBD	TBD 2016	TBD 2020	Health
Gikruiro	CRS	11/11/2015	11/10/2020	Health
Rwanda Rural Sanitation Activity (RRSA)	TBD	TBD 2016	11/10/2020	Health
Akazi Kanoze Youth Livelihoods Project	Education Development Center	10/1/2008	6/30/2016	Education (YOUTH)
Sustainable Partnerships for Education and Economic Development (SPEED)	TBD	TBD 2016	TBD 2021	Education (YOUTH)
Ejo Heza - Integrated Improved Livelihoods Program (IILP)	Global Communities	7/13/2011	7/12/2016	Economic Growth (Feed the Future)
Rwanda Dairy Competitiveness Project II (RDCP II)	Land O' Lakes Inc.	1/6/2012	1/5/2017	Economic Growth (Feed the Future)
Human and Institutional Capacity Development (HICD)	Development Alternatives Inc. (DAI)	4/30/2012	4/30/2017	Democracy and Governance (VOICE)
Private Sector Driven Agricultural Growth (PSD-AG)	Engility	8/1/2014	7/31/2019	Economic Growth (Feed the Future)
Orange Fleshed Sweet Potato (OFSP) Activity	CIP	6/2015	6/2018	Economic Growth (Feed the Future)
Iron Rich Beans Activity	Harvest Plus	6/23/2015	6/23/2018	Economic Growth (Feed the Future)
Feed the Future Rwanda Hinga Wege	TBD	TBD 2016	TBD 2021	Economic Growth (Feed the Future)

Opportunities for Policy Engagement

CHAIN will address five key policy goals and priorities, outlined in the table below. These goals will be conveyed directly by USAID in meetings with government counterparts, as part of donor coordination fora, and in Embassy-led advocacy.

Policy Challenge	Policy Goal
No common external tariff on nutrition-sensitive items	Lower tariffs on goods that play a key role in stunting reduction and adjusting the tariff scheme to make it more nutrition sensitive

Limited adherence to standards for milk and other raw products of animal origin	GOR implements existing regulations for the safe production, handling, and marketing of raw milk and other raw animal products
Prohibitively high taxation on energy	Lower energy project tax rates to increase viability of agricultural projects and promote improved food security
Weak nutrition coordination bodies	Develop donor and national nutrition coordination platforms to increase engagement and complementarity among stakeholders
Limited communication between stakeholders in the existing child protection system	Linkages established between PLHIV, OVC, and other vulnerable families to basic health care, as well as to support services that mitigate the impact of HIV, including services education, economic empowerment, and legal protection

ANNEX A: Logical Framework

	Narrative Summary	Objectively Verifiable Indicators	End-of-Project Targets	Means of Verification
Development Hypothesis	**USAID GOAL** Health and nutritional status of Rwandans improved	• Percentage of children under 5 years who are stunted • Maternal mortality ratio • HIV prevalence rate • Total fertility rate • Under-five mortality rate	• 18% [a,b] • 220 per 100,000 live births [a,b] • 3% [a,b] • 3.4 [a,b] • 42 per 1,000 live births [a,b]	• DHS
	PROJECT PURPOSE Increased utilization of quality health services/products by target populations and communities	• Proportion of children under 5 years old who slept under an insecticide-treated net the previous night • Number of individuals served through USAID directly-funded CSOs • Percentage of currently married women aged 15-49 with unmet need for family planning • Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS • Percentage of women age 15-49 with anemia	• 82% [a,b] • 370,000 (cumulative life-of-project target) • 6% [a] • 620,000 (cumulative life-of-project target) • 10% [b]	• DHS • Partner records • Track 20, DHS • Partner records • DHS
	SUB-PURPOSE 1 Increased awareness of, access to, and demand for high-impact health practices	*Refer to detail on following pages*		
	SUB-PURPOSE 2 Improved protection of vulnerable populations against adverse circumstances	*Refer to detail on following pages*		
	SUB-PURPOSE 3 Increased nutrition knowledge and adoption of appropriate nutrition and hygiene practices	*Refer to detail on following pages*		
	SUB-PURPOSE 4 Improved performance and engagement by CSOs and GOR entities	*Refer to detail on following pages*		

[a] *Targets are set in alignment with those established in the HSSP III M&E Plan.*
[b] *Targets are indicative only; indicators are measured through the DHS, so data will not be available in 2018, at the end of CHAIN.*

	Narrative Summary	Objectively Verifiable Indicators	Means of Verification
	SUB-PURPOSE 1 Increased awareness of, access to, and demand for high-impact health practices	• Number of liters of drinking water disinfected with point-of-use treatment products as a result of USG assistance • Number of PLHIV reached with a minimum package of Prevention with PLHIV (PwP) interventions • Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Partner records
Manageable Interest	**OUTPUT 1.1** Increased access to key health services among target populations	• Number of individuals who received HIV testing and counseling services for HIV and received their test results (disaggregated by key populations) • Number of individuals linked to key health services (disaggregated by key populations and key health service)	Partner records
	OUTPUT 1.2 Increased access to water and sanitation services in target pops	• Number of people gaining access to an improved drinking water source • Number of people gaining access to an improved sanitation facility	Partner records
	OUTPUT 1.3 Improved availability of and access to priority health products	• Number of social marketing products sold (disaggregated by product type) • Number of stock-outs of priority health products reported by partners in the reporting period	Partner records
	OUTPUT 1.4 Increased health-seeking behaviors and demand for priority health products and services	• Number of individuals reached through behavior change communication interventions	Partner records
Inputs	• Provide key populations with integrated prevention packages including: targeted outreach HIV testing and counseling and link to care for those testing HIV positive; peer education outreach activities; provision of information on HIV and STIs, referral for HIV care and treatment, promotion of condom use, and STI screening and treatment; FP/RH services; SGBV sensitization, social support; and economic strengthening activities. • Support HIV prevention programs targeting other vulnerable populations: mobile populations (truck drivers, fishermen) and women 15-24 years old, especially single mothers. • Develop and support prevention with HIV positive people and positive health dignity and prevention approaches including regular assessment of PLHIV and their family members' wellbeing, correct and consistent use of condoms, ART adherence, and promotion of appropriate referral for HIV services such as testing for discordant couples. • Engage facilities on providing friendly services, tailored to the needs of key populations (i.e. tailored prevention services, standing dates/times to receive services, after-hours services, confidentiality). • Strengthen the referral network between the community and facility levels, and empower families to avoid delays in seeking care • Develop and implement health communication activities that enhance behavior change and promote health-seeking behaviors on issues related to HIV/AIDS, malaria, reproductive health, child survival, hygiene, and safe water use at the community and household level. • Strengthen male involvement in family planning services. • Support social marketing of key health products including condoms, contraceptives, and water treatment products. • Support water and sanitation infrastructure development.		

	Narrative Summary	Objectively Verifiable Indicators	Means of Verification
	SUB-PURPOSE 2 Improved protection of vulnerable populations against adverse circumstances	• Percentage of vulnerable individuals receiving USG assistance graduating out of community-level support • Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	Partner records
Manageable Interest	**OUTPUT 2.1** Increased capacities of families and communities to provide better care for vulnerable individuals	• Household vulnerability status • Percentage of households able to access money to meet important family needs • Percentage of households covering full costs of the health, education, and food needs of children	• Annual survey • Partner records
	OUTPUT 2.2 Improved household and community care and support practices for vulnerable populations, especially children	• Percentage of households covered by community-based health insurance • Percentage of family members (adults and children) tested for HIV • Percentage of children whose primary caregiver knows the child's HIV status	• Annual survey • Partner records
	OUTPUT 2.3 Increased access to education and social services for vulnerable populations	• Number of people receiving post-GBV care • Percentage of children regularly attending school • Percentage of children who progressed in school during the last year • Percentage of children under 6 years participating in an ECD program	• Annual survey • Partner records
Inputs	• Support strengthening, expansion, and diversification of income-generating activities, economic associations or cooperatives, and Self Help/Internal Saving and Loan Groups • Build on a market-based economic approach to develop a network of local business service providers, such as microfinance institutions, that support the development of enterprises and cooperatives • Develop skills of cooperatives to manage and allocate resources and income-generating activities to improve health of families • Facilitate women's knowledge of their rights to access comprehensive medical, legal, and social support for services for GBV. Build awareness of gender norms and harmful gender stereotyping, and address any harmful male norms. • Promote couples- and family-centered approaches for voluntary counseling and testing and family planning. • Encourage increased male involvement in child care, FP/RH, PMTCT, and antenatal care • Promote positive parenting practices based on strengthening good traditional child rearing practices and mitigating any harmful cultural practices or attitudes • Link low-income women and child- or female-headed households to income-generating and social welfare and protection programs, including ECD • Strengthen and integrate the SGBV referral systems using community initiatives; an understanding of GBV and clear steps for protection and response will be included.		

	Narrative Summary	Objectively Verifiable Indicators	Means of Verification
	SUB-PURPOSE 3 Increased nutrition knowledge and adoption of appropriate nutrition and hygiene practices	• Prevalence of anemia among children 6-59 months • Women's dietary diversity score: Mean number of food groups consumed by women of reproductive age • Percentage of children 6-23 months receiving a minimum acceptable diet • Percentage of children under 5 with diarrhea who received oral rehydration therapy	• DHS • PBS
Manageable Interest	**OUTPUT 3.1** Increased food security for vulnerable populations	• Number of private enterprises (for profit), producers organizations, water users associations, women's groups, trade and business associations, and community-based organizations that applied new technologies or management practices as a result of USG assistance • Percent of women of reproductive age consuming targeted nutrient-rich value chain crops or products • Percent of children who consume targeted nutrient-rich value chain crops or products	Partner records
	OUTPUT 3.2 Improved WASH actions to reduce diarrheal disease	• Number of households with soap and water at a hand washing station commonly used by family members in USG-assisted programs • Percentage of children under five who had diarrhea in the prior two weeks • Mean score among targeted populations on a test of hygiene knowledge	• Annual survey • Partner records
	OUTPUT 3.3 Improved nutrition behaviors	• Household dietary diversity score • Number of people trained in child health and nutrition through USG-supported programs • Mean score among targeted populations on a test of nutrition knowledge	• Annual survey • Partner records
Inputs	• Develop a nutrition module focused on providing information on a low-cost but fairly typical and desirable locally available diet. This will ensure that consumers interested in maximizing nutrition assistance have the requisite knowledge to prioritize their food expenditures. • If prices of common foods vary significantly in different markets in Rwanda, ensure that this information is readily available to traders to improve functioning of internal markets. • Emphasize the dual function of livestock, particularly their critical role in a healthy diet. Include information on the economics of raising small livestock for egg/meat consumption and sales. • Explore how to support non-public utility provision of water and sanitation facilities at the household level. • Strengthen the knowledge, awareness, and education of appropriate nutrition and WASH practices at multiple levels: from community health workers to local government to formal education system.		

	Narrative Summary	Objectively Verifiable Indicators	Means of Verification
	SUB-PURPOSE 4 Improved performance and engagement by CSOs and GOR entities	• Score in percent of combined key areas of organization capacity among USG direct and indirect local implementing partners • Number of CSOs receiving USG assistance engaged in advocacy interventions • Number of performance solution package recommendations implemented by partner institutions	Partner records
Manageable Interest	**OUTPUT 4.1** Improved organizational systems, processes, and procedures	• Number of CSOs trained in operational skills including M&E	Partner records
	OUTPUT 4.2 Improved technical capacity in health promotion, care and support of vulnerable populations, and nutrition	• Number of CSO staff trained, disaggregated by technical area and gender	Partner records
	OUTPUT 4.3 Improved capacity for and participation in advocacy	• Number of CSOs receiving USG assistance engaged in advocacy interventions	Partner records
Inputs	• HICD activities executed by Democracy and Governance Office • Design of additional technical content for HICD that is CHAIN specific • Capacity building for CSOs and faith-based organizations on advocacy and technical areas (e.g., reproductive health rights, HIV prevention for key and vulnerable populations) • Provide technical assistance to local government institutions as required to strengthen their social protection framework and implementation and relationships with CSOs • Strengthen community organizations and volunteers to recognize the need for and participate in psychosocial support services and social assistance to parents/caregivers at the household level		

ANNEX B: M&E Plan

Indicator Summary Table

DO	IR	Sub-IR	Result	Performance Indicator	Indicator Type	Data Acquisition			Disaggregation
						Data Source	Method of Collection	Frequency	
3	Health and nutritional status of Rwandans improved								
	PROJECT: Community Health and Improved Nutrition								
	3.2		Increased utilization of quality health services/products by target populations and communities	Proportion of children under five years old who slept under an insecticide-treated net the previous night	CDCS/3.1.3.2-6	DHS	Survey	Every 5 Years	Male/Female
				Number of individuals served through USAID directly-funded CSOs	CDCS/Custom	USAID Implementing Partners	Partner Records	Annual	Male/Female
				Percentage of currently married women aged 15-49 with unmet need for family planning	CDCS/Custom	DHS/Track 20	Survey/Track 20 FP Estimation Tool	Every 5 Years/ Annual	n/a
				Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	CDCS/ OVC_SERV	USAID Implementing Partners	Partner Records	Annual	Male/Female
				Percentage of women age 15-49 with anemia	CDCS/Custom	DHS	Survey	Every 5 Years	n/a
		3.2.1	Increased awareness of, access to, and demand for high-impact health practices	Number of liters of drinking water disinfected with point-of-use treatment products as a result of USG assistance	CDCS/3.1.6.8-4	USAID Implementing Partners	Partner Records	Annual	n/a
				Number of People Living with HIV/AIDS reached with a minimum package of Prevention with PLHIV (PwP) interventions	CDCS/3.1.1-65	USAID Implementing Partners	Partner Records	Annual	Male/Female
				Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	CDCS/KP_PREV	USAID Implementing Partners	Partner Records	Annual	Key population type

		3.2.2	Improved protection of vulnerable populations against adverse circumstances	Percentage of vulnerable individuals receiving USG assistance graduating out of USG community-level support	CDCS/Custom	USAID Implementing Partners	Partner Records	Annual	Male/Female
				Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	CDCS/ OVC_ACC	USAID Implementing Partners	Partner Records	Annual	Male/Female
		3.2.3	Increased nutrition knowledge and adoption of appropriate nutrition practices	Prevalence of anemia among children 6-59 months	CDCS/Custom	DHS	Survey	Every 5 Years	Male/Female
				Percentage of children 6-23 mo receiving a minimum acceptable diet	CDCS/3.1.9.1-1	DHS	Survey	Every 5 Years	Male/Female
				Women's dietary diversity score: Mean number of food groups consumed by women of reproductive age	CDCS/3.1.9.1-2	PBS	Survey	Bi-Annual	n/a
				Percentage of children under 5 with diarrhea who received ORT treatment	CDCS/Custom	DHS	Survey	Every 5 years	Male/Female
		2.1.1	Improved performance and engagement by CSOs and GOR entities	Score in percent of combined key areas of organization capacity among USG direct and indirect local implementing partners	CDCS/Custom	HICD	Partner Records	Annual	GOR/CSOs
				Number of CSOs receiving USG assistance engaged in advocacy interventions	CDCS/2.4.1-9	HICD/Land/ International Alert	Partner Records	Quarterly	n/a
				Number of performance solution package recommendations implemented by partner institutions	CDCS/Custom	HICD	Partner Records	Quarterly	GOR/CSOs

Indicator Tracking Table: Baseline, Targets and Actual Results

DO	IR	Sub-IR	Result	Performance Indicator	Baseline		FY 2015		FY 2016	
					Date	Actual	Target	Actual	Target	Actual
3	Health and nutritional status of Rwandans improved									
	PROJECT: Community Health and Improved Nutrition									
	3.2		Increased utilization of quality health services/products by target populations and communities	Proportion of children under 5 years old who slept under an insecticide-treated net the previous night	2010	70	80		N/A	
				Number of individuals served through USAID directly-funded CSOs	2013	72,988	151,503		182,295	
				Percentage of currently married women aged 15-49 with unmet need for family planning	2010 (DHS)	18.9	12		N/A	
					2013 (Track 20)*	14.9	10.1		7.7	
				Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	2013	70,213	98,076		See Target Planning Table	
				Percentage of women age 15-49 with anemia	2010	17.3	12		N/A	
		3.2.1	Increased awareness of, access to, and demand for high-impact health practices	Number of liters of drinking water disinfected with point-of-use treatment products as a result of USG assistance.	2013	365,958,000	176,000,000		176,000,000	
				Number of people living with HIV/AIDS reached with a minimum package of Prevention with PLHIV (PwP) interventions	2013	4,293	See Target Planning Table		See Target Planning Table	
				Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	2013	27,682	12,011		See Target Planning Table	
		3.2.2	Improved protection of vulnerable populations against adverse circumstances	Percentage of vulnerable individuals graduating out of USG community-level support	See Baseline Planning Table	See Baseline Planning Table	See Target Planning Table		See Target Planning Table	
				Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	2014	641	20,496		See Target Planning Table	
		3.2.3	Increased nutrition knowledge and adoption of	Prevalence of anemia among children 6-59 months	2010	38	30		See Target Planning Table	

			appropriate nutrition and hygiene practices	Percentage of children 6-23 mo receiving a minimum acceptable diet	2010	17.27%	See Target Planning Table		N/A	
				Women's dietary diversity score: Mean number of food groups consumed by women of reproductive age	2010	3.34	See Target Planning Table		See Target Planning Table	
				Percentage of children under 5 with diarrhea who received ORT treatment	2010	48	55		N/A	
		2.1.1	Improved performance and engagement by CSOs and GOR entities	Score in percent of combined key areas of organization capacity among USG direct and indirect local implementing partners						
				Number of CSOs receiving USG assistance engaged in advocacy interventions						
				Number of performance solution package recommendations implemented by partner institutions						

Indicator Baseline Planning Table

DO	IR	Sub-IR	Result	Performance Indicator	New Data Collection Effort Required?	Data Collection Method	Data Source	Location and Scope of Data Collection	Means of Analysis	Estimated Date and Time Needed
3	Health and nutritional status of Rwandans improved									
	PROJECT: Community Health and Improved Nutrition									
	3.2	3.2.2	Improved protection of vulnerable populations against adverse circumstances	Percentage of vulnerable individuals graduating out of USG community-level support	Yes	Partner Records	USAID Implementing Partners	Implementing Partner	N/A	Mar-15

Indicator Target Planning Table

DO	IR	Sub-IR	Result	Performance Indicator	Data Collection Method	Source of Data	Frequency of Target Setting	Sources Consulted for Target Setting	Means of Analysis	Estimated Date of Completion
3	Health and nutritional status of Rwandans improved									
	PROJECT: Community Health and Improved Nutrition									
	3.2	3.2.1	Increased awareness of, access to, and demand for high-impact health practices	Number of people living with HIV/AIDS reached with a minimum package of Prevention with PLHIV (PwP) interventions	Partner Records	USAID Implementing Partner	Annual	Implementing Partner	N/A	Mar-15
				Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Partner Records	USAID Implementing Partner	Annual	Implementing Partner	N/A	Mar-15
		3.2.2	Improved protection of vulnerable populations against adverse circumstances	Percentage of vulnerable individuals graduating out of USG community-level support	Partner Records	USAID Implementing Partners	Annual	Implementing Partners	N/A	Mar-15
				Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	Partner Records	USAID Implementing Partners	Annual	Implementing Partners	N/A	Apr-15
		3.2.3	Increased nutrition knowledge and adoption of appropriate nutrition and hygiene practices	Percentage of children 6-23 mo receiving a minimum acceptable diet	Survey	DHS	5 Years	DHS	N/A	Mar-15
				Women's dietary diversity score: Mean number of food groups consumed by women of reproductive age	Survey	PBS	Bi-Annual	PBS	N/A	Apr-15