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Maternal and Child Health Integrated Program RWANDA

MCH BRIDGE PROJECT — IKIRARO 2011

ASSESSMENT/PLANNING REPORT



Date: March 2011

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin combination therapy
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ARI	Acute respiratory illness
ARV	Antiretroviral
ASM	Animateurs de santé maternelle
BCC	Behavior change communication
BCG	Bacille Calmette-Guérin (a tuberculosis vaccine given to infants)
B-EmONC	Basic emergency obstetric and newborn care
BS:	Blood slide
CBP	Community-based provision
CB-ENC	Community-based essential newborn care
CB-MNH	Community-based maternal and newborn health
CB-PPH	Community-based postpartum hemorrhage
CCM	Community case management
C-EMONC	Comprehensive emergency obstetric and newborn care
CENC	Comprehensive essential newborn care
CHD	Community Health Desk
CHW	Community health worker
C-IMCI	Community integrated management of childhood illnesses
CNLS	National Committee Fighting Against HIV/AIDS
CPR	Contraceptive prevalence rate
DDDM	Data-driven decision-making
DH	District hospital
DHS	Demographic and Health Survey
ENC	Essential newborn care
EPI	Expanded Programme on Immunization
FANC	Focused antenatal care
F-IMCI	Facility integrated management of childhood illnesses
FP	Family planning
GOR	Government of Rwanda
HC	Health center
HMIS	Health management information system
HSSP	Health sector strategic plan
HTSP	Healthy timing and spacing of pregnancy
iCCM	Integrated community case management
ICP	Integrated complementary package
IEC	Information, education and communication
IM	Intramuscular
IMCI	Integrated management of childhood illnesses
IMP	Integrated minimum package
IMP/MCH	Integrated minimum package/maternal and child health
IPTp	Intermittent preventive treatment for pregnant women
IST	Intermittent screening and treatment
ITN	Insecticide-treated bed net
IYCF	Infant and young child feeding
KMC	Kangaroo mother care

LAM	Lactational amenorrhea method
LBW	Low birth weight
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MIP	Malaria in pregnancy
MNCH	Maternal, newborn and child health
MOH	Ministry of Health
MUAC	Mid upper arm circumference (a measurement to assess malnutrition)
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
NSV	No-scalpel vasectomy
OJT	On-the-job training
ORS	Oral rehydration salts
PE/E	Pre-eclampsia and eclampsia
PMTCT	Prevention of mother-to-child transmission [of HIV]
PNC	Postnatal care
PNILP	National Malaria Control Program
PO	Program officer
POSACOM	Poste de santé communautaire (community health post)
PPH	Postpartum hemorrhage
RDT	Rapid diagnostic testing
RHODA	Rwanda Horticulture Development Authority
SBA	Skilled birth attendant
SBM-R	Standards-Based Management and Recognition
SP	Sulfadoxine-pyrimethamine
TA	Technical assistance
TBA	Traditional birth attendant
TIP	Trials of Improved Practices
TL	Tubal ligation
Trac Plus	HIV/AIDS, Treatment and Research AIDS Center
TWG	Technical working group
USG	United States Government
VAR	Vaccin anti rougeoleux (measles vaccine)
WHO	World Health Organization
WRA	White Ribbon Alliance

EXECUTIVE SUMMARY

Following the distribution of the needs assessment tool at the end of January 2011, the MCHIP technical teams carried out an assessment analysis and district action plan workshops were conducted for all targeted districts in the country.

Principle findings include:

Facility assessment

Demographic data: Our target population represents 43.5% of the Rwandan population (IDHS 2007–2008).

- **Human Resources:** One doctor serves a population of 19,578. Most doctors are found in Kigali. Most providers are A2 nurses (A2 means enrolled Nurses and A1 Means Registered Nurses), who constitute 80% of all staff. Fewer than 50 midwives are available where expectation is about 260 if we have to consider 1 midwife/ facility and most of these Midwives are concentrated in Kigali.

Trainings: In-service training in a variety of topics is needed in MCHIP-supported districts.

Infrastructure: A major problem in the POSACOMs (community health posts) has to share rooms to offer different services by one or two providers.

Equipment and drugs: Although most equipment was available in most of the facilities, the gynecologic lamp was a challenge as it was lacking in most of the facilities and is one of the important equipment in offering deliveries and FP services. Most facilities lacked drugs (e.g., hydralazine, misoprostol, magnesium sulphate, ergometrine and Coartem).

Indicators: There were discrepancies in some data reported. It was noted that data analysis and use were still a problem in most of the districts.

Community assessment

ASM: They are the maternal and Newborn health community health workers whose service package includes essential newborn care, KMC, Nutrition and facilitate/advise mothers in the community to seek ANC services and delivery. Among 6378 ASMs, 73% were not trained in community-based maternal and newborn health (CB-MNH), and 86% were not trained in nutrition.

Binomes: These are CHWs in-charge of community IMCI whose services package includes management of children under 5 years with Malaria, Pneumonia and Diarrhea. Binomes (male and female community health workers [CHWs]) from Ruhango and Nyanza were not trained in rapid diagnostic testing (RDT).

Indicators: It was noted that there was an insufficiency of capacity of data collectors in data analysis and data use to take decision.

1. BACKGROUND

In Rwanda, although important achievements have been realized in maternal, newborn and child health (MNCH), continued dedication and support to address MNCH programming is necessary to sustain and replicate successes. As outlined in Rwanda's *Health Sector Strategic Plan (HSSP) II 2009–2012*, the Government of Rwanda (GOR)/Ministry of Health (MOH) is committed to improving health outcomes for pregnant women and their children under five years of age by supporting comprehensive MNCH programming. This commitment combined with support from the United States Government (USG) and other donors is critical to ensure further reduction in the maternal mortality ratio (750/100,000 live births), infant mortality rate (62/1,000 live births), under five mortality rate (103/1,000 live births) and total fertility rate (5.5 births per woman), as well as reductions in morbidities related to malaria, HIV/AIDS and malnutrition (52% of children under five are stunted in their growth).¹

The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) is to assist in scaling up evidence-based, high-impact MNCH interventions including the fight against malaria malnutrition and HIV/AIDS, as well as support for family planning (FP) thereby contributing to significant reductions in maternal, newborn and child mortality toward Millennium Development Goals (MDGs) 4 and 5.

Drawing on technical and programmatic expertise from previous global programs including BASICS, IMMBasics and the ACCESS Program, MCHIP/Rwanda has been and continues to be well positioned to support Rwanda's MNCH interventions. Since 2009, with support from the USG, through both core and field support funds, MCHIP has provided technical support to the National Malaria Control Program (PNILP) and the Community Health Desk (CHD) to accelerate efforts to combat malaria in pregnancy (MIP), at the health facility and community levels, as well as in integrated community case management (iCCM). These efforts have led to expanded coverage among pregnant women and children under five to reduce the burden of malaria. MCHIP has also provided technical assistance to support Rwanda in taking steps to introduce the pneumococcal vaccine. With core funds, MCHIP has supported an inquiry on the quality of care elements for providing high-impact, lifesaving interventions such as magnesium sulfate to manage eclampsia, active management of the third stage of labor (AMTSL) to prevent postpartum hemorrhage (PPH) and essential newborn care (ENC). MCHIP's strong leadership at the country level, proven capacity to deliver high-quality results in Rwanda and established stellar relationships with key stakeholders, including the MOH and implementing partners, position the program to support this complex, comprehensive project.

¹ Rwanda Health Sector Strategic Plan 2009–2012

This year (January 1, 2011–December 31, 2011) is a “bridge year” for Rwanda, which will ensure that no opportunities are missed to support high-impact and evidence-based interventions in MNCH, FP, malaria, nutrition and HIV/AIDS. Specifically, the MCHIP Ikiraro project (MCHIP-Ikiraro) will bridge the gap as multiple awards including ACCESS, BASICS, Twubakane and the Capacity Project in Rwanda end, and a new USAID bilateral Family Health Project begins in 2011. MCHIP-Ikiraro will support the MOH in fostering linkages across the MNCH platform to enable the national level to promote and advance effective and high-quality implementation at facility and community levels. At the district level, MCHIP-Ikiraro has approved the project’s target districts in consultation with the MOH and USAID. Consideration was given to the districts outlined in the USAID Program Description² recognizing that these districts did not yet receive support from USAID/Rwanda clinical partners.

Overall Project Goal of MCHIP’s bridge is to contribute to improvements in maternal, newborn and child health and reduction of morbidity and mortality.

To reach this goal, MCHIP-Ikiraro will work in close collaboration with the MOH, USAID and implementing and supporting partners, including the World Health Organization (WHO) and UNICEF, to achieve the following specific objectives: (i) strengthen the capacity of providers to deliver an integrated minimum package (IMP)/MNCH of services effectively at the health center level, as well as an integrated complementary package (ICP) of services at the hospital level, according to national norms and protocols; (ii) equip health centers with critical equipment and tools to provide quality IMP/MNCH services and care; (iii) design and implement a national behavior change communication (BCC) sub-strategy for all MNCH components; (iv) support the MOH with targeted MNCH activities during the transition period, as existing awards end and the new Family Health Project begins; (v) support the nursing council and schools to complete initiatives previously started; and (vi) support the Rwanda White Ribbon Alliance (WRA).

Thus, MCHIP’s bridge interventions will **lead to** 1) improved access to quality care, specifically through strengthening the minimum package of MNCH services at facilities and in communities; 2) an established foundation for demand creation through the development of a national sub-strategy for BCC; 3) a strengthened data collection and management process/system; and 4) increased capacity within the nursing council to improve education for nurses. These results will **contribute to** reductions in MNCH morbidity and mortality.

² Burera, Musanze, Gakenke, Ngororero, Rubavu, Nyabihu, Huye, Gisagara, Nyanza, Gasabo, Kicukiro, Nyarugenge, Ruhango

2. INTRODUCTION

The Maternal and Child Health Integrated Program (MCHIP) supports programming for MNCH, immunization, FP, and the fight against malaria and HIV/AIDS. Additional cross-cutting technical areas include health systems strengthening, water, sanitation, hygiene and urban health.

MCHIP Rwanda- Ikiraro 2010 will provide support to the MOH to focus on high-impact interventions in the following technical areas:

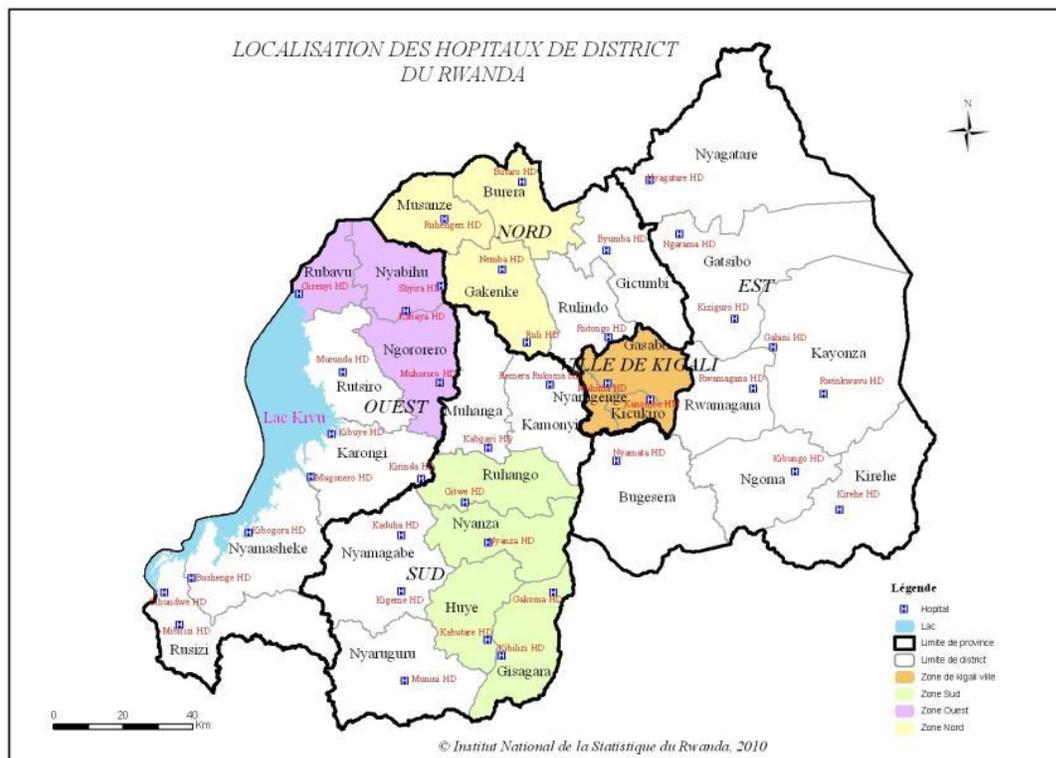
- Maternal and newborn health, including: strengthening health systems, improving facility-level care, improving community-level care
- Child health, including: integrated management of childhood illness (IMCI), promoting healthy timing and spacing of pregnancy (HTSP), messages
- Malaria: Malaria in pregnancy (MIP) programming, MIP surveillance, community case management, implementation of RDTs at the community level, strengthening case management at facilities; providing support for PNILP supervision
- Nutrition: MCHIP-Ikiraro will integrate nutrition across maternal and child health (MCH) technical areas at the facility and community levels, and will work with those responsible for nutrition at the district and central levels, as well as nutrition partners like UNICEF and the Rwanda Horticulture Development Authority (RHODA)
- FP: MCHIP-Ikiraro support will develop strategies to raise awareness and demand for FP during MNCH service contacts (including antenatal care [ANC], postnatal care [PNC] and immunization). Through training and supervision, MCHIP-Ikiraro will improve provider counseling skills and service provision with a focus on long-acting and permanent methods.
- HIV/AIDS: MCHIP-Ikiraro will assist the MOH and its partners to increase early identification, management and referral of HIV-infected infants in the priority districts through the integration of pediatric HIV and prevention of mother-to-child transmission of HIV (PMTCT) at all entry points to care.
- Institutionalizing a national training system for MNCH Services: MCHIP-Ikiraro will provide technical assistance to the MOH to bridge the gap between in-service and pre-service training, and find ways to harmonize training support at all levels”.
- Equipping health centers with critical equipment and tools: MCHIP-Ikiraro will support the MOH to develop a final list of essential equipment and tools.
- Designing and implementing a national BCC sub-strategy for all MNCH components: MCHIP-Ikiraro will work with the MOH to finalize its integrated communication strategy, which will include a BCC sub-strategy for all MNCH components.
- Supporting the MOH with targeted MNCH activities during the transition period, as existing awards end and the new Family Health Project begins, MCHIP-Ikiraro will:
 - Update/review national MCH/FP policy and strategy documents;
 - Conduct a rapid needs assessment for each facility to plan and monitor progress independently;
 - Scale up community-based provision (CBP) of contraceptives, including injectables in two districts;

- Improve the MCH database and support activities (e.g., the annual MCH conference and the MCH mothers' week) and promote attendance at the regional conference on postpartum hemorrhage and pre-eclampsia;
- Introduce the rotavirus vaccine and procure an incinerator for the MOH.

As an immediate first step, MCHIP-Ikiraro will support the MOH to conduct a rapid assessment and planning exercise that targets facilities and communities in selected districts. The assessment and planning exercise will focus on already defined gaps in each district and inputs that MCHIP can provide during the bridge period.

3. ASSESSMENT PURPOSE

To meet the MCHIP-Ikiraro commitment, described above, an assessment was carried out by MCHIP and the MOH. District hospitals directors from in the 13 targeted districts (Gakenke, Musanze, Rubavu, Burera, Ngororero, Nyabihu, Ruhango, Nyanza, Huye, Gisagara, Kicukiro, Gasabo, and Nyarugenge) shown in the map below took part in the assessment.



This activity aimed to gather baseline information on maternal, newborn and child health interventions in the respective facilities and communities in all 13 MCHIP-supported districts. These data would assist MCHIP/MOH and the district teams to gain a better understanding of current services, and then to plan key intervention areas based on priorities identified and inputs received that MCHIP can provide during the bridge period (January through December 2011).

4. APPROACH/METHODOLOGY

From February 7 to 23, 2011, this assessment targeted all the district hospitals (16), health centers (164) and POSACOMs (11) included in the health management information system [HMIS], as well as the community health workers (CHWs), i.e., ASMs and binomes, in the 13 districts mentioned above. Our assessment focused on the personnel trained in various subject areas by cadre and by gender, equipment and infrastructure, drugs and supplies, data collection tools and job aids, information, education and communication (IEC) materials and service indicators. Community and facility assessment tools were developed and pre-tested in Bugesera district and distributed to all districts teams to carry out a self-assessment at district hospitals, health centers and in communities for a week after approval by MOH. Data from the community were to be collected from the in-charge of CHWs at the district hospital (the person who compiles all data from all health centers). Data from all health centers and all district hospitals were collected by the in-charge of data and MNCH services and approved by the district hospital (DH) director/health center (HC) director. Each district organized a two-day workshop to conduct its own assessment and come up with its own action plan for one year. All assessments followed these main steps:

- At an official opening, the participants agreed on group norms and presented their expectations of the workshop. (Workshop participants included the districts' executive secretaries, in-charges of health from all districts, district hospital directors, in-charges of CHWs from the district hospitals, the data managers from the district hospitals, and all health center managers.)
- Working norms and workshop expectations were developed.
- A presentation on MCHIP was followed by a discussion.
- Then the participants were divided into three groups, one for community, two for health facilities. These groups were tasked with compiling data for entry into a database. Each group had a facilitator and a team leader who circulated among all three groups to provide orientation.
- Working groups were formed to identify gaps/needs in other districts. This was followed by a plenary session.
- Data compiled in the database was presented. Data were checked for errors and consistency, and then cleaned.
- Action plans were developed, based on areas of intervention, and inputs that MCHIP can provide during the bridge period were determined. Problems and gaps were identified. Activities, persons responsible and time frame required were noted and district authorities closed the workshops.

Limitations of this assessment

- Some of the data collectors noted that some of the indicators were not clear to them, and that data collection was challenging for them. This challenge may have arisen because some data collectors were not oriented to the data collection tool by the district teams. (These district teams were oriented by MCHIP staff before data collection began.)
- Some indicators collected during this assessment were not routinely collected through the HMIS.
- Some information requires a specialist (e.g., specialized information about infrastructure/rehabilitation, equipment)

5. FACILITY RESULTS

5.1. Number of health facilities and villages and the population per district in MCHIP-Ikiraro project intervention zones, based on results of the January 2011 baseline assessment.

DISTRICT	Total POPULATION	Number of sectors	Number of cells	Number of villages	Number of facilities			TOTAL FACILITIES
					DH	HC	POSACOM	
RUBAVU	377,189	12	80	525	1	9	7	17
NYABIHU	305,921	12	73	473	1	15	6	22
NGORORERO	331,160	15	73	419	2	12	12	26
RUHANGO	273,414	9	59	533	1	13	8	22
NYANZA	268,722	10	51	420	1	15	0	16
HUYE	293,661	14	77	508	1	13	9	23
GISAGARA	304,962	13	59	524	2	12	8	22
GAKENKE	359,851	19	134	753	2	19	8	29
MUSANZE	347,653	15	68	432	1	12	5	18
BURERA	320,128	17	69	571	1	15	8	24
GASABO	351,557	15	73	494	1	13	7	21
KICUKIRO	271,415	11	49	371	1	8	0	9
NYARUGENGE	246,937	10	47	355	1	8	1	10
13 DISTRICTS	4,052,570	172	912	6,378	16	164	79	259

The MCHIP target population, as shown in the table above, represents 43.5% of the Rwandan population (IDHS 2007–2008). MCHIP will work in 13 districts, 912 cells, 6,378 villages, and 259 facilities (DH, HC, POSACOM).

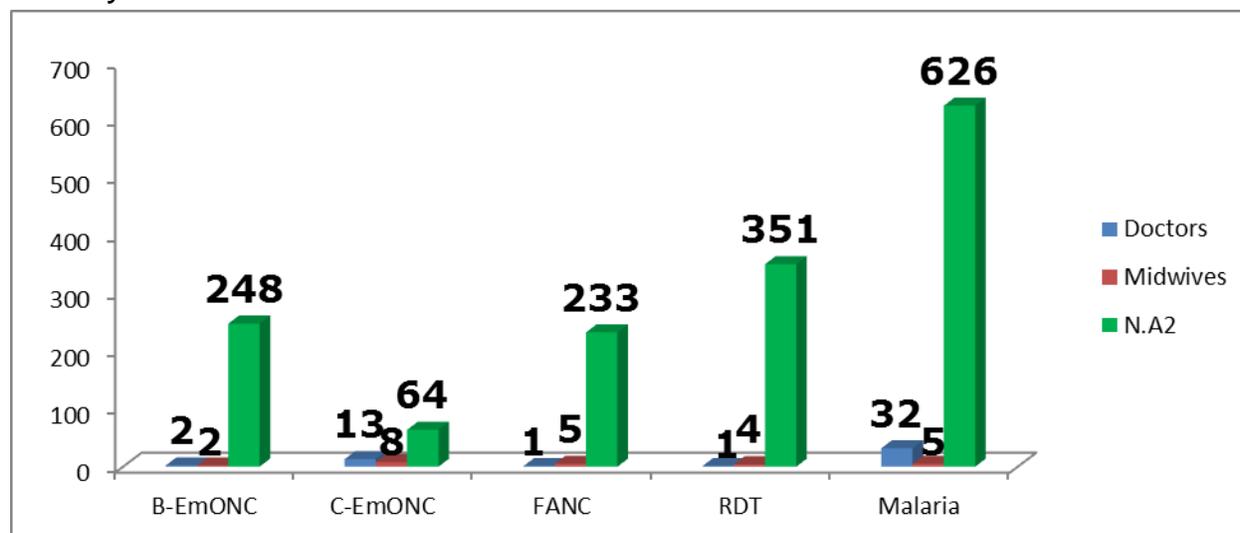
5.2. Number of human resources available by category for each district, based on results of the January 2011 baseline assessment.

DISTRICT	DOCTORS	Midwives	N. A1	N. A2	ANESTHETISTS	TOTAL
RUBAVU	14	2	27	188	4	235
NYABIHU	12	2	37	164	3	218
NGORORERO	14	1	21	182	2	220
RUHANGO	11	0	41	163	1	216
NYANZA	11	3	16	169	3	202
HUYE	12	0	11	180	4	207
GISAGARA	13	2	21	162	4	202
GAKENKE	18	7	35	230	7	297
MUSANZE	25	3	36	235	5	304
BURERA	12	3	23	200	3	241
GASABO	6	7	55	328	5	401
KICUKIRO	36	3	32	263	11	345
NYARUGENGE	23	16	21	228	11	299
13 DISTRICTS	207	49	376	2,692	63	3,387

The doctor-per-population ratio for the assessed districts is low. One doctor serves a population of 19,578, as compared to the WHO recommendation that one doctor serve a population of 5,000. This means that there is still a gap in the number of doctors available to serve the targeted district hospitals.

Most of the health care providers in these districts 80% of all staff are A2 nurses. These nurses need more continuous supervision, in-service training and refresher training to maintain the skills required to offer quality services. Assuming one midwife per facility, we would expect to have about 260 midwives in supported districts; however, in total, these facilities have fewer than 50 midwives available. Most of these midwives (26 out of 49) are concentrated in Kigali. (A1 are registered nurses and A2 are enrolled nurses)

5.3. Number of providers trained by qualifying in C-EmONC, B-EmONC, FANC and malaria in the MCHIP-Ikiraro project intervention zone, based on results from the January 2011 baseline assessment.



Because most of the providers are A2 nurses, they are the most in need of training in basic emergency obstetric and newborn care (B-EmONC), comprehensive emergency obstetric and newborn care (C-EmONC), focused antenatal care (FANC), RDT and malaria case management in all the supported districts.

As indicated in the table below, the assessment revealed that no provider was trained in both B-EmONC and C-EmONC in Gakenke district in the past two years, and no complete EmONC teams were found in Nyabihu, Nyanza, and Gakenke districts. However the Kicukiro and Nyarugenge districts have a good number of providers trained in C-EmONC. Also, the Burera district has no providers trained in FANC, RDT and malaria case management, and not a single provider in Ngororero district was trained in FANC and RDT in the past two years.

District	B-EmONC	C-EmONC	FANC	RDT	Malaria case management
RUBAVU	9	9	54	82	70
NYABIHU	8	0	8	44	84
NGORORERO	1	4	0	0	26
RUHANGO	45	20	15	44	84
NYANZA	17	0	6	16	103
HUYE	11	2	11	34	122
GISAGARA	19	3	2	5	42

District	B-EmONC	C-EmONC	FANC	RDT	Malaria case management
GAKENKE	0	0	98	61	100
MUSANZE	20	14	5	7	1
BURERA	88	12	0	0	0
GASABO	22	10	11	4	28
KICUKIRO	13	12	35	54	55
NYARUGENGE	12	18	18	29	1
Total	265	104	263	380	716

5.4. Number of providers trained in FP methods by district, based on results of the baseline January 2011 assessment.

District	IUD	Tubal ligation	Vasectomy	OJT/regular methods
RUBAVU	1	0	1	3
NYABIHU	12	0	3	11
NGORORERO	14	0	1	8
RUHANGO	21	0	0	59
NYANZA	14	0	0	5
HUYE	5	0	0	48
GISAGARA	5	0	0	1
GAKENKE	59	0	5	31
MUSANZE	7	0	2	1
BURERA	0	0	2	0
GASABO	26	0	1	0
KICUKIRO	10	0	0	3
NYARUGENGE	42	0	1	0
TOTAL	216	0	16	170

The table above shows that no single provider was trained in tubal ligation in all the supported district hospitals in the last two years. The Ruhango, Nyanza, Huye, Gisagara and Kicukiro districts did not have any providers trained in no-scalpel vasectomy (NSV). The assessment also revealed that no provider in Burera district had received IUD training; however, a good number of providers Gakenke and Nyarugenge districts had received IUD training.

5.5. Number of providers trained in vasectomy and IUD, compared to services provided

District	Trained in vasectomy	Vasectomies performed	Trained in IUD	IUD users
RUBAVU	1	18	1	154
NYABIHU	3	130	12	1,412
NGORORERO	1	11	14	64
RUHANGO	0	63	21	725
NYANZA	0	0	14	18
HUYE	0	8	5	98
GISAGARA	0	8	5	16
GAKENKE	5	69	59	283
MUSANZE	2	138	7	77
BURERA	2	5	0	4
GASABO	1	0	26	237
KICUKIRO	0	0	10	13
NYARUGENGE	1	5	42	309
TOTAL	16	455	216	3,410

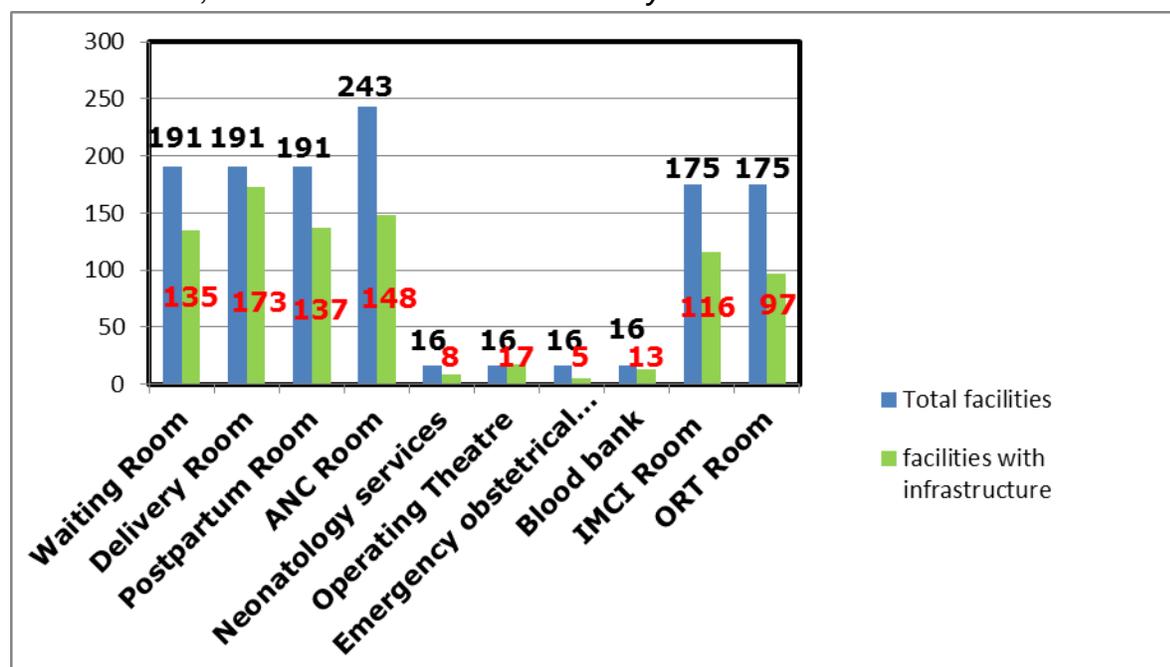
As shown in the table above, where providers were trained in IUD and vasectomy, these services were generally provided. However, in Burera four IUDs were inserted by providers who had not received training; in Ruhango, Huye, and Gisagara, vasectomies were performed by untrained providers. The vasectomies here might be scalpel vasectomies performed by doctors who did not receive in-service training, but simply relied on knowledge they acquired in medical school.

5.6. Number of providers trained in F-IMCI in the MCHIP-Ikiraro project intervention zone, based on results from the January 2011 baseline assessment

District	F-IMCI	Nutrition
RUBAVU	28	1
NYABIHU	15	0
NGORORERO	67	12
RUHANGO	38	6
NYANZA	36	0
HUYE	21	0
GISAGARA	27	2
GAKENKE	65	24
MUSANZE	24	4
BURERA	12	9
GASABO	24	5
KICUKIRO	17	7
NYARUGENGE	21	5
Total Trained	395	75

Very few providers especially in Rubavu and Gisagara districts have been trained in nutrition,. And none of the providers in Nyabihu, Nyanza and Huye districts were trained in nutrition. Providers in all districts have been trained in facility integrated management of childhood illnesses (F-IMCI); however, in Nyabihu and Burera, few have been trained in this area.

5.7. Proportion of facilities in the MCHIP zone having the infrastructures required to offer services, based on results of the January 2011 baseline assessment



In MCHIP intervention zone, we have 191 facilities (16 DH, 164 Health centers and 11 POSACOM) that offer delivery services, we also have all the health facilities offer ANC services except DH, district hospitals are the facilities that offer complementary EmONC services and only 164 health centers and 11 POSACOM provide Facility IMCI services.

Most of the hospitals do not have emergency obstetrical room and neonatology services. Most of the facilities have a waiting room, delivery room, postpartum room and ANC room; those that do not have these facilities are all POSACOMs. In general, a major infrastructure/human resource problem occurs in POSACOMs (community health posts) where one or two providers have to share a room to offer different services.

5.8. Proportion (percentage) of district health facilities in the MCHIP zone having delivery room equipment, based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Delivery kit	10	16	22	14	14	14	10	19	12	16	13	8	6	174	91
Kit for repairing the cervix	1	0	2	2	1	1	2	1	1	1	1	1	0	14	88
Vacuum extraction Kits	1	3	3	8	1	1	4	3	1	2	1	0	3	31	16
MVA kits	1	0	0	3	0	1	3	0	1	1	0	0	2	12	6
Suction machine	8	14	10	10	9	13	6	14	11	12	11	5	6	129	67
Warming lamp	4	5	6	11	9	5	9	4	3	3	4	3	3	69	36

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Oxygen source	1	2	3	2	1	2	3	2	2	1	2	2	1	24	13
Oxygen mask	2	3	5	1	2	1	1	3	9	2	1	2	1	33	17
Aspiration tube	5	8	10	10	2	11	5	7	7	10	11	2	6	94	49
Refrigerator or ice	3	4	5	6	7	4	10	9	4	5	5	2	5	69	36
Fetoscope	10	16	22	14	14	14	12	20	13	16	13	9	6	179	93
Baby weighing scale	10	13	21	14	14	13	14	17	12	16	13	8	6	171	89
Syphignomanometer and stethoscope	10	16	23	14	14	13	14	20	13	16	13	6	6	178	93
Delivery bed	10	16	23	14	14	14	14	19	12	16	13	8	7	180	94
Plastic cover for the delivery bed (mackintosh)	8	15	23	11	9	13	10	10	12	14	9	6	5	145	76
Gynecologic examination lamp	5	6	5	12	9	5	9	11	7	10	6	4	5	94	49
Urinary catheter and bag	4	7	11	13	12	12	7	15	7	14	8	5	5	120	63
Protein and sugar dipsticks	5	7	9	11	11	7	5	13	6	10	7	4	4	99	52
Ambu bag	4	11	10	12	12	13	11	15	11	13	8	8	5	133	69

The assessment revealed that most of the facilities do not have a gynecologic examination lamp and that manual vacuum aspiration (MVA) is not practiced in most of the health facilities. Some districts (e.g., Nyabihu and Nyarugenge) do not have cervical repair kits. Most of the facilities lack reanimation equipment.

5.9. Proportion (percentage) of district health facilities in the MCHIP zone having FANC equipment, based on results of the January 2011 baseline assessment (n= 191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Measuring tape	9	16	23	13	15	13	12	21	13	16	14	8	9	182	95
Fetoscope	9	16	24	13	14	13	12	21	12	16	14	8	9	181	94
Gynecologic lamp	3	1	7	7	4	2	2	2	3	1	2	3	5	42	22
Speculum	6	14	14	12	14	8	8	10	4	5	5	4	8	112	58
Adult weighing scale	9	16	23	13	16	13	11	18	11	14	13	7	9	173	90
Syphignomanometer and stethoscope	9	16	24	13	16	13	11	19	11	16	12	7	9	176	92
Instrument box	5	8	7	12	10	8	6	4	5	5	10	3	8	91	47
Thermometer	8	16	26	13	15	13	9	17	7	9	13	4	9	159	83
Hemoglobin and hematocrit	9	14	14	12	14	11	12	15	11	11	11	8	9	151	79
RPR test/syphilis	5	13	11	12	12	5	8	11	5	7	10	7	9	115	60

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
HIV test	6	13	12	13	12	7	6	11	11	7	13	8	9	128	67
Syringe and needle	9	15	22	13	15	13	9	17	12	7	13	9	9	163	85
Vacutainer tubes	9	13	10	13	14	13	9	17	12	10	13	8	9	150	78
Specimen labels	0	1	4	3	5	2	2	2	2	1	3	1	8	34	18
RDT kit	8	14	11	13	16	8	5	8	7	10	8	6	9	123	64

In general with the exception of gynecologic examination lamps, specula and instrument boxes most of the required FANC equipment is available in most of the facilities that offer these services. Although specimen labels are not available at all facilities, this does not handicap provision of services. RDT Kits are not generally integrated in the package of FANC services in all facilities.

5.10. Proportion (percentage) of district health facilities in the MCHIP Zone having FP equipment, based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Weighing scale	5	15	21	13	16	14	12	18	13	13	11	2	8	161	84
Table	10	15	21	13	15	14	11	20	13	13	12	6	9	172	90
Chair	10	16	21	13	14	14	12	21	13	16	13	9	9	181	94
Galley pot	8	12	16	7	8	6	2	5	5	8	4	3	7	91	47
IUD kit	7	12	16	12	7	10	5	14	11	8	9	3	7	121	63
Implant removal kit	6	13	15	12	11	13	7	12	6	9	12	3	7	126	66
Pipette container	9	16	21	12	14	14	11	17	9	13	10	3	7	156	81
Instrument tray	6	16	23	11	13	13	8	11	10	14	12	4	7	148	77
Waste receptacle	5	4	6	7	10	7	6	5	4	3	8	3	4	72	38
Stethoscope	10	16	23	12	16	14	12	20	9	16	13	3	8	172	90
Examination table	10	15	20	12	16	13	12	16	10	13	9	3	6	155	81
Sterilization instrument container	10	16	24	12	15	13	12	20	12	14	13	3	8	172	90
Sphygmomanometer	10	16	24	11	15	14	12	20	9	13	13	4	8	169	88
Gynecologic lamp	1	3	12	5	4	4	4	3	1	0	4	8	5	54	28
Chiteau forceps (lifting forceps)	6	16	24	11	16	14	10	17	12	12	12	2	7	159	83
Drapes	9	13	21	11	14	12	12	16	12	9	13	3	8	153	80

As indicated above, a gynecologic lamp is not always available even in FP services, and galley pots are not always available in some of the districts (Huye, Gisagara, Gakenke, Musanze, Gasabo and Kicukiro). Some districts (e.g., Gisagara and Kicukiro) have few IUD kits, and Kicukiro has few implant removal kits.

5.11. Proportion (percentage) of district health facilities in the MCHIP Zone having infection prevention equipment, based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Safety boxes for sharps	10	15	26	14	15	14	14	21	13	16	14	9	9	190	99
Bucket for decontaminating gloves	10	15	22	12	13	12	13	21	9	14	14	7	8	170	89
Bucket for decontaminating instruments	10	15	22	13	14	13	14	17	7	12	14	8	9	168	88
Bucket for cleaning instruments	9	15	21	13	14	12	14	17	6	16	14	8	9	168	88
Bucket for rinsing instruments	8	14	18	12	11	12	13	16	7	15	13	8	8	155	81
Bucket for processing used linen	8	13	17	13	12	12	14	13	7	12	13	7	8	149	78
Waste bin for non-contaminated materials	10	16	26	14	14	13	13	21	10	16	14	9	9	185	96
Waste bin for contaminated materials	9	16	26	13	15	13	13	20	11	15	13	9	9	182	95
Waste bin for the placenta	9	13	21	13	11	12	11	17	11	15	13	6	6	158	82
Utility gloves	6	15	12	12	10	11	11	12	10	15	12	5	9	140	73
Sterilization equipment	9	14	14	12	4	14	10	15	11	11	12	7	9	142	74
Plastic apron	10	15	18	14	12	14	14	19	12	15	12	7	6	168	88
Boots	10	16	19	14	14	14	12	19	12	16	12	7	9	174	91
Surgical cap	6	12	11	13	6	13	14	6	6	14	8	2	7	118	61
Eye protection goggles	10	16	16	13	11	14	13	16	8	16	10	7	8	158	82
Chlorexidine and other disinfectant	10	16	26	14	16	14	14	20	12	15	14	9	9	189	98
Jik (bleach)	8	11	10	12	10	13	12	17	6	7	14	8	8	136	71

It was found that most of the infection prevention materials and equipment were available in all facilities, which means this is not a big problem in the supported districts.

5.12. Proportion of district health facilities in the MCHIP Zone having EmONC tracer drugs, based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION
Hydralazine	0	1	3	0	1	1	0	2	0	1	0	1	1	11	6
Misoprostol	0	1	3	0	1	1	1	2	0	1	0	1	1	12	6
Oxytocin	9	16	20	14	14	14	14	20	12	16	12	6	6	173	90
Magnesium sulphate	1	3	5	0	1	4	3	4	3	1	6	2	1	34	18
Ergometrine	4	10	9	7	6	8	6	6	2	9	3	1	3	74	39
Ampicillin	7	16	21	13	14	11	13	17	10	13	12	9	7	163	85
Gentamycin	6	16	21	14	16	11	13	19	9	11	14	8	7	165	86
Metronidazole	9	11	21	14	14	13	13	19	10	6	14	9	5	158	82
Diazepam	9	16	21	14	15	14	11	20	10	7	14	8	8	167	87
Ringer lactate	9	16	22	14	15	14	14	20	12	15	14	9	7	181	94
5% dextrose	9	16	21	14	15	14	14	20	11	14	14	9	8	179	93
Normal saline	1	2	9	1	5	9	9	17	3	5	6	6	6	79	41

Most of the facilities had most of the tracer drugs needed for EmONC with the exception of some drugs (e.g., hydralazine, misoprostol, magnesium sulphate, ergometrine and normal saline) that were not used by most of the facilities in the supported districts. This could be a problem if these facilities need to manage certain complications (e.g., pre-eclampsia, eclampsia and postpartum hemorrhage).

5.13. Proportion (percentage) of district health facilities in the MCHIP Zone having IMCI drugs based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
Amoxicillin	10	15	24	14	16	14	14	13	11	16	14	9	9	179	93
Ampicillin 500 mg injectable	10	14	19	14	16	12	11	11	8	11	13	9	8	156	81
Gentamycin 80 mg	9	16	18	14	16	11	14	10	11	11	14	8	7	159	83
Cotrimoxazole	10	16	25	13	16	14	14	12	9	9	14	9	9	170	89
Ciprofloxacin	10	16	22	14	12	12	14	12	10	9	14	9	9	163	85
Erythromycin	10	14	23	14	16	14	14	12	10	9	14	9	9	168	88
Ophthalmic tetracycline ointment	10	16	25	14	16	14	13	12	11	10	14	9	9	173	90
Metronidazole	10	16	25	14	16	14	14	12	10	9	14	9	9	172	90
Diazepam	10	16	24	13	16	14	14	12	11	6	14	8	9	167	87
Gentian violet	10	16	23	13	14	13	13	12	9	9	13	7	9	161	84
Artemeter IM	6	12	3	11	13	14	12	13	4	6	12	5	9	120	63
Quinine 2 ml injectable	10	10	15	11	16	13	11	13	6	10	13	8	7	143	74

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION (%)
PRIMO red	10	16	23	13	16	14	14	14	10	11	8	4	6	159	83
PRIMO yellow	10	16	23	13	16	14	14	14	10	12	9	4	6	161	84
Mebendazole	10	16	18	13	16	14	14	14	11	11	14	9	9	169	88
Vitamin A	9	16	18	9	16	11	14	12	7	9	14	9	8	152	79
ORS	10	16	23	12	16	12	14	13	11	13	14	9	9	172	90
Zinc	10	16	22	12	16	14	15	13	11	12	11	6	7	165	86
Iron folate	10	16	19	12	15	14	13	13	8	7	13	9	9	158	82
Plumpy'nut	4	11	18	1	11	9	13	10	7	9	9	3	9	114	59

The assessment revealed that most IMCI drugs were available in almost all facilities, with the exception of arthemeter intramuscular (IM) and Plumpy'nut few facilities in MCHIP-supported districts have these drugs.

5.14. Proportion of district health facilities in the MCHIP zone having FANC drugs, based on results of the January 2011 baseline assessment (n=191)

	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	TOTAL	PROPORTION
Ferrous and folic acid	9	16	23	13	16	13	13	19	13	14	13	9	9	180	94
Mebendazole	9	16	18	13	16	13	13	19	9	12	14	9	9	170	89
Coartem	3	16	7	7	10	7	4	5	1	1	2	6	9	78	41
Quinine	5	15	16	10	11	9	8	13	6	4	13	6	9	125	65
ARV for women in PMTCT	8	13	10	11	11	9	9	12	7	9	9	8	8	124	65
ARV for the exposed infants	8	13	10	11	11	9	9	12	7	9	9	8	8	124	65

The assessment revealed that most of the facilities had FANC drugs with the exception of Coartem, which seemed to be missing in the supported districts.

In summary, during the assessment, it was noted that Most of required operating theater equipment was available in all district hospitals and in all facilities, and 84% of required infection prevention equipment was available. It was also noted that 74% of the health facilities had all the required FP equipment to permit them offer FP services; 83% and 70% of facilities had F-IMCI and FANC drugs available, respectively. All the health facilities had all the required data collection tools. And the IEC materials found were for infection prevention, HIV/AIDS and FP.

5.15. MNCH program indicators in MCHIP-supported districts (January to December 2010)

While analyzing various indicators and data reported by the health facilities, it was found out that during January through December 2011, 60.5% of the total deliveries took place in facilities, which means that at 39.5% the home delivery rate is still high in MCHIP-supported districts. Among the facility-based deliveries reported during that period, 92% used partographs and 82% used AMTSL.

During the assessment, it was found that, in 2010, 5.74% of newborns were of low birth weight (LBW), and only 32.4% of them received kangaroo mother care (KMC) services. Also it was noted that, generally, maternal death audits are done systematically for all maternal deaths of the 70 deaths reported in 2010, 68 were audited. The number of deaths at birth (413 deaths out of 100,585 deliveries as reported in HMIS *décès à la naissance*) and the number of intrauterine fetal deaths (1,220 deaths out of 100,585 deliveries as reported in HMIS *décès in utéro*) seem to be high and need to be reinvestigated.

5.15.1. Proportion (percentage) of cesarean sections carried out in MCHIP-supported facilities, based on results of the January 2011 baseline assessment

INDICATOR	DISTRICT HOSPITALS													TOTAL
	Gisenyi	Shyira	Muhororo & Kabaya	Gitwe	Nyanza	Kabutare	Gakoma & Kibilizi	Nemba & Ruli	Ruhengeri	Burera	Kibagabaga	KMH	Muhima	
Total cesarian	997	379	838	848	768	768	942	869	1,603	192	970	813	1,919	11,906
Total deliveries at health facilities in the district	9,714	6,438	9,459	7,299	6,812	7,047	7,260	8,332	9,417	6,703	6,573	6,317	9,214	100,585
Proportion of cesarean (%)	10	6	9	12	11	11	13	10	17	3	15	13	21	12

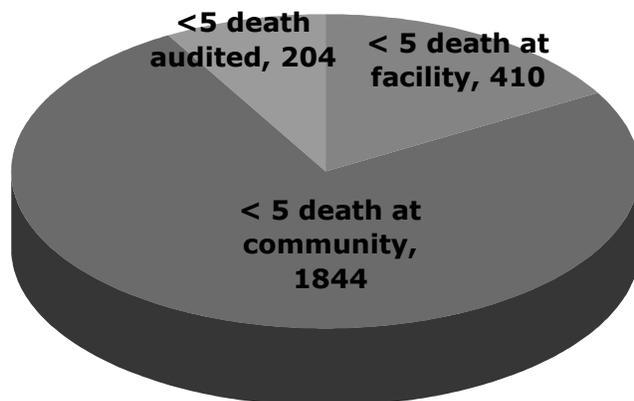
In the entire intervention zone, 11.8% of deliveries were reported to be cesarean section; however, some districts reported higher or lower cesarean section rates in Burera (2.8%), Nyarugenge (21%) and Musanze (17%). These variations can be explained. For example, Butaro district hospital in Burera started recently, and referred all cesarean section cases to other hospitals (e.g., Ruhengeri district hospital in Musanze, which shows a larger number of cesareans sections). Muhima hospital in Nyarugenge district specializes in maternity and is located in Kigali, where it is understandable that some women request cesarean section rather than going into labor.

5.15.2. FP users, by method, in MCHIP-Ikiraro project-supported facilities, based on results of the January 2011 baseline assessment

INDICATOR	DISTRICT													TOTAL
	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
Pills	5,197	1,632	12,948	16,641	4,825	9,303	4,313	6,449	7,778	3,422	4,932	1,880	7,237	86,557
Injectables	16,870	11,477	10,078	25,885	20,980	24,323	9,123	16,839	13,396	16,889	16,816	6,050	23,064	211,790
Implants	5,838	3,333	5,301	3,134	2,538	3,359	1,735	3,447	1,334	1,880	2,796	835	4,281	39,811
IUD	154	1,412	64	725	18	98	16	283	77	4	237	13	309	3,410
Cycle beads	136	161	85	463	82	127	100	252	139	194	128	182	178	2,227
Barrier	192	655	1,966	240	441	1,449	115	813	251	349	120	264	117	6,972
Tubal ligation	56	26	6	103	0	11	19	168	69	13	7	0	58	536
Vasectomy	18	130	11	63	0	8	8	69	138	5	0	0	5	455
Total users	28,461	18,826	30,459	47,254	28,884	38,678	15,429	28,320	23,182	22,756	25,036	9,224	35,249	351,758

The use of most FP methods seems to be good in most of the districts with the exception of permanent methods. In Nyanza, Gasabo and Kicukiro districts, few or no users of permanent methods were registered. In Burera district, only four cases of IUD use were recorded.

5.15.3. Number of deaths among children under age five registered and those that are audited in MCHIP-Ikiraro project-supported facilities, based on results of the January 2011 baseline assessment



For the facility IMCI, it was noted that many deaths among children under age five occurred in 2010, but few received death audits. The cause of these deaths is not known, and requires further investigation. Community death audits are not generally done by health facilities. It is also evident that the reporting system of CHWs in Kicukiro district is problematic, because they reported only 22 deaths at health facilities and two in communities.

6. COMMUNITY RESULTS

6.1. Number of ASMs trained in the ASM training package and nutrition in MCHIP-Ikiraro project-supported districts from the baseline assessment January 2011:

DISTRICT	Number of Villages	ASMS TRAINED IN CB- MNH	
		ENC/KMC/Malaria	Nutrition
RUBAVU	525	79	0
NYABIHU	473	473	473
NGORORERO	419	0	419
RUHANGO	533	0	0
NYANZA	420	0	0
HUYE	508	0	0
GISAGARA	524	0	0
GAKENKE	753	787	0
MUSANZE	432	432	0
BURERA	571	0	0
GASABO	494	0	0
KICUKIRO	371	0	0
NYARUGENGE	355	0	0
13 DISTRICTS	6,378	1,771	892
% ASMs trained		28%	14%

The ASM training package is being implemented in three of the 13 district (Gakenke, Nyabihu, and Musanze). For Rubavu district, the training took place in only Busasamana health center. In MCHIP-supported districts, the partners implementing this package are UNICEF and MCHIP in collaboration with the MOH. The training materials and ASM kits are harmonized and provided by partners. Very few ASMs have been trained in nutrition (14%), and 28% of the ASMs were trained in the ASM training package in the last two years.

6.2. Services provided by the ASMs

During the assessment, it was found that ASMs carry out the following functions:

- Identify and register pregnant mothers in their communities;
- Advise pregnant mothers on the importance of ANC and pregnancy-related danger signs;
- Carry out home visits, and help mothers develop their delivery plans;
- Identify danger signs and refer women and newborns;
- Provide immediate postnatal services in the first week; and
- Fill in the registers and do activity reports.

6.3. Number of binomes in MCHIP-supported districts trained in community integrated management of childhood illnesses (C-IMCI), integration of RDT and those trained as trainers, based on results of the January 2011 baseline assessment

DISTRICT	Number of villages	BINOMES TRAINED IN C-IMCI	
		C- IMCI	RDT
RUBAVU	525	1,278	1,278
NYABIHU	473	982	982
NGORORERO	419	838	838
RUHANGO	533	1,066	0
NYANZA	420	848	0
HUYE	508	1,016	1,016
GISAGARA	524	992	1,006
GAKENKE	753	1,234	1,234
MUSANZE	432	864	864
BURERA	571	1,329	1,329
GASABO	494	912	874
KICUKIRO	371	408	204
NYARUGENGE	355	252	270
13 DISTRICTS	6,378	12,019	9,895
% of BINOMES trained in C-IMCI		94%	78%

Generally, all binomes in the 13 districts have been trained in C-IMCI and RDT except in Ruhango and Nyanza where RDT is not yet integrated into C-IMCI. However, most of these trainings occurred more than two years ago; therefore, refresher training is required. The assessment also revealed that most CHWs haven't received a single supervision visit in the past six months, and community-based provision of FP is not yet implemented in all 13 districts it is only implemented in Kicukiro district.

Binomes are CHWs in-charge of community IMCI whose services package includes management of children under 5 years with Malaria, Pneumonia and Diarrhea. Binomes (male and female community health workers [CHWs])

6.4. Availability and use of CHW equipment, drugs and coordination of CHWs in MCHIP-supported districts, based on results of the January 2011 baseline assessment

Regarding coordination of CHWs, it was noted that all CHWs who are trained receive a kit that comprises an umbrella, boots, a bag, a thermometer, a weighing scale and a timer together with data collection tools (counseling cards, transfer forms, follow-up cards and register). Each district has an in-charge of CHWs at the district hospital with the exception of Musanze district, which did not have a coordinator at the time the assessment took place. At the cell level, one of the CHWs is chosen to be a coordinator of all CHWs. Each health center has an in-charge of CHWs in that center's catchment area. No stock-outs of drugs (e.g., amoxicillin, Coartem and oral rehydration salts [ORS]) were noticed during the evaluation; however, zinc is not available everywhere.

6.5. C-IMCI indicators collected in MCHIP-supported districts, based on results of the January 2011 baseline assessment

DISTRICT	C- IMCI INDICATORS								
	Children under 5 years old seen by the CHW	Total children under 5 tested with RDT	Total RDT positive	Total treated for malaria	Total treated for malaria correctly (refer to protocol)	Number of children in yellow MUAAC	Number of children in red MUAAC	All children under 5 deaths in community	Number of households with kitchen gardens
RUBAVU	?	8,610	759	1,692	759	26,594	3,728	231	
NYABIHU	9,723	2,029	121	1,433	335	8,106	1,072	362	
NGORORERO	25,590	13,375	751	1,539	1,539	4,006	730	4	
RUHANGO	40,393	0	0	36,267	34,269	719	107	0	
NYANZA	32,736	1,754	140	29,590	27,950	427	117	238	
HUYE	2,061	1,382	190	190	190	2,391	281	14	
GISAGARA	49,849	3,020	1,149	1,149	1,149	?	?	4	
GAKENKE	13,926	1,362	32	137	137	795	70	657	69,387
MUSANZE	15,588	3,362	643	638	618	4,551	1,043	106	30,082
BURERA	18,385	5,651	116	1,236	116	322	33	210	
GASABO	834	599	578	614	614	62	51	12	
KICUKIRO	14,101	0	0	12,315	12,007	1,519	164	4	
NYARUGENGE	4,307	0	0	2,667	1,716	55	8	2	
13 DISTRICTS	227,493	41,144	4,479	89,467	81,399	49,547	7,404	1,844	99,469

It is noted that no children under the age of five were tested with RDT in Ruhango, Nyarugenge and Kicukiro. This is explained by the fact that CHWs in these districts have not yet been trained in RDT; but they have been trained in community case management. Some of these data might not be correct, especially data on the deaths of children less than five years of age in the community; this number seems to be low in Ngororero, Ruhango, Gisagara, Kicukiro and Nyarugenge districts. In Gisagara district, no data were collected on malnutrition. With the exception of Gakenke and Musanze, districts did not report the number of households that have kitchen gardens.

7. KEY GAPS IDENTIFIED DURING THE BASELINE ASSESSMENT

7.1. Facility level

Human Resources:

- The assessment revealed a low doctor-to-population ratio; and
- Generally we have few midwives in our intervention districts.

Training:

- The assessment revealed a high number of A2 not trained in the field of maternal, newborn and child health;
- Of the 13 district hospitals, 11 do not have complete C-EmONC teams, and no provider is trained in C-EmONC in Nyabihu, Nyanza and Gakenke districts;
- Among 2,692 A2 nurses, 248 nurses are trained in B-EmONC, 233 in FANC and 351 in RDT;
- No provider is trained in B-EmONC in Gakenke district and in five health facilities in Gisagara district;
- The assessment revealed that no medical doctor is trained in tubal ligation (minilap), also only 16 of 207 medical doctors are trained in NSV; and
- 12% of providers are trained in F-IMCI, and only 2% are trained in nutrition.

Infrastructure:

- POSACOMs do not fulfill the norms in terms of required infrastructure;
- Among 16 of district hospitals, eight have neonatology services; five of the 16 district hospitals have emergency obstetrical services; and
- 44% of health centers do not have IMCI rooms.

Indicators:

- Data collectors' and decision-makers' capacity in data analysis is insufficient;
- Data are collected and transmitted, but are not fully used at all levels to make appropriate decisions based on available means (data-driven decision-making [DDDM]);
- In many cases, cause of death at birth and of intrauterine fetal death not known.

7.2. Community level

Trainings:

- Among ASMs 63% were not trained in CB-MNH, and 86% were not trained in nutrition;
- Ruhango and Nyanza binomes were not trained in RDT; and
- CHWs that are to be trained will need kits after training.

Indicators:

- The capacity of data collectors in data analysis is insufficient; and
- Deaths that occur at the community level are not audited.

8. HOW MCHIP WILL RESPOND TO IDENTIFIED GAPS

8.1. Strategic interventions at the health facility level

To close the gaps identified during the assessment, MCHIP worked with district teams to propose the following priority interventions at the facility level:

- Reinforce providers' competencies/skills in various domains to improve the quality of services. Apply an on-the-job training approach that will: reduce staff absenteeism, keep training costs to a minimum and allow training of as many providers as possible. Provide post-training follow-up to check providers' skills acquisition;
- Implement continuous supportive supervision for providers to strengthen their ability to deliver high-quality services;
- Apply a performance and quality improvement process, based on set standards; and
- Set up a monitoring system at the facility level, and emphasize the importance of using data for decision-making.

MCHIP will carry out the interventions listed above in all 13 districts, but the package will vary depending on the gaps identified and the priorities set for one year of implementation. The table below gives technical areas and the districts in which they will be implemented.

TECHNICAL AREAS	DISTRICTS
EmONC/ENC	Gakenke, Burera, Nyanza, Huye, Kicukiro, Ngororero
MIP/FANC/PMTCT	Gakenke, Musanze, Burera, Nyabihu, Rubavu, Nyanza, Gisagara, Ruhango, Kicukiro
MIP SURVEILLANCE/IST	Musanze, Nyanza, Ruhango, Kicukiro
FP/OJT	Burera, Gisagara
FP/IUD/TL	Gakenke, Burera, Nyabihu, Nyanza, Huye, Gisagara, Ngororero
FP/NSV	Nyanza, Gisagara
IMCI	Nyabihu, Huye, Gisagara, Ruhango, Gasabo, Kicukiro, Nyarugenge
NUTRITION	Gakenke, Huye, Ruhango

8.2. Strategic interventions at the community level

At the community level, the district teams identified the following priority interventions to be implemented in one year:

- Build the capacity of CHWs to increase demand for quality services. In some districts this will be accomplished by training new CHWs; in other districts refresher training will be provided for CHWs who have already been trained. . After training, CHWs will receive post-training follow-up to check how they are acquiring skills;
- Offer peer supportive supervision up to the cell level to follow up how CHWs are offering quality health services;
- Ensure continuous improvement of CHWs' monitoring and reporting systems;
- Procure kits and tools for CHWs;
- Scale up ~~saving~~ CBP in four additional districts;
- Introduce postpartum hemorrhage prevention with misoprostol at the community level in four districts; and
- Promote family kitchen gardens in four districts, in partnership with RHODA.

MCHIP will implement the following interventions at the community level. The table below shows the technical areas and the districts in which these areas will be implemented.

TECHNICAL AREAS	DISTRICTS
C-IMCI/RDT/HTSP	Huye, Ruhango, Gasabo, Kicukiro, Nyarugenge
CB-PPH/MISOPROSTOL	Gakenke, Musanze, Rubavu , Nyanza
CBP/FP	Huye, Gakenke, Burera, Nyanza
BCC/NUTRITION/MALARIA	Gakenke, Musanze, Rubavu, Nyanza, Huye, Ruhango
RDT	Ruhango, Nyanza

8.3. National level interventions

The following are national interventions that contribute to district-level activities in one way or another.

- Revise and adapt EmONC, FANC, IMCI and nutrition policy and guidelines
- Evaluate and elaborate national BCC and FP strategies
- Support rotavirus introduction in Rwanda
- Revise and adapt MNCH training materials
- Institutionalize training
- Implement supportive supervision at the DH level
- Provide a list of key supplies/equipment for MNCH
- Support specific events like MCH week, Child health summit, maternal and child survival annual conference

- Procure an industrial incinerator for the MOH
- Support the pre-service education and nursing/midwifery council
- Support attendance to regional MNCH conferences
- Support the WRA strategic plan

8.4. Other needs expressed by districts

Districts expressed the need for:

- More ambulances to facilitate the referral of cases;
- Building/renovating some infrastructures, especially POSACOMs;
- Some equipment/supplies;
- Payment to cover salaries for some additional staff, especially midwives; and
- Support for mutual fees for indigents.

9. LESSONS LEARNED FROM THE BASELINE ASSESSMENT

While carrying out this assessment, we learned that:

- Carrying out a needs assessment and planning activities with the participation of district stakeholders ensures ownership and sustainability of the program;
- Collecting baseline information prevents/reduces duplication of effort and saves resources. The baseline assessment allowed us to identify other partners working in the MCHIP-supported districts and analyze the scope of their technical intervention areas so that we could complement their activities by charting new activities that will address what remains to be accomplished in those districts; and
- Involving the MOH in the planning process provides leadership and guidance based on country priorities.

10. RECOMMENDATIONS

- Continue to conduct a participative planning process so that district stakeholders have the opportunity to take part;
- Share this information with the MOH and partners so they can plan complementary activities to address identified gaps;
- Establish review meetings to measure the program's progress;
- Advocate for a response to district needs that will not be implemented by the MCHIP-Ikiraro project;
- Conduct an audit of all deaths among children under the age of five and of maternal deaths at health care facilities and at the community level;
- Investigate the causes of intrauterine fetal deaths and death at birth;
- Build the capacity of data collectors (providers and CHWs) and decision-makers to perform monitoring and evaluation activities; and
- Encourage decision-makers to use data to inform decision-making (DDDM).

Conclusion

In general, the baseline assessment and planning in 13 districts was completed, gaps were identified and action plans were developed for all 13 districts. Data were entered in a database in EPIINFO, analyzed by district, facility and technical area, and a report was produced. The needs assessment revealed some gaps that cannot be filled in one year. The project's duration, its budget and the MCHIP mandate call for continued advocacy. Although services are provided at the facility level, there is a need to build providers' capacity to provide a high-quality integrated minimum package of services, as well as complementary MNCH packages. At the community level, where child health services are provided in all districts, provider capacity building is needed. There is also a need to reinforce CB-MNH services, including training and equipping the ASMs. While implementing this program, to achieve complementarity, MCHIP recognizes the need to collaborate with a variety of partners and stakeholders in the field of MNCH/RH.

Annexes

1. EmONC indicators

INDICATOR	DISTRICT													TOTAL
	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
Total facility deliveries	9,714	6,438	9,459	7,299	6,812	7,047	7,260	8,332	9,417	6,703	6,573	6,317	9,214	100,585
Total home deliveries reported by CHWs/ASMs	997	1,377	1,925	277	612	938	1,505	784	918	1,140	224	136	92	10,925
Total deliveries by SBA	9,714	6,438	9,458	7,299	6,810	7,047	7,260	8,273	9,417	6,703	6,573	6,317	9,014	100,323
Total normal deliveries	8,679	6,023	8,736	6,441	5,872	5,920	5,678	7,000	8,335	8,509	3,608	5,504	7,184	87,489
Total assisted deliveries (by vacuum extractor or forceps)	37	28	1	7	194	303	738	187	17	0	47	0	111	1,670
Number of deliveries with AMTSL	7,146	5,661	8,772	6,444	6,398	6,015	4,148	5,771	9,158	3,830	4,456	5,504	9,207	82,510
Total deliveries by SBA using partographs	8,944	6,431	9,319	6,444	6,807	6,709	5,983	8,195	8,910	6,705	6,573	6,317	9,214	96,551
Number of maternal deaths registered	7	2	4	2	11	9	3	8	5	2	11	3	3	70
Total newborn babies with weight < 2,500 grams	164	217	357	179	868	284	359	677	901	178	175	956	456	5,771
Total newborn babies with weight < 2,500 grams who received KMC	36	28	1,063	87	131	55	108	104	66	62	56	72	0	1,868
Number of deaths at birth	28	12	40	16	59	45	39	44	28	18	29	16	39	413
Number of intrauterine deaths	136	50	116	40	92	100	76	116	196	29	69	52	148	1,220
Number of maternal deaths audited	7	2	4	1	11	6	5	8	5	2	11	3	3	68
Number of cesarian sections performed	997	379	838	848	768	768	942	869	1,603	192	970	813	1,919	11,906
Number of newborn babies who received antibiotics in the first 3 days after birth	0	78	422	63	15	4	124	115	0	2,570	622	676	1	4,690

2. FANC indicators

INDICATOR	DISTRICT													TOTAL
	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
ANC														
New cases in ANC	12,995	10,713	10,892	10,108	11,842	9,013	10,853	8,691	10,503	9,715	11,431	9,598	10,630	136,984
Number of pregnant women with four standard ANC visits	2,021	705	1,694	1,156	1,934	2,070	1,178	2,553	2,008	2,248	741	625	742	19,675
Number of pregnant women who received ITNs	7,074	5,217	10,194	5,458	4,464	3,366	5,275	5,595	6,681	5,640	3,005	8,171	4,055	74,195
IST														
Number of pregnant women tested with RDT	80	114	62	10	30	0	723	14	4	0	1	3	21	1,062
Number of pregnant women who became positive to RDT	68	0	9	6	5	0	51	4	0	0	1	2	21	167
Number of pregnant women treated for malaria	68	0	9	28	113	0	152	28	9	0	61	13	42	523

3. FP service indicators

INDICATORS	DISTRICT													TOTAL
	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
Pills	5,197	1,632	12,948	16,641	4,825	9,303	4,313	6,449	7,778	3,422	4,932	1,880	7,237	86,557
Injectables	16,870	11,477	10,078	25,885	20,980	24,323	9,123	16,839	13,396	16,889	16,816	6,050	23,064	211,790
Implants	5,838	3,333	5,301	3,134	2,538	3,359	1,735	3,447	1,334	1,880	2,796	835	4,281	39,811
IUD	154	1,412	64	725	18	98	16	283	77	4	237	13	309	3,410
Cycle beads	136	161	85	463	82	127	100	252	139	194	128	182	178	2,227
Condom	192	655	1,966	240	441	1,449	115	813	251	349	120	264	117	6,972
Tubal ligation	56	26	6	103	0	11	19	168	69	13	7	0	58	536
Vasectomy	18	130	11	63	0	8	8	69	138	5	0	0	5	455

4. Facility IMCI indicators

INDICATOR	DISTRICT													TOTAL
	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
Number of children < 5 years who came for consultation	37,183	35,797	34,341	11,489	33,064	36,105	35,766	58,117	65,542	51,897	47,073	19,427	93,734	559,535
Number of children < 5 years registered on the IMCI individual card	7,002	13,701	24,121	7,259	16,041	3,737	17,667	29,701	13,325	476	22,409	79	0	155,518
Number of children < 5 years who presented with diarrhea	5,502	5,609	6,828	1,735	4,060	4,005	5,523	6,484	8,908	3,054	5,498	1,965	7,480	66,651
Number of children < 5 years treated for diarrhea with ORS and zinc	4,825	4,253	5,425	1,732	3,557	2,806	5,215	6,101	7,772	2,848	5,031	1,962	6,949	58,476
Number of children < 5 years who presented with pneumonia	1,126	4,216	7,211	1,897	2,938	3,248	3,298	12,211	7,900	4,493	3,070	1,096	3,130	55,834
Number of children < 5 years treated for pneumonia	1,124	4,177	5,248	1,896	2,892	3,243	5,721	12,206	7,929	4,226	3,099	1,093	2,971	55,825

Indicator	Rubavu	Nyabihu	Ngororero	Ruhango	Nyanza	Huye	Gisagara	Gakenke	Musanze	Burera	Gasabo	Kicukiro	Nyarugenge	
Number of children < 5 years tested for malaria using Blood Slide	4,269	3,340	5,439	5,007	10,230	13,855	8,403	17,401	6,009	4,460	15,925	2,241	16,107	112,686
Number of children < 5 years tested for malaria with RDT	527	673	5,097	584	638	1,987	2,925	3,261	36	887	90	1	482	17,188
Number of children < 5 years confirmed malaria positive on BS and RDT	720	136	221	1,745	3,058	8,222	7,816	357	172	39	4,004	1,657	1,306	29,453
Number of children < 5 years treated for malaria	720	105	156	1,745	7,162	10,681	11,081	367	227	336	4,738	1,574	1,306	40,198
Number of deaths of children < 5 years registered by the facility	0	21	0	9	5	57	35	122	123	16	0	22	0	410
Number of deaths of children < 5 years audited	0	13	0	7	0	49	77	53	5	0	0	0	0	204
Immunization services														
Total number of children who received BCG	14,751	8,604	15,101	8,092	7,431	8,518	8,844	8,273	11,463	7,926	11,572	6,359	10,955	127,889
Total number of children who received P3-DTC-HepB/Hib3	14,554	9,326	15,194	10,780	9,528	8,821	9,601	9,251	9,945	10,317	11,162	5,830	6,489	130,798
Total number of children who received measles vaccine (VAR)	14,345	9,717	14,729	10,360	10,109	9,354	9,957	8,582	10,243	9,530	10,543	7,529	6,417	131,415

5. District partners

District	Partners
Gakenke	MCHIP
Musanze	GTZ, UNICEF, MCHIP
Burera	PIH, MCHIP
Nyabihu	UNFPA, UNICEF, MCHIP
Rubavu	UNFPA, UNICEF, MCHIP
Ngororero	UNFPA, UNICEF, MCHIP
Nyanza	UNICEF, FHI (2 H/C), MCHIP
Huye	GTZ, MCHIP
Gisagara	UNICEF, MCHIP
Ruhango	FHI, MCHIP
Gasabo	IntraHealth, MCHIP
Kicukiro	EGPAF (2 H/C), MCHIP
Nyarugenge	EGPAF (2 H/C), MCHIP

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