

PD-ABA-286



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**TRIP REPORT B - # 39-1 and 2**

**Travelers:** Ms. Maureen Corbett, INTRAH  
Program Officer  
Mr. Onanga Bongwele, INTRAH  
Francophone Regional  
Evaluation and Supervision  
Specialist

**Country Visited:** Rwanda

**Date of Trip:** September 9-25, 1993

**Purpose:** To assess the INTRAH/ONAPO  
training project accomplishments  
(including impacts) and lessons  
learned and determine directions  
for future project activities,  
September 13-24, 1993.

**Program for International Training in Health**

**PAC IIb**

**University of North Carolina at Chapel Hill  
Chapel Hill, North Carolina 27514 USA**

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**EXECUTIVE SUMMARY**

INTRAH Program Officer Ms. Maureen Corbett and INTRAH Francophone Regional Evaluation and Supervision Specialist Mr. Onanga Bongwele visited Rwanda from September 13-24 to conduct a review of the ONAPO/INTRAH PAC IIb project, activity #17 in the subcontract workplan. The project review was preceded by a follow-up (August 16-September 10, 1993) of a sample of participants trained during PAC IIb (see Trip Report B-#249), activity #16 in the subcontract workplan.

The INTRAH team held briefings with the follow-up team, USAID/Rwanda and ONAPO and had several work sessions with ONAPO staff (from the IEC Section, Training Sub-Section, Family Health Section and the MSH Management Advisor), clinical trainers, and with MCH/FP services and training staff from the Ministry of Health. Mid-visit debriefings and final debriefings were held with the Director of ONAPO and USAID. Meetings also took place with the Head of Administration and Finance at ONAPO.

Based on findings and recommendations from the follow-up and supplementary information collected during meetings and work sessions, conclusions were drawn and recommendations were formulated about: ONAPO's capacity and capability to plan, conduct and evaluate clinical FP training for service providers; ONAPO's capability to technically manage clinical FP training; links between clinical FP training and the supervision of FP services; and, the training of health auxiliary workers to provide clinical FP services.

Major accomplishments included:

1. A review of project accomplishments was conducted, project implementation problems were identified and recommendations for resolving problems were formulated, presented and discussed with the ONAPO

Director and Heads of IEC Section, Training Sub-Section and Family Health Section, USAID and the MSH Management Advisor at ONAPO.

2. Priority activities for the next year were identified, including a clinical FP update for clinical trainers, preceptors and supervisors immediately followed by the revision of the clinical FP skills curriculum, for which ONAPO requested INTRAH technical assistance. Activities to be suspended to make funds available for priority activities were also identified (i.e. FP auxiliary training).
3. A list of jobs and tasks to be done to strengthen ONAPO's clinical FP training capability and the links between clinical FP training and FP supervision was prepared with staff from the Training Sub-Section and Family Health Section, at their request and in response to problems they have experienced.
4. A plan was proposed for the development of a strategy for training health auxiliary workers in clinical FP.

Major recommendations included:

1. The Training Sub-Section and Family Health Section should include the priority activities identified for CY 1994 in their annual workplan, to be developed during November 1993.
2. The ONAPO Director, in consultation with the Heads of the IEC Section, Training Sub-Section and Family Health Section should select one of the two options proposed for designating the technical jobs and tasks for clinical FP training, by the end of November 1993.
3. INTRAH, in consultation with their CTO, should determine how to respond to ONAPO's request for technical assistance for the clinical FP update and curriculum revision workshop. INTRAH should follow-up with USAID and ONAPO.
4. The proposed plan for developing a strategy for training health auxiliary workers in clinical FP should be implemented as recommended.

SCHEDULE OF ACTIVITIES

- September 9** Ms. Maureen Corbett departed Chapel Hill at 7:30 p.m.
- September 11** Arrived in Kigali at 6:30 a.m.
- The INTRAH follow-up team (Francophone Evaluation and Supervision Specialist Mr. Onanga Bongwele and Consultants Dr. Anne-Charlotte Royer and Mrs. Justine Belem) debriefed Ms. Corbett on results of the ONAPO/INTRAH trainee follow-up, conducted August 16 - September 10.
- September 12** Continued the debriefing on the ONAPO/INTRAH trainee follow-up.
- September 13** Met at Hotel Mille Collines with ONAPO/INTRAH Project Coordinator and Head of Sub-Section of Training and School Programs Mr. Jean-Damascene Mbonigaba.
- Dr. Royer departed Kigali for Paris at 6:00 p.m.
- September 14** Briefed at USAID/Rwanda with Mr. Bill Martin and Assistant Health and Population Officer Mr. Patrice Nzahabwanamungu.
- Work session at ONAPO to vet follow-up recommendations with Head of Family Health Section Dr. Alphonse Munyakazi, Family Health Section Technical Officer/Supervisor Mrs. Regine Sindikubwabor, National Trainer Mrs. Viviane Mukakarara, Mr. Mbonigaba and Training Coordinator for the Sub-section of Training and Schools Programs Mrs. Margot Uwamariya.
- September 15** Work session at Hotel Mille Collines.
- Distributed the follow-up team's debriefing memo to USAID/Rwanda and ONAPO.
- Ms. Corbett met at ONAPO with Head of Administration and Finance Mr. Celestin Tereraho.
- Work session at ONAPO with national clinical trainers/service providers/preceptors Mrs. Mukakarara and Mrs. Bernadette Nyirangerageze, Mrs. Sindikubwabor, Mrs.

Uwamariya and Head of IEC Section Mr. Castule Kamanzi.

- September 16** Met at ONAPO with Mr. Kamanzi to confirm his expectations of the project review and discuss his feedback and comments on the follow-up recommendations.
- Met at ONAPO with Mr. Mbonigaba and Mrs. Uwamariya to review project activities and accomplishments and identify successes and problems in project implementation.
- September 17** Work session at ONAPO with Ministry of Health MCH/FP Supervisor Mr. Leon Nsegimana, MOH Family Health Project Training Coordinator and follow-up team member Mrs. Josephine Mukagahimana, Dr. Munyakazi, Mr. Mbonigaba, Mrs. Sindikubwabor and Mrs. Uwamariya.
- September 18** Work sessions.
- September 19** Work sessions at Hotel Mille Collines.
- September 20** Work session at ONAPO with Mr. Mbonigaba and Mrs. Josephine Mukakalisa, Head of School Programs, to review project activities and quantitative accomplishments concerning pre-service tutors.
- Work session at the Ministry of Health with Training Coordinator for the Family Health Project Mrs. Josephine Mukagahimana (also a member of the follow-up team).
- Work session at ONAPO with Mr. Mbonigaba, Mrs. Mukakarara, Mrs. Uwamariya and Mrs. Mukakalisa to discuss the clinical FP training capacity and capability of the Training Sub-Section.
- September 21** Work session at ONAPO with Dr. Munyakazi.
- Mid-visit debriefing at ONAPO with Mrs. Gaudence Habimana, Director.
- Mid-visit debriefing at USAID with Mr. Martin, Mr. Nzahabwanamungu, Program Officer Mr. Chris Grundmann and Dr. Roberts.
- Ms. Corbett met at ONAPO with Mr. Tereraho.

Work session at ONAPO with Mr. Mbonigaba, Mrs. Mukakarara, Mrs. Umamariya and Mrs. Mukakalisa.

- September 22** Work session at Hotel Mille Collines.
- Work session at ONAPO with Mr. Mbonigaba, Mrs. Umamariya and Mrs. Mukakalisa.
- September 23** Debriefing at USAID with Mr. Martin, Dr. Roberts and Mr. Nzahabwanamungu.
- Work session at Hotel Mille Collines.
- September 24** The INTRAH team and Mr. Mbonigaba debriefed at ONAPO with Mrs. Habimana.
- Mr. Bongwele departed Kigali at 12 noon.
- September 25** Ms. Corbett departed Kigali at 7 a.m.
- September 26-  
October 8** Personal time for Ms. Corbett.
- September 29** Mr. Bongwele arrived in Lome at 4 p.m.
- October 9** Ms. Corbett arrived in Chapel Hill at 1 p.m.

**I. PURPOSES OF TRIP**

The purposes of the trip were to assess the INTRAH/ONAPO training project accomplishments (including impacts) and lessons learned and determine directions for future project activities.

**II. ACCOMPLISHMENTS**

- A. Work sessions were conducted with ONAPO clinical trainers, FP supervisors and the staff of the Training Sub-section to determine the degree of achievement to-date of INTRAH/ONAPO PAC I Ib project and operational objectives. Findings were confirmed, conclusions were drawn and recommendations were formulated about: ONAPO's capacity and capability to plan, conduct and evaluate clinical FP training for service providers; ONAPO's capability to technically manage clinical FP training; link between clinical FP training and the supervision of FP services; and, the training of health auxiliary workers to provide clinical FP services.
- B. ONAPO priority activities for the next 12-18 months (until the end of CY 1994) were identified in consultation with USAID/Rwanda. These activities include a workshop to revise the clinical FP skills training curriculum, preceded by a clinical FP update for clinical trainers, preceptors and supervisors who will participate in the curriculum revision workshop. ONAPO requested INTRAH technical assistance for these activities and recommended that INTRAH buy-in funds be used to finance this assistance.
- C. ONAPO, USAID and INTRAH recommended that selected activities in the INTRAH/ONAPO workplan earmarked for funding by USAID through a Project Implementation Letter (PIL) to ONAPO must be suspended and the funds used to support priority activities. The activities to

be suspended are FP auxiliary training and clinical FP training scheduled for 1993.

- D. Other activities in the INTRAH/ONAPO workplan should be financed as planned, include training in evaluation for regional trainers, training of trainers in training methodologies and the final review of the INTRAH/ONAPO project. The future of ONAPO training of pre-service tutors in population education will depend on results of a follow-up scheduled for October 1993 and will be determined by ONAPO and USAID/Rwanda.
- E. Two options were proposed to improve ONAPO's technical management of clinical FP training and the link between clinical FP training and the supervision of FP services. A list of jobs and tasks for the technical management of clinical FP training was drafted, discussed with the ONAPO Director, the MSH Management Advisor, the Heads of the Family Health Section, the IEC Section and the Training Sub-section, and finalized. The ONAPO Director should select one of the two options no later than the end of November 1993 and confirm her decision with the Heads of the IEC Section, Family Health Section and Training Sub-Section.
- F. Due to the anticipated changes in leadership at the Ministry of Health, USAID has not yet confirmed expectations for the proposed coordination meeting of cooperating agencies working in MCH and FP in Rwanda. INTRAH agreed to propose agenda items for the meeting of USAID after USAID confirms their expectations for the meeting and who will participate.
- G. ONAPO confirmed the per diem rate for the national members of the follow-up team.
- H. Briefing meetings were held with Head of the IEC Section Mr. Castule Kamanzi and with staff from the

Training Sub-Section, a mid-visit briefing was conducted with the ONAPO Director and debriefing meetings were held with the Director, the Head of the IEC Section and the staff of the Training Sub-Section and the Family Health Section.

### **III. BACKGROUND**

INTRAH and the Rwanda National Office of Population (ONAPO) developed a 2 1/2 year training and technical assistance project as part of USAID/Rwanda's bilateral MCH/FP II project with the Government of Rwanda. The goal of the project is to strengthen ONAPO's capability and capacity to plan, manage, conduct and evaluate FP training in order to improve the quality and increase the quantity and availability of FP services in the 10 health regions, and improve the use of FP-related curricula by tutors in pre-service health and social work schools. USAID/Rwanda financially supported activities technically assisted by INTRAH via a buy-in; ONAPO/INTRAH workplan activities not technically assisted by INTRAH were funded by USAID directly to ONAPO using a Project Implementation Letter (PIL).

The visit described in this report was the first review of the ONAPO/INTRAH PAC IIb project although annual project reviews had been scheduled in the workplan. Previously scheduled reviews had to be postponed because of sporadic political and civil unrest in the country.

### **IV. DESCRIPTION OF ACTIVITIES**

#### **A. USAID/Rwanda**

The INTRAH team briefed with Health and Population Officer Mr. Bill Martin, Project Officer for the new bilateral Integrated MCH/FP Project (RIM) Mr. Chris Grundmann and MSH Management Advisor at ONAPO Dr. Dick

Roberts. The purposes and expected outcomes of the visit were reviewed and the team clarified the relationship of the project review to the recently completed trainee follow-up. USAID expressed concerns about ONAPO's clinical FP training capability, based on follow-up findings, and asked INTRAH for recommendations concerning USAID's continued financial support to ONAPO for clinical FP training. USAID was also concerned about ONAPO's capability to manage all of the training for which they are responsible. They asked the INTRAH team to assist ONAPO to identify priority activities for the next year and to recommend the suspension of clinical FP training until certain actions were taken, if that was deemed necessary.

The INTRAH team reminded USAID that INTRAH has no formal responsibilities for the clinical FP training conducted by ONAPO and financed by USAID via a Project Implementation Letter (PIL), but would work with ONAPO to identify priority activities for the next year and those to be suspended if necessary, to make funds available for priority activities. INTRAH had agreed to include the follow-up of clinical FP service providers trained by ONAPO without INTRAH technical or financial responsibilities because INTRAH is responsible for helping first generation trainees (those trained with INTRAH technical and financial assistance) to follow-up their trainees (INTRAH second generation trainees).

The team confirmed that the project review would focus on further examining issues identified during the follow-up, including ONAPO's clinical FP training capability and capacity, the relationship of clinical FP training to FP services and supervision, and the training of health auxiliary workers to provide FP services.

Mr. Martin updated the INTRAH team on the status of the external evaluation of the bilateral MCH/FP II Project with ONAPO. The evaluation team is expected in Rwanda in November, and an audit of the project by REDSO/ESA was scheduled to take place in late September/early October 1993. Mr. Martin asked the team to prepare a comprehensive debriefing memo to USAID/Rwanda and ONAPO before leaving the country for use by USAID and the MSH Management Advisor to monitor ONAPO's implementation of recommendations and as a reference for the external evaluation team.

Mr. Martin confirmed his interest in INTRAH continuing to work with ONAPO beyond July 1994 if there is a no-cost extension to the PACD of the PAC I Ib project because the PACD of the MCH/FP II Project has been extended to July 1995.

During the debriefing at USAID, agreements were reached among USAID, INTRAH and the MSH Management Advisor at ONAPO that the MSH Management Advisor would monitor implementation of the project review recommendations by ONAPO, including the inclusion of recommended activities in ONAPO's annual workplan and budget for 1994 to be prepared in November 1993.

**B. ONAPO**

The INTRAH team held several work sessions at ONAPO with staff from the IEC Section, Training Sub-Section and Family Health Section, ONAPO clinical trainers and the Ministry of Health's MCH/FP Division and Training Department to further examine follow-up findings and reinforce follow-up recommendations, draw conclusions and formulate recommendations.

The following is an overview of work sessions focussing on the problems with the clinical FP training

curriculum identified by clinical trainers and preceptors, problems with lack of equipment and supplies needed for providing FP services and possible solutions, and problems with the sterilization of FP equipment and supplies and possible solutions. Detailed findings, conclusions and recommendations resulting from other work sessions are included in Appendix B, detailed findings, conclusions and recommendations.

- Problems experienced by clinical trainers and preceptors in using the clinical FP skills training curriculum: Clinical trainers and preceptors have found that the duration of clinical FP training (one week of theory and two weeks of practice) is too short to accomplish training objectives so the content is presented in lecture form and there are no case studies or role plays and little time for questions and answers; practical training sites do not have a sufficient number of FP clients (new acceptors and continuing users) for trainees to meet practicum objectives and preceptors are not involved in preparing for training and often do not know they are expected to precept a trainee until the trainee arrives at the practicum site; and, participants are trained to provide services which they will not offer in health centers (i.e. IUD insertion). Trainees arrive at the practicum site without having had practice managing the side-effects of a client on oral contraceptives, performing a pelvic exam or using FP service protocols (developed by the Family Health Project of the Ministry of Health and a recommended training material).
  
- Problems with lack of equipment and supplies needed for providing FP services and possible

solutions: Trained service providers have problems applying workshop learnings at their worksites because of lack of FP equipment and supplies (i.e. gloves, blood pressure machine, stethoscope, equipment to perform pelvic exams, sterilization equipment). FP supervisors observed that when dispensaries were upgraded to health centers several years ago, funds were not budgeted for purchasing and distributing equipment and supplies for FP services. Several donor agencies have provided equipment and supplies to health centers, but where there is equipment and supplies there are often management problems. For example, equipment breaks or is otherwise non-functional, it is not available when needed (i.e. equipment is shared between the maternity and the health center), or it is stolen or misplaced. In the future, funds collected in health centers for curative services, per the Bamako Initiative, can be used to purchase consumable supplies needed for FP services but decisions will depend on the health committee.

Problems with the sterilization of FP equipment and supplies and possible solutions: Appropriate sterilization procedures are not followed in health centers for several reasons, including lack of equipment and supplies and lack of knowledge among health center staff responsible for equipment sterilization. The responsibility is often delegated by the head of the health center to the health auxiliary or other worker, who performs the task without training or adequate supervision. The MOH should take the lead to establish and sanction standardized sterilization procedures, and include a list of the required

equipment and supplies. These procedures should guide the distribution of sterilization equipment and supplies to health centers and the training and supervision of the health auxiliary or other worker responsible for sterilizing equipment and supplies.

Work sessions were also held to identify priority activities for the next year, based on recommendations from the follow-up and project review. These activities are:

- revision and adaptation of the clinical FP skills curriculum preceded by clinical FP update for clinical trainers, preceptors and supervisors who will participate in revising/adapting the curriculum
- development of a strategy for training health auxiliary workers in clinical FP
- revision of the supervisory instrument
- follow-up of pre-service tutors trained by ONAPO in population education

Most of these activities will be conducted by ONAPO and MOH without INTRAH assistance, and will require leadership by both ONAPO and the MOH and monitoring by the MSH Management Advisor.

During the team's debriefing at ONAPO, the Director asked to be kept informed about the future of INTRAH-assisted training activities after July 1994 (the end of the PAC IIb project).

**V. MAJOR FINDINGS AND RECOMMENDATIONS (see Appendix B for detailed Findings, Conclusions and Recommendations)**

**1. Finding**

ONAPO's capability and capacity to manage clinical FP training is weak. For example, clinical FP trainers and preceptors observed during training

that trainees had many problems with the management of side-effects of clients using hormonal contraceptives. They reported the problems to the Training Sub-section and recommended that work sessions should be organized to revise the curriculum. Work sessions, however, were never organized by the Training Sub-section. Among the reasons cited were the illness of the ONAPO/INTRAH project coordinator, lack of funds to organize work sessions (i.e. petrol for the vehicle to transport the clinical trainer who works at a hospital several miles from ONAPO Central Office).

### **Recommendation**

One of the two options to strengthen ONAPO's clinical FP training capability recommended by ONAPO Training Sub-section and Family Health Section staff and discussed with the ONAPO Director, MSH Management Advisor and USAID/Rwanda should be selected. ONAPO should make a decision by the end of November 1993 and the Family Health Section and Training Sub-Section should take the decision into account when they prepare their annual workplan for 1994. The ONAPO/INTRAH project coordinator should inform INTRAH/Lome about the decision.

## **2. Findings**

Clinical trainers are called upon by ONAPO to conduct clinical FP skills training at the Kicukiro Training Center with very little notice, sometimes just 3-4 days before trainees are scheduled to arrive in Kigali. The trainers have no time to prepare for training and they and their supervisors do not have time to plan for the trainer's absence. Clinical preceptors are not involved in preparing for training and are not notified that trainees are arriving at their site in time for them to prepare the site; they learn about the practicum objectives when the trainees arrive at the practicum site.

Staff at the Training Sub-Section reported that funds are not available for a preparation phase prior to training because activity budgets were prepared only for the activity itself and not for preparation.

**Recommendation**

One week (5 days) should be added to clinical FP training activity budgets to permit clinical trainers and preceptors to prepare for training.

**3. Finding**

ONAPO has only three clinical trainers who are regularly called upon to conduct clinical FP training although there are FP clinicians in the health regions trained in training methodologies. This latter group are not involved in ONAPO-assisted clinical training because they do not support ONAPO's per diem policy for persons travelling to Kigali from the health regions.

**Recommendations**

ONAPO should invite selected FP clinicians who have been trained as trainers to participate in the clinical FP update and workshop to revise the clinical FP skills curriculum. These clinicians should then work as apprentices to experienced clinical trainers before conducting clinical training. This would result in an increase in ONAPO's clinical training capacity.

ONAPO should revise the per diem policy for staff from the health regions travelling to Kigali to prepare for and conduct training because of the negative effect it has on the availability of trainers.

**4. Findings**

There are many problems with the clinical FP skills training curriculum. For example, the curriculum includes training objectives which are not among trainees' post-training functions and participatory training methods are not used because there is too much content to cover and too little time.

The plan to pre-test the clinical FP skills curriculum and revise it based on clinical trainers and preceptors comments and feedback before it was finalized and 50 copies were printed was not carried out because it was not clear to ONAPO who was responsible for this job.

### **Recommendations**

The clinical FP skills curriculum should be revised and adapted to respond to the reality of FP services and trainees' post-training functions. A two-week residential workshop should be technically assisted by INTRAH and should involve clinical trainers and preceptors and FP supervisors. The workshop should be preceded by a one-week clinical FP update so that participants revising the curriculum have an updated and common base of clinical FP knowledge.

A detailed action plan for pre-testing, revising and finalizing the clinical FP skills curriculum, which should involve the participation of clinical trainers and preceptors and FP supervisors should be developed and carried out under the responsibility of ONAPO's technical manager for clinical FP training (see recommendation 1).

ONAPO recommended that INTRAH buy-in funds be used to finance the technical assistance. INTRAH should determine the feasibility of this recommendation, in consultation with INTRAH's CTO at A.I.D., and follow-up with USAID/Rwanda and ONAPO in mid-November 1993.

Copies of the clinical FP skills curriculum already distributed to ONAPO Regional Offices should be recalled by the Training Sub-Section.

#### **5. Finding**

A comparison of the expected number of clinical FP trainees in the INTRAH/ONAPO workplan to be trained by ONAPO without INTRAH technical or financial assistance and the actual number trained to date revealed low target achievement. Much of this is a result of political instability in the country since early 1993.

#### **Recommendation**

None.

#### **6. Findings**

The Training Sub-Section does not know the number of persons (or their profile) trained as FP auxiliaries because information about this training is not communicated to, nor is it required by, ONAPO Central Office. ONAPO has not

followed-up these trainees and does not know the impact of FP auxiliary training on FP services.

The FP auxiliary training is organized by ONAPO Regional Offices and conducted in the regions, and is financed by USAID/Rwanda funds through a PIL. ONAPO Regional Offices request and receive funds for these activities directly from ONAPO Administrative and Finance Office.

#### **Recommendation**

FP auxiliary training should be suspended to make financial resources available to ONAPO for priority activities.

#### **7. Finding**

Clinical training is being conducted in the health regions in the absence of a strategy for the decentralization of clinical training. Little is known about the outcomes of the clinical training conducted in the health regions because training activity reports are not submitted to ONAPO Central Office, nor does ONAPO Central Office require reports. ONAPO does not follow-up trainees and there are no mechanisms in-place for supervisors from the Family Health Section to discuss findings with staff from the Training Sub-Section.

#### **Recommendation**

ONAPO and the Ministry of Health central and regional level officials should determine which types of training should take place in the health regions and prepare a strategy to guide decentralized training. The strategy should take into account the training needs and available resources in each region and should include definitions for conditions which must exist in the region before training is conducted.

#### **8. Finding**

Equipment and supplies are not always properly sterilized in health centers because of lack of sterilization materials or lack of knowledge of appropriate sterilization procedures. Infections have resulted, including abscesses in vaccinated children and Depo-provera clients. The job of sterilizing equipment and supplies is often delegated by the head of the health center to the

health auxiliary or other worker without training or adequate supervision.

### **Recommendations**

Improving sterilization procedures in health centers should be a high priority for the Ministry of Health and ONAPO because of the serious implications of inadequate sterilization of equipment and supplies on the quality of services. Standardized sterilization procedures should be agreed upon and sanctioned by the Ministry of Health and disseminated to all service directors, supervisors and managers and the heads of all health centers and other service sites.

Health auxiliary workers or other types of workers in health centers who are delegated the responsibility for sterilizing equipment and supplies should be trained to do this job. After training they should be assisted by the heads of health center and their supervisors to apply their skills.

### **9. Finding**

The criteria established for selecting participants for training are not communicated to regional supervisors from ONAPO and the MOH, who propose candidates for training.

### **Recommendation**

ONAPO should inform regional supervisors about the criteria for selecting workshop participants and should not accept candidates who do not meet those criteria. This, too, should be communicated to supervisors.

**APPENDIX A**

**Persons Contacted/Met**

## APPENDIX A

### **Persons Contacted/Met**

#### USAID/Rwanda

Mr. Bill MARTIN, Health and Population Officer  
Mr. Patrice NZAHABWANAMUNGU, Assistant Health and Population  
Officer and MCH-FP II Project Manager  
Mr. Chris GRUNDMANN, Program Officer for bilateral project  
Rwanda Integrated MCH/FP Bilateral Project (RIM)  
Dr. Sosthene BUCYANA, Acting Program Officer for RIM

#### ONAPO

Mrs Gaudence HABIMANA Nyarasafri, Director  
Mr. Castule KAMANZI, Head of IEC Section  
Mr. Jean-Damascene MBONIGABA, Head of Sub-section of  
Training and School Programs  
Mrs. Marguerite (Margot) UWAMARIYA, Training Coordinator for  
the Sub-section of Training and Schools Programs  
Mrs. Viviane MUKAKARARA, National Trainer attached to ONAPO  
Regional Office/Kigali  
Mrs. Regine SINDIKUBWABOR, Family Health Section Technical  
Officer  
Dr. Alphonse MUNYAKAZI, Head of Family Health Section and  
Acting Head of Studies  
Mrs. Bernadette NYIRANGERAGEZE, Clinical Trainer  
Mr. Celestin TERERAHO, Head of Administration and Finance  
Mr. Olivier CYRIAQUE, Accountant in Administrative and  
Finance Service (SAF)  
Mrs. Josephine MUKAKALISA, Head of School Programs  
Dr. Dick ROBERTS, MSH Management Advisor

#### Ministry of Health

Mrs. Josephine MUKAGAHIMANA, Training Coordinator for Family  
Health Project  
Mr. Leon NSEGIMANA, MCH/FP Supervisor

#### CARE

Mr. Sixte ZIGIRUMUGABE, Maternal Health/Family Planning  
Project Manager, CARE/Rwanda

**APPENDIX B**

**Detailed Findings, Conclusions and Recommendations**

## APPENDIX B

### **Detailed Findings, Conclusions and Recommendations**

#### **FINDINGS AND CONCLUSIONS**

##### **A. Links Between Clinical FP Training and the Provision of FP Services in Health Centers**

There are training objectives in ONAPO's clinical FP skills training curriculum which do not reflect the post-training functions of trainees or the reality of the FP services situation. For example, service providers are trained to insert and remove IUDs but they are not able to master these skills during training and health centers do not offer IUD insertion services because of the low demand for this method (0.2% of married women currently use the IUD, DHS 1992) and because the equipment and materials necessary for IUD insertion are not available, and are trained to provide natural family planning (NFP) although NFP services are only offered in Catholic-supported health centers. Service providers are also trained to supervise the abakangurambaga, yet the supervision of the abakangurambaga is not one of their jobs. In addition, the time allotted in the curriculum during the theoretical phase to NFP and IUD insertion is greater than the time devoted to the two methods most used most in the country, oral and injectable contraceptives (3% of married women currently use oral contraceptives and 8% use injectable contraceptives, DHS 1992).

Trainees do not return to their worksite after training with an action plan for applying workshop learnings in their worksite because, according to trainers, preparation of such a plan was not included in the curriculum.

##### **B. Equipment and Supplies for MCH/FP Services**

The MOH does not have the financial resources (at the central or the regional level) to provide the equipment and supplies necessary for quality FP services in the health centers, although 81% and 82% of current pill and injectables users obtain these methods in health centers (DHS 1992). The MOH relies on donor support via projects to provide equipment and supplies although there is no standard list (or standard lists) of MCH/FP equipment and supplies required for each type of service site.

In sites where there is equipment there are often management problems and problems to keep equipment functional.

## **Sterilization of Equipment and Supplies**

Central level supervisors (ONAPO and MOH) stated that sterilization of equipment and supplies in the health centers is done by health auxiliary workers or social workers. (This was confirmed during the follow-up in August/September 1993.) These workers sterilize the equipment without having been trained in sterilization techniques and without sufficient materials and adequate supervision. The heads of health centers reported to members of the follow-up teams that they delegate the task of sterilizing to health auxiliary and other workers because they do not have time to do it themselves.

The MOH should be very concerned about the lack of standardized procedures for sterilizing equipment and supplies because of the high level of vaccination coverage (90% of the children from 12-23 months of age have been fully vaccinated, DHS 1992) and because of Rwandan's preference for injectable contraceptives.

### **C. Selection of Participants to be Trained in Clinical FP**

#### **1. Background**

Since 1989 and the end of the ONAPO/INTRAH PAC IIa project, several factors have influenced the health services system in Rwanda, including the 1989 policy of privatization of health services which led to the departure of qualified personnel to the private sector (for example: medical assistants, A1 and A2 nurses); implementation of the Bamako initiative which gave new responsibilities to the heads of health centers; and, the creation by the MOH of a new cadre of worker, the health auxiliary worker (A4 nurse), to provide integrated MCH/FP services. The in-service clinical FP training strategy did not adapt to these changes and respond to new FP service delivery training needs.

#### **2. Adherence to the Criteria for Selection of Service Providers to be Trained in Clinical FP**

During the ONAPO/INTRAH PAC IIb project, the criteria for selecting service providers to be trained in clinical FP have not been respected. For example:

- trainees (trained by ONAPO without INTRAH assistance) are not necessarily those who are providing FP services; and,
- the selection criteria did not include expectations that trainees should come from well-equipped health centers where they will be able to apply workshop learnings.

The process used by the Training Sub-Section to select trainees is not effective. Selection is based on requests from ONAPO regional delegates. Requests come in the form of a letter addressed to the ONAPO Director and contain only the names of the proposed trainees and their professional qualifications.

#### **D. ONAPO's Capability to Plan Clinical FP Training**

##### **1. Case Study**

"ONAPO supervisors at the central and regional levels have recognized for about one year that most of the FP services provided in health center are provided by health auxiliary workers who have not been trained in clinical FP. As a result of this finding, ONAPO's regional office in Gisenyi asked for and received financing from ONAPO Central Office to conduct a clinical FP training workshop for health auxiliary workers. In order to do this, the ONAPO Director asked the Training Sub-Section and the Family Health Section to prepare a curriculum. This curriculum could not be developed and in spite of that, the training session in Gisenyi took place in August and September 1993. Regional trainers conducted the workshop using the clinical FP training curriculum and the FP auxiliary training curriculum. During the August/September 1993 trainee follow-up, the trained clinical preceptors were precepting the health auxiliary workers. These preceptors stated that the basic level of the health auxiliary workers did not permit them to do what was expected of them in the curriculum.

##### **Lessons learned from this case study:**

ONAPO conducted this clinical FP skills workshop without conducting a training needs assessment, including an assessment of health auxiliary workers' clinical FP knowledge and skill; without identifying their post-training functions; and, without involving clinical preceptors in the preparation of the workshop or orienting them to practicum objectives.

##### **2. ONAPO (Training Sub-Section) Capability to Organize Clinical FP Training**

Clinical FP training as it is currently organized does not include a preparation phase (for example: one week) with clinical trainers. The objectives of this preparation phase should be (among others):

- clarify the roles and responsibilities of each trainer on the team

- contact and orient the clinical preceptors and help them prepare the training sites
- contact and orient resource persons
- prepare rooms for the theoretical training
- collect baseline data on the performance of proposed trainees and analyze and use these data to adapt the training to actual needs
- prepare sufficient clinical case studies to evaluate trainees' decision-making
- develop daily session plans
- confirm the methods to be used to evaluate the training

The training activity budgets should be increased to include one week of preparation for the trainers.

According to current practice, clinical trainers and their supervisors are informed only 2-7 days prior to the training session. Consequently, they do not have sufficient time to free themselves from their professional responsibilities and plan the training. The preceptors do not know the practicum objectives until the trainee arrives at the practicum site.

According to the Training Sub-Section, this situation (no preparation) is due to lack of money needed to buy fuel to use the vehicle during the planning phase, because according to the training activity budget training begins with the arrival of the trainees. Another reason given by the Training Sub-Section is the absence of a clinician/clinical trainer in the Training Sub-Section responsible for the technical aspects of clinical FP training.

## **E. ONAPO's Capability to Conduct Clinical FP Training**

### **1. Clinical Trainers**

The Training Sub-Section expects to have two clinical trainers for the entire duration of each clinical FP training activity. Currently, there are only three clinical trainers in Kigali who conduct clinical FP training (see Appendix C). These three clinical trainers also provide FP services in their worksites and are involved in other training (for example: VSC and NORPLANT counseling).

There are at least five other FP clinicians/trainers in the health regions who were trained as trainers during PAC

IIB who could be used for clinical FP training session (see Appendix C). Unfortunately, there are some obstacles. For example:

- ONAPO will not ask regional trainers to conduct clinical FP training because of budgetary implications
- regional trainers are not interested in conducting clinical FP training for ONAPO because of ONAPO's per diem policy for persons coming to Kigali from the health regions

## **2. Clinical FP Training Curriculum**

See #1 under "Findings and Conclusions."

## **3. Clinical Training Sites**

There are currently eight (8) training sites in six health regions which meet ONAPO and MOH expectations (see Appendix D). Among these 8, seven are hospitals and one is a health center next to a hospital.

Each site can accommodate an average of two trainees (CHK has a capacity of 3) because of problems of space/consultation rooms and client load.

There are three other sites (hospitals) which are not used as training sites for several reasons:

- lodging problems for trainees
- lack of security due to war
- low demand for services
- the lack of a resident preceptor

## **F. ONAPO Capacity and Capability to Evaluate Clinical FP Training**

The training in evaluation conducted in January/February 1993 contributed to an increase in the capacity and improved the capability of ONAPO and MOH to evaluate training.

Examples of evaluation capacity and capability:

- use of different approaches for training evaluation (for example: participant reaction form, participant biodata form, a pre and post-test of knowledge, a daily process review)
- collection of baseline data on performance and the use of these data to orient training in response to needs

- preparation of reports on training activities which include findings and recommendations based on evaluation results
- the filing of data and reports in the ONAPO Central Office

Training in performance evaluation was not included in the January/February 1993 training evaluation activity.

#### **H. Coordination between Clinical FP Training and FP Supervision**

The scheduling of clinical FP training and FP supervisory visits are not coordinated so as to use supervision to identify or confirm training needs (for example: the selection of participants to be trained to resolve a performance problem) and in the follow-up of trainees in their worksites after training.

The Training Sub-Section does not take into account the rhythm of supervision when they plan training activities. They do not have the supervisors' schedule for supervision visits.

The management of clinical FP training by the Training Sub-Section consists of preparing a schedule of training activities, organizing logistics, preparing activity budgets, informing regional delegates of dates, registering participants, etc.

The technical aspects of clinical FP training which are not considered by the Training Sub-Section are: adherence to selection criteria so that training responds to service needs, including the material conditions of the sites; the on-going use of supervisory findings to receive feedback on the on-site performance of trained service providers; and, the continual adaptation of the clinical FP curriculum (theory and practicum) in response to the collective experiences of the trainers and preceptors and training evaluation results.

A concrete example: Clinical trainers identified problems in the use of the curriculum and they shared these problems with the ONAPO/INTRAH project coordinator. Yet the project coordinator was not able to take any action because, according to him, an activity to respond to clinical trainers concerns had not been included in the annual work plan of the Training Sub-Section.

**SHORT-TERM RECOMMENDATIONS** (from now until the end of 1994)

The criteria used to develop short-term recommendations were:

- recommendations should respond to priority needs expressed by ONAPO
- feasible, based on ONAPO and MOH current capability and capacity and the recommendation to both institutions that they include activities in their annual workplans in order to commit necessary financial and human resources
- could be financed by substituting priority activities for less-priority but funded activities

**A. Clinical FP Training Curriculum**

1. ONAPO and MOH technical staff (clinical trainers, preceptors, central and regional level supervisors, staff who participated in the follow-up during August and September 1993) should revise and adapt the clinical FP skills training curriculum during a two-week in-residence workshop in early 1994, before conducting any further clinical FP training. The residential aspect is necessary to enable participants to devote themselves entirely to the task at hand. A Secretariat should be set up for this workshop and the costs secretariat should be included in the budget. ONAPO should explore the possibility of involving the Health Learning Materials Project (MEPS) as the Secretariat.

The revision and adaptation should be guided by findings and recommendations from the August/September 1993 follow-up, observations made during the ONAPO/INTRAH project review and other results of supervision. The curriculum should include the following:

- title
- duration of the workshop (days)
- target group and criteria for selecting trainees, including entry-level qualifications of participants
- post-training jobs and tasks
- number and qualifications of trainers, including those to be involved in practical training
- goal of the training activity
- theoretical and practical training objectives
- content and methodology (using an established format)
- session plans
- evaluation methods and instruments

- list of references and training material for trainers and trainees
- training activity schedule
- plan for testing the curriculum

The curriculum must be ready at the conclusion of this workshop so that it can be tested during two clinical FP training sessions for service providers proposed to take place at the Kicukiro Center in April/May and June/July of 1994. The clinician/trainers in the regions should participate as apprentices in the planning, implementation and evaluation of these two sessions alongside experienced clinical trainers. This apprenticeship will contribute to strengthening the capacity of ONAPO to conduct clinical FP training. The results of the two pre-tests will enable ONAPO to finalize the curriculum under the supervision of the person responsible at ONAPO for the technical management of clinical FP training.

2. A clinical FP update should be conducted during the week prior to the curriculum revision workshop so that workshop participants have a common base of updated and up-to-date clinical FP knowledge.

Technical assistance from INTRAH should be provided for the clinical update and the curriculum revision workshop. The technical assistance team should include a clinical trainer and a specialist in training methodologies and curriculum development.

## **B. Health Auxiliary Workers**

### **Introduction**

A clinical FP training strategy for health auxiliary workers should be developed by ONAPO in collaboration with the MOH prior to training health auxiliaries in clinical FP. The following approach is recommended for the preparation of this training strategy in order for the training of health auxiliary workers to result in an increase in the quality, quantity and availability of the FP services.

1. ONAPO and the MOH should organize a work session before the end of November 1993. The objective of this work session is to emphasize the importance of health auxiliary workers in providing FP services (based on data collected during the follow-up and from supervision visits) and the necessity for team-work to prepare a strategy for training them in FP. ONAPO should invite the MOH to participate in this work session, via a letter from the Director of ONAPO to the MOH (the Department of Integrated Medicine and the Division of Training) and to the Ministry of Primary and Secondary Education (the Department responsible for the basic training of health auxiliary workers).

One outcome of the initial work session should be the creation of a team to develop the strategy and preparation of a work schedule. Members of the team should be committed to participating in the entire process and should include clinical trainers and preceptors, service supervisors, and pre-service tutors from the schools where health auxiliary workers have received their basic training. This team will be led by a representative from the Family Health Section of ONAPO and by a member of the Division of Training at the MOH.

2. The team will collect baseline data necessary to prepare the strategy. Data collection should take place over a 3-4 month period of time (i.e. from the end of November 1993 to mid-February 1994) and should enable the team to respond to the following questions concerning the health auxiliary workers:

- who are they? (profile)
- what do they do in MCH/FP?
- what is their basic training?
- what are their post-training functions?
- what are the expectations of Minisanté and of ONAPO regarding their post training FP functions?
- who supervises them (from the regional level) and who supervises them at their worksite?
- how many of them are there and where are they located?
- who are their basic training tutors/teachers?
- what is the strategy used for their basic training, including the practicum?
- what is their skills level in MCH/FP when they complete their basic training and when they are in the field?
- how are MCH/FP services organized in the sites where they work?

The team should also contact local MCH/FP projects (the RIM/Minisanté Project and CARE/Rwanda) to collect data.

The data collected should be carefully analyzed and interpreted and conclusions/lessons learned identified and used to prepare an in-service training strategy.

These data could also be used also by Minisanté to strengthen the basic training of health auxiliary workers.

3. Based on conclusions and lessons learned, the team should organize a two-week workshop (o/a mid-end of March 1994) to develop an in-service clinical FP training strategy for health auxiliary workers which includes the following elements:

- definition of post-training FP jobs and tasks and the relationship between FP and other MCH services offered by health auxiliary workers
- definition of worksite conditions necessary to support trainees' application of knowledge and skills after training (i.e. materials, equipment, supervision)
- preparation of a training curriculum based on post-training jobs and tasks and entry-level qualifications
- number of health auxiliary workers to be trained
- a plan for evaluating the impact of training health auxiliary workers on the quality, quantity and availability of FP services
- a plan for preparing practical training sites, preparing trainers, orienting supervisors and heads of health centers, etc.

The team should define all the conditions necessary for the effective implementation of this plan (i.e. what must be done, when, by whom, and with what human and financial resources, etc.).

### **C. Links Between Clinical FP Training and Supervision**

The links between in-service clinical FP training and the supervision of FP services should be strengthened in order to maximize the impact of training on the quality, quantity and availability of services. The following conditions should be observed by the Family Health Section and the Training Sub-Section:

1. All supervisory activities (the central level to the regional level and the regional level to the periphery) should include objectives linked to training such as:
  - identify training needs on a continual basis (i.e. performance problems of health workers in the field)
  - monitor adherence to the criteria for selecting participants for training activities (for example, assure that trainees are selected from sites where appropriate materials are available so trainees can apply workshop learnings)
  - follow-up trained service providers and help them to apply workshop learnings
  - assist service providers to improve the management of services in the health centers (for example, the

organization of services and supplies, client flow, record-keeping, etc.)

2. To enable the Training Sub-Section to better utilize results of supervision (see C.1., above), there should be close collaboration between the Training Sub-Section and the Family Health Section when supervisory visits and clinical FP training activities are scheduled. For example: clinical FP training activities should be preceded by supervisory visits, and vice-versa.

3. The Family Health Section (Dr. Alphonse Munyakazi) and the MCH Section (Mr. Leon Nsegimana) should organize a five-day workshop in January or February 1994 to revise the supervisory instrument to be used by the regional supervisors. The revision should take into account tasks to be supervised and critical indicators and should include training-related objectives (see C.1., above). Supervisors from the Family Health Section should continue to seek feedback on the instrument from the regional supervisors during supervisory visits made between now and the workshop.

4. The supervisory visits from the Central Office to the Regional Offices should take into account regional supervisors' schedule for supervision visits to health centers. Central level supervisors should visit the field (health regions) either at the end of or during supervision conducted in the field by the regional supervisors. This will give central level supervisors the opportunity to become more familiar with the problems in the region, discuss possible solutions and plan the next supervisory visit. For this to take place, effective and continuous communication between the Family Health Section and the Regional Offices is required.

5. The capacity and capability of the ONAPO Central Office to technically manage clinical FP training should be strengthened as soon as possible (o/a early November 1993). This strengthening could be accomplished through one of the two following options:

- a. Designate a clinician in the Family Health Section to be responsible for the technical management of clinical FP training
- b. Place a clinical trainer in the Training Sub-Section to assume responsibilities for the technical management of clinical FP training

ONAPO should make a decision during their next monthly coordination meeting.

The following are the recommended jobs and tasks for the technical manager of clinical FP training, and the necessary qualifications:

### **Planning**

- integrate into ONAPO's workplan all activities necessary for the revision, testing and finalization of the clinical FP curriculum (including the clinical FP update to take place prior to the revision of the curriculum)
- prepare a quarterly calendar for clinical FP training, in coordination with ONAPO supervisors and their proposed calendar of supervision visits
- identify the clinical trainers and resource persons to be involved in planning, conducting and evaluating training
- distribute the quarterly training calendar to trainers and resource persons and ask about their availability one month prior to the beginning of the training activity
- distribute the quarterly training calendar and the criteria for selecting trainees to other central-level supervisors
- communicate the quarterly calendar and the participant selection criteria to ONAPO delegates and regional medical directors (Mediresa) and request information on proposed trainees at least three weeks prior to the beginning of the training activity
- verify that the criteria for selecting trainees were respected before confirming participation of proposed trainees, at least two weeks before the beginning of the training activity
- organize the technical preparation of the training (i.e. conduct planning sessions with other clinical trainers, communicate with the preceptors and orient them to expectations and practicum objectives, and in collaboration with the coordinator of training logistics, make sure that logistics are arranged)
- systematically use the results of supervision to link training and the on-site application of knowledge and skills acquired during training
- adjust the training curriculum on an on-going basis (theory and practice) in response to trainers'

and preceptors' experiences, the results of training and supervision findings and recommendations

- identify necessary reference materials to be distributed to trainees at the time of training
- verify that the content of reference documents (as well as hand-outs and brochures) is not in conflict with the content in the curriculum
- visit the practical training sites to confirm that the established criteria for practical training sites are respected (during supervision visits)

#### **Implementation**

- be a clinical trainer during the clinical FP training activities

#### **Evaluation/Supervision**

- conduct the follow-up of trainees trained in clinical FP and determine the impact of training on the quality and quantity of services

assess new training needs during quarterly supervisory visits

- participate in other evaluations of clinically FP-trained service providers

- prepare, in collaboration with other members of the Training Sub-Section, a technical report for each training activity and distribute it for comments and feedback to the Head of the Sub-Section, Head of the IEC Section, Head of the Family Health Section, Head of the MCH/FP Section at Minisanté, and others (to be identified) at least two weeks after the activity is completed; the report must include at least the following: major accomplishments, problems encountered, findings and recommendations, evaluation results, the names and worksites of trainees, the names of the preceptors and the practical training sites, and names and specialty areas of the trainers and resource persons

- participate, in collaboration with other central level supervisors, in the preparation of supervisory reports and use of the results which concern training and the on-site application by trainees of workshop learnings

The qualifications necessary to carry out the above jobs and tasks are:

#### **Qualifications**

- A1 or A2 nurse or a medical assistant
- at least two years of experience as a clinical trainer and clinical FP service provider
- to be a supervisor or to have precepting experience
- to be an employee of ONAPO

NOTE: Considering the urgency expressed by ONAPO for the revision and adaptation of the clinical FP curriculum and the preparation of a strategy for the in-service clinical FP training of health auxiliary workers, it is necessary to prioritize training activities to be financed by USAID and scheduled in the ONAPO/INTRAH project in order to use available funds for the highest priority activities. Clinical FP training and the training of FP auxiliary workers should be suspended and funds should be used to support implementation of the above recommendations. ONAPO should prepare budget estimates for the priority activities to determine if there are sufficient funds. The training of FP auxiliary workers should continue only after evaluating their impact and contribution to FP.

#### **LONG-TERM RECOMMENDATION**

The following recommendation is a long-term recommendation because it involves commitment from the central level for resources and to the process of development, testing, revision, finalizing, dissemination and implementation/application.

The MOH, responsible for health services in the country, should prepare a national MCH/FP service policy and standards to guide service delivery, training, supervision and evaluation. This guide should state the reasons for FP, target groups, contraceptive methods to be offered at each type of service site, the categories of personnel who are authorized to provide FP services at each type of site and their qualifications, the expected work conditions (i.e. equipment and supplies) and the regularity of services' provision. The development of this guide should involve the participation of other agencies working in FP in Rwanda, including ONAPO, INTRAH, CARE, GTZ, etc., and should take into account the MCH/FP service standards recently published by the Family Health Project of the MOH, the plan proposed by ONAPO and the MOH to develop a national FP policy and MOH directives and ministerial circulars concerning FP services.

**APPENDIX C**

**Lists of Clinical Trainers and Resource Persons  
Used for Clinical FP Training at the Kicukiro  
Training Center and the Clinician/Trainers in  
the Health Regions Who Could Become Clinical FP Trainers**

## APPENDIX C

### **LISTS OF CLINICAL TRAINERS AND RESOURCE PERSONS USED FOR CLINICAL FP TRAINING AT THE KICUKIRO TRAINING CENTER AND THE CLINICIAN/TRAINERS IN THE HEALTH REGIONS WHO COULD BECOME CLINICAL FP TRAINERS**

#### **A. Clinical FP Trainers**

1. Mlle MUKAKARARA Viviane
2. Mme NYIRANGERAGEZE Theodette
3. Mme NYIRANGERAGEZE Bernadette
4. Mme MUKARONI Marie (trained in training methodologies in August/September 1993)
5. Mme MUKABALISA Consolee (recently left ONAPO to work with ARBEF)
6. Dr. MUHAWENIMANA Alexandre (currently in the US for a 2 year program of studies)

#### **B. Resource Persons and Their Specialties**

1. Dr. MUNYAKAZI Alphonse (sexually-transmitted diseases and infertility)
2. Dr. UKULIKIYIMPFURA Cyridion (VSC and NORPLANT)
3. Dr. SEBIKALI Boniface (sexually-transmitted diseases and hormonal methods)
4. Mme BAZIRAMWABO Madeleine (management of FP services)
5. Mr. MBONIGABA Jean-Damascene (IEC)
6. Mr. KAMANZI Castule (IEC)

#### **C. Clinician/Trainers in the Health Regions**

1. GAHIRWA Benoit
2. INGABIRE Marie Josee
3. NYIRANGENDO Sophie
4. BEMEZA Theogene
5. GASASIRA Sylvestre

Source: ONAPO Training Sub-Section, September 25, 1993

**APPENDIX D**

**Clinical FP Practicum Sites in Rwanda**

## APPENDIX D

### CLINICAL FP PRACTICUM SITES IN RWANDA (Eight sites in 6 prefectures/health regions)

Sites	Trainers	Prefecture
1. Kigali Central Hospitalier (CHK)	-NYIRANGERAGEZE Bernadette -MUKANDOLI Marie -MUKARONI Theodette -GATUNGO Josianne	Kigali
2. Kanombe Hospital	-MUKAKARARA Viviane	Kigali
3. Gitarama Health Center	-INGABIRE Marie Josée	Gitarama
4. University Center for Public Health (CUSP)	-NTABYERA Augustin -MUKABARABGA Agnès -BIZIYAREMYE J. Nepomuscene -MUKANKAKA J. Françoise -KARUCWIRO Epaphodite	Butare
5. Nyanza Hospital	-TWAGIRAYEZU Onesphore	Butare
6. Ruhengeri Hospital	-GASASIRA Sylvestre	Ruhengeri
7. Gisenyi Hospital	-BEMEZA Theogène -NYIRANGENDO Sophie -MUTUMWINKA Thérèse	Gisenyi
8. Kibungo Hospital	-GAHIRWA Benoit -KANYANGIRA Ideobald	Kibungo

N.B. 1. Sites which have been used but which have problems:

- a. Rwamagana Hospital (Prefecture of Kibungo) with RUDASINGWA Sixte as its preceptor. This site does not have enough clients and the preceptor is affiliated with the Rukara Health Center and not with the hospital.
- b. Bushenge Hospital (Prefecture of Cyangugu) with NDAGIJIMANA Aaron as its preceptor. This site has a problem providing lodging for trainees.

2. The Ruhengeri Hospital has not been used this year because of the war.
- c. SINDIKUBWABO Régine, ONAPO Central Office
- d. MWONGEREZA Augustin, presently Mediresa in Gikongoro
- e. NZARERWANIMANA Celestin, with the ONAPO Regional Office in Byumba

On behalf of Training,

UWAMARIYA Marguerite (September 25, 1993)

**APPENDIX E**

**Summary of Accomplishments of Operational Objectives**

**REVUE DES REALISATIONS DES OBJECTIFS OPERATIONEL  
DU PROJET ONAPO/INTRAH PAC IIB**

Seances de travail a l'ONAPO entre Jean-Damascene, Josephine et Margot de l'ONAPO et Bongwele et Maureen d'INTRAH

le 16 et le 20 septembre 1993

#1. Former 18 formateurs national en evaluation de la formation.

- 16 sur 18 ont ete forme

- 2 sur 16 n'ont pas repondu au critere d'etre forme comme formateur (Margot et Regine) mais c'etait planifie comme ca: Margot a ete recrutee pour s'occuper de l'evaluation de la formation dans la Sous-Section Formation et Regine en tant que superviseur/technicien

#2. Recycler 40 formateurs regionaux en methodologies de formation et l'utilisation des curricula de PF clinique et pour les auxiliaires de PF

- 18 ont ete forme avec assistance d'INTRAH/TRG

- 15 ont ete forme par ONAPO sans INTRAH

--

33 total (sur 40)

et il y en a une session pour 10 formateurs regionaux prevue dans le plan de formation ONAPO/INTRAH (avec le financement de l'USAID)

- un probleme: 2-3 participants convoque de la formation des formateurs avec assistance INTRAH/TRG n'ont pas pu participer a plein temps parce qu'il ont du conduire une formation des auxiliaires de PF qui etait organise au meme moment de la formation des formateurs

- ces 2 activites n'etait pas les recyclages des formateurs mais plutot les formations de formateurs (de base) parce que les agents qui ont ete forme comme formateurs dans le passe (PAC IIa ou avec Projet Sante Familiale) ne sont plus sur place

- l'orientation aux participants a l'utilisation des curricula ne faisait pas parti des objectifs de la formation parce que ce n'etait pas prevue

- #3 Former 15 formateurs regionaux en evaluation de la formation
- cette activite aura lieu au mois de decembre 1993 avec assistance INTRAH
  - les participants seront selectionnes parmi les formateurs regionaux qui viennent d'etre forme en methodologies de formation (au mois d'aout/septembre) (finance par l'USAID)
- #4 Reviser et finaliser le curriculum en PF clinique pour la formation des prestataires en renforcent la composante du counseling
- le curriculum n'a pas benefice d'un (ou plusieurs test(s) avant d'etre finalise, reproduit et diffuse dans les regions sanitaires
  - le formulaire qui a ete developpe pour collecter le feedback des formateurs sur le curriculum n'etait pas utiliser parce que les formateurs ont dit au coordinateur du projet qu'ils ont prefere un atelier pour exprimer leurs feedback/commentaires pour la revision et finalisation du curriculum; cet atelier jusqu'ici malheureusement n'a pas ete ni planifie ni realise
  - le curriculum de counseling de AVSC n'etait pas utilise pendant la revision du curriculum comme prevue parce qu'il n'etait pas disponible dans le pays
- #5 Reviser et finaliser le curriculum de formation en IEC/PF destine aux auxiliaires de FP
- le curriculum a ete revise et finalise
- #6 Developper un curriculum en Education en Matiere de Population (EMP) pour la formation des enseignants des ecoles secondaires
- le curriculum a ete developpe et teste pendant 3 sessions (aout/sept 92) mais il reste toujours en draft parce que les formateurs ont constate certains lacunes dans le contenu (themes peu developpe) et la methodologie
  - pendant la phase de developpement, les responsables ont constate que base sur les attentes des enseignants a la fin de la formation, il faut une formation de deux semaines mais elle a ete prevue (et budgetise) pour une semaine

- ONAPO a recommande a la Direction que la duree est prolongee a 2 semaines
  - Josephine a planifie un suivi d'un echantillon des enseignants deja formes (au mois d'octobre) et a planifie le suivi dans le budget
- #7 Reproduire et distribuer 50 curricula de PF clinique, 100 curricula de IEC/PF et 100 curricula en EMP
- 50 copies du curriculum en PF clinique ont ete reproduit et diffise dans les regions sanitaires
  - 100 copies du curriculum pour les auxiliaries de PF ont ete reproduit; 2 copies par region sanitaire (le reste en stock)
  - le curriculum en EMP n'est pas encore finalise
- #8 Reproduire pour chaque prestataire forme un jeu de protocols de PF
- le jeu de protocol/arbre de decision qui ont ete inclut dans le curriculum est remis a chaque prestataire forme en PF clinique
  - malheureusement, ces arbres de decision ne sont pas exploite pendant la formation a cause de manque de temps, et ne sont pas bien utilise par les prestataires sur le terrain
- #9 Distribuer 15 formatheques
- les 15 formatheques sont tous distribuer
  - un sur 9 observe pendant le suivi a ete perdu et seulement 40% parmi les 9 sont sur les etageres et utilise par les formateurs; les autres restent toujours dans les cartons et sont non-disponible et non utilise
- #10 Fournir le materiel de formation pour 235 participants
- le materiel a ete recu a temps a l'ONAPO
- #11 Fournir les formulaires d'evaluation
- INTRAH a fournit les formulaires et ONAPO les a adapte et les reproduit pour chaque activite de formation
- #12 Inventorier les sites de terrains de stages afin de selectionner ce qui peut etre developpe comme terrain de stage (pendant un suivi)

- cette activite (le suivi) n'etait pas menee comme prevue, avant la formation des encadreurs, a cause des problemes politique dans le pays
  - comme resultat, certains sites selectionnes ne repond pas aux criteres d'un terrain de stage pratique pour la formation en PF clinique
  - il y a 8 terrains de stages dans 6 regions sanitaires qui repondent aux criteres de l'ONAPO et Minisante
- #13 Former 30 prestataires de PF en techniques d'encadrement y compris un recyclage en PF clinique
- 23 sur 30 ont ete forme
  - il y a 18 encadreurs forme qui travaillent dans les 8 terrains de stage qui repondent aux criteres
- #14 Fournir les documents de reference en PF clinique au site de stage pratique
- ce sont les documents donnees aux participants lors de la formation
- #15 Fournir une copie d'un livre de reference a 110 ecoles normales, sociales et medicales
- pas encore realise a cause de problemes a commander le livre identifie
- #16 Former 15 superviseurs regionaux
- 15 ont ete formes
  - 7/15 n'avaient pas recu une formation en FP clinique
  - parmi les 7, 0 ont ete forme en PF comme recommande
  - le developpement d'un instrument pour la supervision formative en PF n'etait pas prevue lors de l'elaboration du projet
  - le plan pour tester, finaliser et diffuser l'instrument n'etait pas respecter par la Section Sante Familiale
- #17 Former 235 prestataires en PF clinique (la formation de 15, la premiere groupe, a mener avec assistance INTRAH)

- 95 sur 235 ont ete forme (39%); 13 avec assistance INTRAH (sur 15 prevue) et 82 sans assistance INTRAH (c.a.d. 82 sur 220, ou 37%, ont ete forme par ONAPO)
  - les participants de ces formations ne viennent pas des regions la ou il y a le projet GTZ/ONAPO (Gikongoro et Butare)
  - le profile (A1, A2, A3, Assistant Medicaux) ce ces prestataires formes est: \_\_\_\_\_
- #18 Mettre a jour les competences clinique de 110 prestataires formes lors du PAC IIa (1987/88)
- ces formations ont ete remplacees par la formation en PF clinique parce que ces agents (forme en 1987/88) ne sont plus la et ONAPO et MOH a mis accent sur les prestataires dans les centres de sante qui n'ont pas ete forme en PF
- #19 Former 990 auxiliaires de PF en IEC/PF pendant 33 sessions de formation
- la Sous-Section de Formation n'a pas ces informations
- #20 Former 480 enseignants des ecoles secondaires en EMP pendant 16 sessions de formation
- 87 ont ete forme en 1992
  - 33 en 1993 (avril)
  - -
  - 120 total (moyen 30 par session)
- #21 Mener les suivis annuelle des participants formes
- le premier suivi a ete programme pour sept/oct 92; il a ete re-programme pour nov/92; malheureusement a cause de la situation politique dans le pays le suivi ne pouvait pas etre mene en nov 1992; donc il a ete re-programme pour mars 93 mais la situation politique ne permettait pas l'execution de l'activite jusqu'au mois de aout/sept 1993
  - le suivi d'un echantillon des agents forme avec assistance INTRAH et par ONAPO sans assistance INTRAH a ete mene en aout/sept 1993
- #22 Mener les revues annuelles du projet
- la revue du projet suit le suivi; donc, la premiere revue du projet est en cours actuellement