



CONCERN WORLDWIDE

Gisagara Health District, Rwanda

CHILD SURVIVAL PROGRAM

**Capacity Assessment of the Health Facilities
& Community Based Associations
- Final Report -**

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SUMMARY

The overall objective of this study is to evaluate the capacity as well as the performance of the health facilities (HF) and community associations (community health workers associations (CHW), traditional birth attendant associations (TBA) and associations of people living with HIV (PLWHA), operating in the Gisagara (formerly Kibilizi) District.

This is a descriptive study, combining the quantitative and qualitative methods, based on the focus group discussion technique and individual interviews. All the health care centers are targeted as well as a sample of patients who benefited from the Antenatal Clinic (ANC) services, child consultation, and community based associations.

The main results of the analysis show that:

- The health infrastructures of Gisagara are old, with an average age of 37 years; the average number of beds per Health Center (HC) being of 32 beds, with an average of 23,000 inhabitants per HC, which is in the average recommended by the Ministry of Health.
- Each health center has an average health staff number of 17 people; but there is a lack of the professional staff A1 and A2 nurses.
- The number of community health workers in Gisagara district are sufficient number (1300) and have grown rapidly these last years, thanks to the support of the CSP Concern project.
- All health centers have health functional committees and the overall management of services has improved.
- The number of the curative and preventive consultations in all health centers has increased tremendously (almost by three times) during these 5 last years. Almost all services (including HIV/AIDS) are now functional, except some health centers which do not have the VCT and PMTCT services yet.
- Efforts were made to organise the training of health staff, in several priority areas of which malaria, HIV/AIDS, respiratory infections and nutrition.

- The supervision of health staff and the community volunteers have been organised regularly and especially more often in the years 2004-2005. Information concerning the organised training and supervisions is not always available.
- Community Health Workers (CHWs) are referring more and more patients towards health facilities. The main reasons of transfers are primarily due to complicated childbirth and complicated malaria cases. On the other hand, counter-referral and feed back from health facilities is almost inexistent, which is a nationwide common practice.
- The analysis of the capacity and quality of the VCT services reveals that almost all FOSA have a functional VCT service, except for Kirarambogo. The knowledge and experience of the VCT health staff are of medium quality. Most of the interviewed agents who have given good spontaneous answers reached a rather low level (20% - 40%).
- The clients perception of the quality of ANC and consultation of children services is very good, however there is some issues of dissatisfaction in particular with regard to the time spent waiting at the Health facility, which is very long (an average of almost 4 hours to a maximum time of 8 hours for some), the high cost of drugs, and the lack of patient follow-up.
- The clinical practice of personnel of VCT and children consultation services is not very satisfactory, because some basic processes are not systematically used such as measuring patients' pulse, or advising the patients with regard to the follow-up.
- The knowledge of patients, with regard to the danger signs related to pregnancy and children diseases, is rather at a medium level because the majority of patients was unable to quote all major danger signs.
- The head of Health Centre and the district management health team (DMHT) state to have noticed positive changes since the CSP Project Concern started to operate in the district of Gisagara, especially in the projects' 4 intervention areas: Malaria, Nutrition, HIV/AIDS, as well as maternal and child Health. The

- management services, the meetings related to the planning and supervisions became more regular, whereas the relation with the partners more constant.
- CHWs, Traditional Birth Attendants (TBAs) and People Living With HIV/AIDS (PLWHAs) have formed associations; they all unanimously state that the CSP *Concern* project has contributed a lot to their initial training but also helped them to fulfil their daily duty in the community.
 - After the end of the CSP *Concern* project, the head of Health Centres, the DMHT, and members community associations state to be willing to continue the activities initiated by the CSP project. This would be possible thanks to the acquired technical skills of the health staff and volunteers but also by reinforcing local and national leaders support. The creation of income generating projects for the volunteers is one of the ways to enable them to become financially independent.

In **conclusion**, the capacity assessment of health facilities and Community based associations, operating in Gisagara district revealed that the level of management and services performance as well as the level of activities has significantly increased since the beginning of the CSP *Concern* project. However, the quality of the provided services is not yet satisfactory in general; particular efforts are necessary in order to reach the desired quality level. Though all the stakeholders of the district seem to be willing to continue the activities initiated by the CSP project, their sustainability remains a challenge, therefore, transition strategies and support will still be necessary.

Acknowledgements

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The field data collection was done by a team of 4 investigators, under the supervision of the principal investigator:

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ABBREVIATIONS

| | |
|------------|--|
| AIDS: | Acquired Immuno Deficiency Syndrome |
| ANC: | Antenatal Clinic |
| ARI : | Acute respiratory infections (ARI) |
| CA: | Catchment Area |
| CHW: | Community Health Worker |
| COSA : | Health Committee |
| CSP : | Child Survival Program |
| DHS: | Demographic and Health Survey |
| DMHT: | District Management Health Team |
| EPI: | Expanded Program of Immunization |
| FARN : | French acronym for Hearth |
| FP: | Family Planning |
| HBM: | Home Based Malaria Treatment |
| HC : | Health Centre |
| HF: | Health Facility |
| HIS: | Health Information System |
| HIV: | Humane Immunodeficiency Virus |
| KPC : | Knowledge, Practice, and Coverage |
| Minisanté: | Ministry of Health |
| PLWHA: | People Living with HIV/AIDS |
| PMTCT: | Prevention of Mother To Child Transmission |
| STD: | Sexually Transmitted Diseases |
| TBA: | Traditional Birth Attendant |
| TT: | Tetanus Toxoid |
| USAID : | United States Agency for International Development |
| VCT : | Voluntary Testing Center |
| WHO: | World Health Organization |

I. INTRODUCTION

CONCERN/RWANDA has set up a project entitled "CHILD SURVIVAL" in Gisagara District (former Kibilizi district), in the Southern Province of Rwanda, since October 2001, for 5 years period, financed by the USAID. This project has as overall objective to contribute to the reduction in maternal and child mortality and morbidity, and increased life expectancy in Kibilizi District, Butare Province of Rwanda.

Concern Worldwide US, Inc. is an affiliate of Concern Worldwide which began activities in Rwanda in 1994. It is in 1998 that CONCERN/RWANDA started its technical assistance programme to the health district of Kibilizi (now Gisagara).

To achieve its goal, the project worked out an action plan with strategies based on the objectives of the Ministry of Health as well as those of the USAID in Rwanda. The main strategies are primarily based on the staff capacity building in health services and of community based organizations in order to encourage them to participate in the prevention of health problems and addressing the local population health issues.

The present study evaluates the capacity and performance of the health facilities and community based associations, compared to the objectives of the Child Survival Project conducted in June 2006.

II. BACKGROUND

The former Kibilizi Health District (now a part of Gisagara District) is located in the Southern province and includes seven Health centres which provide a minimum package of health activities to the population. The district hospital is not functioning yet. The district of Kibilizi covers two administrative districts (Mugombwa and Kibingo), with 43 sectors and 142 cells (the smallest administrative unit). In 2006, the total population is estimated at 178,502 inhabitants. The former health district of Kibilizi was characterised by high child and maternal morbidity and mortality due mainly to poor access and quality of health services.

The *CONCERN* programme entitled Kibilizi Child Survival Partnership Program used three main strategies to achieve its goal: (1) building the management capacity of the district health staff and supervisors; (2) developing the capacities of the health staff of the district in the four program fields of intervention; and, (3) strengthening the district's community outreach approach.

The four major fields of interventions of the program are:

1. HIV/AIDS prevention
2. Malaria Control
3. Nutrition and prevention of chronic malnutrition
4. Mother and Newborn care.

The expected program outputs are:

- 1) Improved district health management systems
- 2) Improved quality of services on the four selected interventions
- 3) Increased health care coverage
- 4) Decentralized and institutionalized health services
- 5) Sensitized District Health Team and population on gender health issues
- 6) Empowered population for disease prevention and risk reduction
- 7) Improved Concern-CSP planning, design, and management capacity

The overall objective of this study aims at evaluating the capacity as well as the performance of the health facilities and Community based associations (Community health workers associations (CWH), associations of traditional birth attendants (TBA) and associations of the people living with HIV/AIDS (PLWHA) operating in the district of Gisagara.

This study aims specifically at : (i) evaluating the general level of performance of the Health Centres (HC) in terms of achieved activities and health staff general point of view especially with regard to the project 4 major interventions (Malaria, nutrition, maternal and child health and HIV/AIDS); (ii) evaluating the knowledge and the technical skills of the health staff with regard to the HIV voluntary testing; (iii) evaluating the satisfaction and performance level of the health staff in connection with the antenatal consultation and children care; and, (iv) evaluating the management and technical capacity of associations, and the way they are perceived at the community level, compared to the objectives of the project.

This study will give CONCERN/RWANDA and the health staff, and the community based associations, the impact of their interventions and also the challenges which still remain ahead.

III. METHODOLOGY

This is a descriptive study which used quantitative as well as the qualitative methods. Focus group discussion and individual interview were used. The target populations of the study are all health centers and community based associations based in Gisagara district.

1. Sampling

This study surveyed all health centers of the district of Gisagara (7 health centers), 14 patients who attended antenatal consultation services (7 patients) and external children consultation (7 patients), and 12 community based associations. A sample of 12 community based associations has selected by taking into account their activities (CWH, TBAs, and PLWHA) and their performance criteria (See appendix 3).

2. Questionnaires

Four questionnaires have been developed by the Child Survival team; these are: 1) questionnaire for the head of health centers, 2) questionnaire concerning the VCT service, 3) "exit interview" questionnaire of patients attending antenatal clinic and children outpatient consultation, and 4) questionnaire for focus group discussion with community based associations and the district management health team. All questionnaires have been pre-tested on field and corrected accordingly before the field work (see appendix 1).

The questionnaire for head of health centers contains information on the number and the qualification of the health personnel, the use of health services, the type and number of training and supervision performed.

The questionnaire concerning the VCT evaluates the knowledge and practice of the health staff working in this service. It also covers staff qualifications, the type and number of trainings received, the knowledge and attitude with regard to counselling patients before and after an HIV test.

The exit interview questionnaire targets those who attended antenatal clinic and children outpatient consultation. The questionnaire seeks to evaluate the patient opinion on the

time spent at health center, the services costs, the consultation quality, and the patient's knowledge with regard to danger signs related to pregnancy and childhood diseases which require an urgent medical consultation.

The focus group discussion questionnaire for community based associations inquire about their activities, trainings received, support received from the CSP project, and the sustainability plans. As for the district management health team (DMHT) questionnaire, it focuses on the management capacity (meetings, supervision, reports, relations with MINISANTE and other stakeholders) and the technical capacity of the DMHT in the project's four intervention areas.

3. Training of investigators and field data collection

Four investigators were recruited and trained during two days in interview and "focus-group" discussion techniques. The training courses related primarily to: 1) the objectives of the assessment, 2) the objectives and indicators of the project 3) interview and focus-group discussion techniques, 4) data quality control and data collection 5) member's role and responsibilities.

After the training, a pre-test was carried out at CUSP health center in the district of Huye, Southern province. This site was selected because it is located close to the training site and also because it does not belong to the survey area.

For field data collection, the investigators were assigned in 2 teams of 2 people and each team was assigned a specific number of health centers and community associations to survey. The field investigation was carried out from June 12-16, 2006 (see appendix 2). A total of 7 health centres, 14 patients of ANC (7 patients) and children outpatient consultation (7 patients), 12 community based associations, and the Gisagara DMHT team were successfully surveyed as planned.

Two approaches were used to collect information on field, namely the quantitative approach and the qualitative approach. The *quantitative approach* used structured

questionnaires for data collection from head of health centers, the in charge of the VCT service, and the users of the ANC and children outpatient consultation.

The *qualitative approach* used focus-groups discussion technique (FGD) with members of community associations and the district management health team as well as individual interviews with the head of health centers.

Each focus group discussion was comprised with an average of 10 people from the association. The FDG guide was divided in major themes and each theme had several questions from a more general question to detailed and specific sub-questions which would allow the facilitator to lead the discussion and cover all the aspect of the theme. Moreover, the facilitator encouraged participants to give more details. Before the end of the discussion the facilitator asked the participants if they still had questions and/or additional topics before the conclusion of the meeting.

A verbal consent of the participants was always obtained before the beginning of each interview.

4. Data entry and Analysis

The data entry was carried out by the investigators, using MS WORD and EPIDATA software. The internal coherence of the answers was checked before the analysis of the data. The statistical analyses were done MS EXCELL and STATA (version 7) software.

IV. RESULTS

A. QUANTITATIVE RESULTS

1. Health Facilities

Infrastructure

All the seven health centres of the Gisagara District (3 public and 4 private) were surveyed. As indicated in table1, the population benefiting from the health centre amounts to an average of 23,322 inhabitants, varying from 17,503 to 28,000. The health centres have been operational for several decades, with an average of 37 years, with large variations, going from 20 to 73 years and have an average hospitalization capacity of 32 beds.

Table 1: Characteristic of the Health Centers

| Characteristic | Average | Min | Max |
|-------------------------------------|----------------|------------|------------|
| Age of the FOSA | 37 | 20 | 73 |
| Population benefiting from the FOSA | 23,322 | 17,503 | 28,000 |
| Numbers of beds | 32 | 24 | 39 |

Human Resources

Health staff

The analysis of human resources shows that the total number of the personnel working in the health centres of the Gisagara district amounts to 121 people, with an average of 17 people per health centre. Table 2A shows that there are 4% of A1 nurses, 304% of A2 nurses, 1.7% of A3 nurses, 7.4% of auxiliary nurses, and 6.6% of laboratory technicians. The social workers and nutritionists respectively constitute 5% and 1.7% of the total number of workers. The support staff (workers and others) represent 43.4 % of the total staff.

Table 2A: Staff distribution by Health Center in Gisagara district

| Health Center | Social | | | | | | | | Total |
|-----------------------|-------------|--------------|-------------|-------------|-------------|-------------|-------------|--------------|-------------|
| | A1 | A2 | A3 | A4 | Assistant | Nutrition | Labo | Workers | |
| KIBAYI | 0 | 8 | 0 | 1 | 0 | 1 | 0 | 7 | 17 |
| KIBILIZI | 4 | 2 | 0 | 0 | 0 | 0 | 1 | 9 | 16 |
| KIRARAMBONGO | 4 | 1 | 1 | 0 | 2 | 0 | 0 | 11 | 19 |
| KANSI | 0 | 5 | 0 | 0 | 1 | 0 | 1 | 7 | 14 |
| MUGOMBWA | 2 | 3 | 0 | 4 | 2 | 1 | 1 | 4 | 17 |
| KIGEMBE | 0 | 5 | 0 | 2 | 1 | 0 | 3 | 8 | 19 |
| GIKORE | 1 | 5 | 1 | 2 | 1 | 0 | 2 | 7 | 19 |
| Total | 11 | 29 | 2 | 9 | 7 | 2 | 8 | 53 | 121 |
| % Total | 9,1% | 26,4% | 1,7% | 7,4% | 5,8% | 1,7% | 6,6% | 33,4% | 100% |
| Average per HC | 1.6 | 4.6 | 0.3 | 1.3 | 1.0 | 0.3 | 1.1 | 5.4 | 17.3 |

Table 2B below shows the distribution of staff by sex and the majority of the health staff is female, since 62% of them are women.

Table 3B: Staff distribution by sex in Gisagara district

| Sex | A1 | A2 | A3 | Auxil | Ass Sociale | Nutrit | Tech lab | Trav | Autre | Total | % |
|--------------|-----------|-----------|----------|----------|-------------|----------|----------|-----------|-----------|------------|-------------|
| Male | 0 | 14 | 1 | 2 | 2 | 0 | 3 | 21 | 3 | 46 | 38% |
| Female | 11 | 18 | 1 | 7 | 5 | 2 | 5 | 17 | 9 | 75 | 62% |
| Total | 11 | 32 | 2 | 9 | 7 | 2 | 8 | 38 | 12 | 121 | 100% |

Community Volunteers

Gisagara district has a total of 1308 Community volunteers (in 2006) with an average of 187 volunteers per health center. As shown in table 3 below, the distribution per category of community volunteers is as follow: 259 traditional birth attendants (TBA), 161 community health workers (CWH), 449 community based anti-malaria drug distributors, 320 people living with HIV/AIDS, and 119 other volunteers. Women represent 47% of the total staff but they have almost the total majority of TBAs and a slight majority among people living with HIV/AIDS.

Table 3: Distribution of community volunteers in Gisagara district

| Health Center | Malaria | | | | | Total |
|----------------------|------------|------------|-------------|------------|------------|-------------|
| | TBA | CWH | distributor | PLWHA | Others | |
| KIBAYI | 64 | 27 | 110 | 48 | 54 | 303 |
| KIBILIZI | 40 | 21 | - | 32 | 0 | 93 |
| KIRARAMBONGO | 10 | 21 | 68 | 0 | 0 | 99 |
| KANSI | 30 | 19 | 82 | 32 | 0 | 163 |
| MUGOMBWA | 50 | 22 | 59 | 35 | 52 | 218 |
| KIGEMBE | 20 | 19 | 60 | 47 | 13 | 159 |
| GIKORE | 45 | 32 | 70 | 126 | 0 | 273 |
| Total | 259 | 161 | 449 | 320 | 119 | 1308 |
| Average by HC | 37 | 23 | 64 | 46 | 17 | 187 |
| Male | 2 | 133 | 317 | 149 | 92 | 693 |
| Female | 257 | 28 | 132 | 171 | 27 | 615 |

Health services management

All health centres of the district of Gisagara have a functional management committee, 71% of which meet monthly and 29% meet on quarterly basis. As shown in table 4 below, the majority of health centers (85.7%) have introduced some form of exemption payment system for the poorest. 43% of health centers apply a total exemption of fees payment , 57% grant reduced tariffs and 29% distribute gifts in kind to the poor.

Table 4: Health Services Management

| Category | Numbers | Percentage |
|-------------------------------------|---------|------------|
| Health Management Committee (HMC) | 7 | 100% |
| HMC meeting | | |
| Monthly | 5 | 71.4% |
| Quarterly | 2 | 28.6% |
| System of exemption for the poorest | 6 | 85.7% |
| Type of exemption | | |
| Free health care | 3 | 42.9% |
| Tariff Reduction | 4 | 57.1% |
| In kind | 2 | 28.6% |

Use of the services

As summarised in table 5 below, the total number of people who have benefited from health services in the district of Gisagara during the last six months (from December 2005 to May 2006), is estimated at 42,433 patients with a monthly average of 7 079 cases. Hospitalisation cases are estimated at 2840 with a monthly average of 473 patients during the same period. Children growth monitoring (18,485 cases), malaria (7,227 cases), and antenatal consultations (6,299 cases) constitute the majority of the consultations. We also note that over the same period there is a monthly average of 30 cases of STD (syndromic approach), 313 cases of VCT and 259 cases of PMTCT. Cases of transfer by ambulance amounts to 207 patients but this number is underestimated as most of the health centres do not record these data.

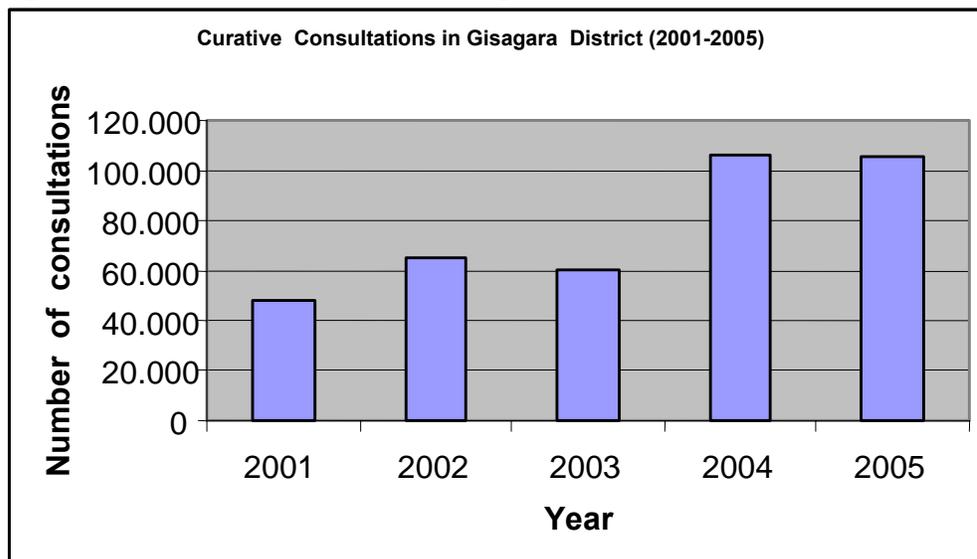
Table 5: Use of the Health care services (December 2005 to May 2006)

| Categories | Kanzi | Mugombwa | Kirarambogo | Kibiliz | Kibayi | Gikore | Kigembe | Total: 6 months | Average per month |
|----------------------------|-------|----------|-------------|---------|--------|--------|---------|-----------------|-------------------|
| Malaria | 1 408 | 1 982 | 959 | 786 | 974 | 614 | 504 | 7 227 | 1 205 |
| Children Growth Monitoring | 3 389 | 473 | 6 597 | 3 211 | 401 | 2 381 | 2 033 | 18 485 | 3 081 |
| CPN | 1 263 | 730 | 1 703 | 913 | 368 | 586 | 736 | 6 299 | 1 050 |
| Post-natal Care | - | - | - | - | - | - | - | - | - |
| Normal delivery | 264 | 192 | 136 | 88 | 130 | 129 | 209 | 1 148 | 191 |
| Assisted childbirth | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Blood transfer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| STD Diagnosis | | | | | | | | | |
| Etiological | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Syndromic approach | 20 | - | 11 | 18 | 12 | 73 | 45 | 179 | 30 |
| STD Treatment | 20 | - | 11 | 18 | 12 | 73 | 45 | 179 | 30 |
| STD Counselling | 20 | - | 11 | 18 | 12 | 73 | 45 | 179 | 30 |
| HIV/AIDS | | | | | | | | | |
| VCT | 0 | 62 | 0 | 285 | 630 | 82 | 819 | 1 878 | 313 |
| ART | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PMTCT | 0 | 0 | 0 | 373 | 443 | 0 | 736 | 1 552 | 259 |
| External consultations | 7 475 | 8 911 | 3 396 | 5 955 | 6 958 | 3 330 | 6 448 | 42,473 | 7 079 |
| Hospitalizations | 578 | 438 | 440 | 197 | 280 | 615 | 292 | 2 840 | 473 |
| References (ambulance) | 37 | 150 | - | - | 20 | - | - | 207 | 35 |

Post natal care service is not established yet as a distinctive unit from the children general consultation service; this is the reason why this rubric does not contain data. The anti-retroviral drugs (ARV) service dedicated to HIV/AIDS patients was not yet functional in any of the health centers of Gisagara district during the above mentioned period.

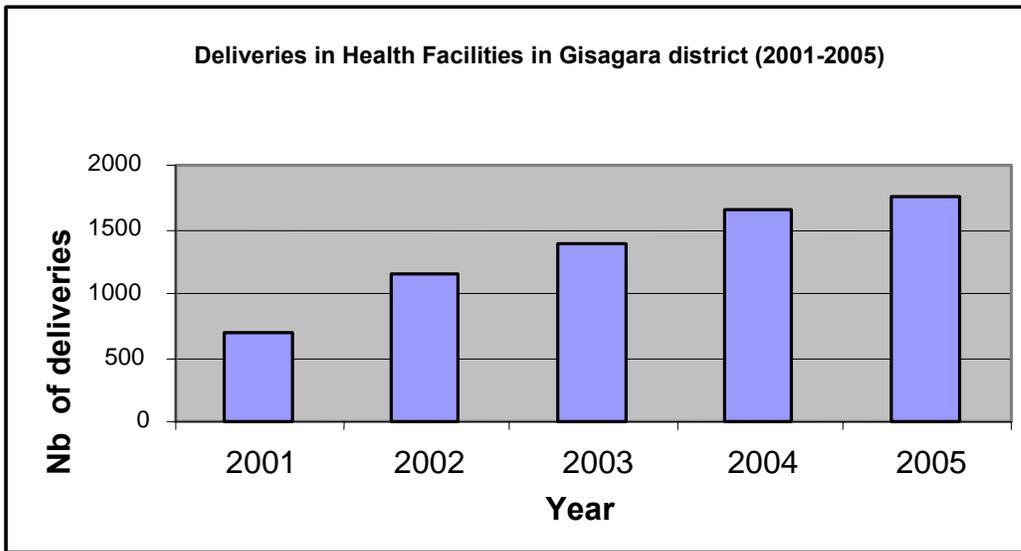
There is a very sharp increase of the number of curative consultations in all health centers in Gisagara district over the last past five years (2001-2005). As shown in figure 1, the number of consultations raised from 42 000 cases in 2001, to more than 100 000 cases in 2005.

Figure 1: Curative consultations in Gisagara District (2001-2005)



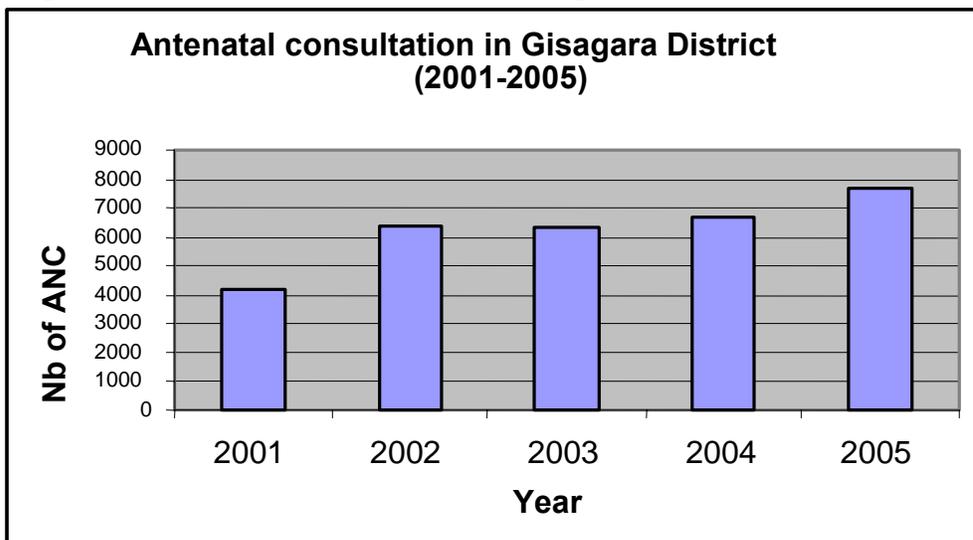
As indicated in figure 2, deliveries in health facilities increased almost our times during the five year period raising from 600 in 2001 to 1800 cases in 2005.

Figure 2: Deliveries in Health Facilities in Gisagara District (2001-2005)



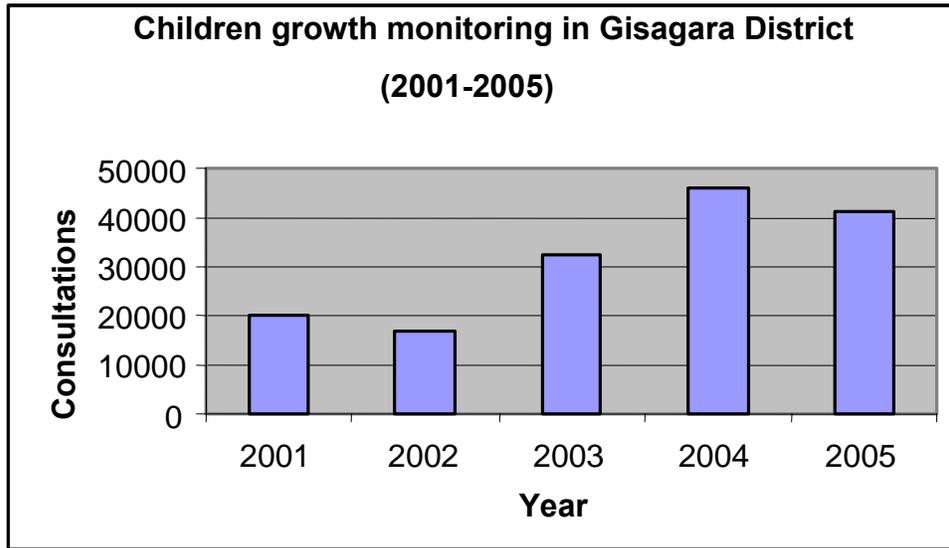
The preventive activities such as antenatal consultations also experienced a significant increase during the last 5 years in Gisagara district. As shown in figure 3 below, antenatal consultations rose from 4 000 cases in 2001 to almost 8 000 cases in 2005.

Figure 3: Antenatal consultations in the Gisagara District (2001-2005)



There is also a significant increase with regard to the children growth monitoring, consultations rose from 20,000 cases in 2001 to more than 40,000 cases in 2005 as shown in figure 4 below.

Figure 4: Children growth monitoring in Gisagara District (2001-2005)



Training, supervision and transfer

Training

The total number of type of trainings conducted and the number of health staff trained in Gisagara district during the last 5 years (2001-2005) is estimated respectively at 95 trainings and 186 people trained. The majority of trainings (75%) and staff trained (65%) were done during the year 2005 only. Some of the health centers did not always have the necessary information, especially during the first years of the project, thus introducing an underestimation of these trainings. As shown in table 6, the types of training cover several conditions and diseases, the most frequent of which being malaria, STD/AIDS and nutrition.

Table 6: Categories of training and trained people (2001-2005)

| Categories | 2001 | 2002 | 2003 | 2004 | 2005 | Total |
|--------------------------|-----------|-----------|-----------|-----------|------------|------------|
| <i>Pathologies</i> | | | | | | |
| Deliveries | 0 | 0 | 0 | 0 | 6 | 6 |
| ANC | 1 | 0 | 0 | 0 | 4 | 5 |
| VCT | 0 | 0 | 0 | 0 | 5 | 5 |
| PMTCT | 0 | 0 | 0 | 0 | 5 | 5 |
| Nutrition | 0 | 0 | 1 | 1 | 8 | 10 |
| Diarrhoea | 0 | 0 | 0 | 0 | 0 | 0 |
| Malaria | 0 | 3 | 0 | 1 | 9 | 13 |
| STD | 0 | 2 | 0 | 2 | 3 | 7 |
| Postnatal consultation | 0 | 0 | 0 | 0 | 1 | 1 |
| Health Mutuelle | 0 | 0 | 0 | 0 | 6 | 6 |
| Family planning | 1 | 0 | 0 | 1 | 4 | 6 |
| Gender | 0 | 0 | 0 | 0 | 1 | 1 |
| HIV/AIDS | 0 | 2 | 0 | 0 | 8 | 10 |
| IEC | 1 | 3 | 0 | 0 | 1 | 5 |
| Respiratory infections | 0 | 0 | 1 | 0 | 0 | 1 |
| Others | 2 | 0 | 1 | 0 | 11 | 14 |
| Total pathologies | 5 | 10 | 3 | 5 | 72 | 95 |
| Staff Trained | 16 | 12 | 14 | 24 | 120 | 186 |

Supervisions

During the period between 2001 and 2005, there were 186 supervisions of the health center personnel in Gisagara district, with an average of 37 supervisions per annum. The supervision experienced had a sharp increase from 2004. We noticed that some health centers did not have complete information about the supervisions, especially in Gikore and Kibilizi health centres.

Table 7: Number of supervisions conducted in Gisagara district (2001-2005)

| Health Centre | 2001 | 2002 | 2003 | 2004 | 2005 | Total |
|---------------|-----------|-----------|-----------|-----------|-----------|------------|
| KIGEMBE | 3 | 11 | - | 10 | 16 | 40 |
| KIBAYI | - | 2 | 5 | 13 | 20 | 40 |
| MUGOMBWA | 5 | 3 | 5 | 8 | 12 | 33 |
| KIRARAMBONGO | 12 | 4 | 4 | 11 | 15 | 46 |
| GIKORE | - | - | - | - | - | - |
| KIBILIZI | - | - | - | - | - | - |
| KANSI | 4 | 3 | 2 | 9 | 9 | 27 |
| Total | 24 | 23 | 16 | 51 | 72 | 186 |

The types and number of supervisions from December 2005 to May 2006 are summarised in table 8 below. There were a total of 61 supervisions conducted during these six months, and these ANC (3), Immunization (19), HIV/AIDS (12) and malaria (27). The average number of supervisions per health center is estimated at 9, varying from 3 supervisions in Kibilizi to 13 supervisions in Kansi.

Table 8: Type and number of supervisions conducted (Dec. 2005 – May 2006)

| Health Centres | CPN | Vaccination | VIH | Malaria | Total |
|----------------|----------|-------------|-----------|-----------|-----------|
| KIGEMBE | 2 | 3 | 4 | 2 | 11 |
| KIBAYI | 1 | 1 | 3 | 5 | 10 |
| MUGOMBWA | 0 | 4 | 0 | 1 | 5 |
| KIRARAMBONGO | | 4 | | 6 | 10 |
| GIKORE | | 3 | | 6 | 9 |
| KIBILIZI | | 1 | 1 | 1 | 3 |
| KANSI | | 3 | 4 | 6 | 13 |
| Total | 3 | 19 | 12 | 27 | 61 |

The health staff also carried out supervisions of community based associations comprised by community health workers, TBAs, anti-malaria drugs distributors, the “mamans lumières” (Positive deviant mothers who are poor but have well nourished children) and health committees. Table 9 summarises the types and number of supervisions conducted. There were a total of 295 supervisions over a 6 months period from Dec 2005 to May 2006 (note that there was missing information in some health centers), the majority of which focused on “mamans lumières” and anti-malaria drug distributors.

Table 9: Type of supervisions conducted at the community level (Dec.2005-May 2006)

| Health Centres | CHW | TBA | Malaria Distributors | “Mamans Lumières” | Health Mutual | Total |
|----------------|-----------|-----------|----------------------|-------------------|---------------|------------|
| KIGEMBE | 11 | 11 | - | 50 | 1 | 73 |
| KIBAYI | 9 | 0 | 81 | 48 | 0 | 138 |
| MUGOMBWA | 6 | 0 | 24 | 0 | - | 30 |
| KIRARAMBONGO | - | - | - | - | - | - |
| GIKORE | 6 | 6 | - | 6 | - | 18 |
| KIBILIZI | - | - | - | - | - | - |
| KANSI | 6 | 6 | - | 18 | 6 | 36 |
| Total | 38 | 23 | 105 | 122 | 7 | 295 |

Referrals

The total number of referrals, transfers and counter-referrals is estimated at 1 588 cases during from December 2005 to May 2006, as indicated in table 10 below. The referrals made by Community agents amounts to 1,386 cases, whereas transfers made by the health staff amounts to 197 cases. Counter-referrals are almost non-existent and are estimated at 3 cases only, for the whole period. Malaria cases, deliveries and respiratory infections cases constitute the majority of the referrals. The only cases of counter-reference (3 cases) are related to deliveries.

Table 10: Transfers, referrals and counter- referrals (Dec. 2005-May 2006)

| Health Centres | Referrals | Transfers | Counter references | Total |
|-----------------------|--------------|------------|--------------------|--------------|
| Deliveries | 522 | 154 | 3 | 679 |
| Malnutrition | 0 | 5 | 0 | 5 |
| Respiratory Infection | 95 | 2 | 0 | 97 |
| Malaria | 739 | 24 | 0 | 763 |
| Diarrhoeal Diseases | 0 | 0 | 0 | 0 |
| Immunizations | 30 | 0 | 0 | 30 |
| HIV/AIDS | 0 | 12 | 0 | 12 |
| Total | 1 386 | 197 | 3 | 1 586 |

Meeting

Table 11 below presents the period during which the last meeting took place, together with the head of health facilities and the community agents. Most meetings took place on monthly basis, except for the meeting with the health insurance committee which was held every three months. Only Kigembe health center never organised any meeting with the Community volunteers.

Table 11: Meeting of head of health facilities with other partners

| Health Centers | Health Center staff | CHW | TBA | Volunteers | Other HC | DMHT | HMC | Anti-Malaria drugs Distr. | Mutual Com |
|----------------|---------------------|-----|-----|------------|----------|------|-----|---------------------------|------------|
| KIGEMBE | 1 | 1 | 2 | 4 | 1 | 1 | 1 | 1 | 3 |
| KIBAYI | 1 | 1 | 2 | - | 1 | 1 | 1 | 1 | 2 |
| MUGOMBWA | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 1 |
| KIRARAMBONGO | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 2 | 3 |
| GIKORE | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 |
| KIBILIZI | 2 | 2 | 1 | 1 | 1 | 1 | 3 | 1 | 3 |
| KANSI | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |

NB: 1: <= 1month; 2: 1-3 month; 3: > 3month; 4: Never

Common pathologies

According to head of health facilities interviewed at the time of this study, the three most frequent pathologies in the health centers among children under 5 years are malaria, respiratory infections and diarrhoeal diseases, whereas among pregnant women, the most frequent diseases are malaria, respiratory infections, and pregnancy complications, as described in table 12 below.

Table 12: The most frequent pathologies among children (<5years) and pregnant women

| Health Centres | Children < 5 years | | | Pregnant woman | | |
|----------------|--------------------|------------------------|---------------------|----------------|------------------------|--------------------------|
| | Malaria | Respiratory Infections | Diarrhoeal Diseases | Malaria | Respiratory infections | Childbirth Complications |
| KIGEMBE | X | X | X | X | | X |
| KIBAYI | X | X | X | X | X | |
| MUGOMBWA | X | X | X | X | X | |
| KIRARAMBONGO | X | X | X | X | X | |
| GIKORE | X | X | X | X | | X |
| KIBILIZI | X | X | X | X | X | |
| KANSI | X | X | X | X | X | |

2. VCT Service

The voluntary counselling and testing service (VCT) is established in six out of seven health centers of the Gisagara district, only the Kirarambogo HC did not have a VCT service by the time of the survey, as indicated in table 13 . The health staff in charge of VCT was mainly constituted by A2 nurses and A2 laboratory technicians. All of the VCT staff interviewed stated that they had additional training courses since the end of their study.

Table 13: VCT health staff: qualification and training

| Health Centre | VCT Service | Qualification | Training |
|---------------|-------------|---------------|----------|
| KANSI | Yes | A2 Nurse | Yes |
| KIBILIZI | Yes | A2 Nurse | Yes |
| GIKORE | Yes | A3 Lab | Yes |
| KIBAYI | Yes | A2 Nurse | Yes |
| MUGOMBWA | Yes | A3 Lab | Yes |
| KIGEMBE | Yes | A2 Nurse | Yes |
| KIRARAMBOGO | Non | - | - |

Table 14 below shows the type of trainings followed by the VCT staff, as well as the agencies which organised these training courses. One notes that all agents were trained in VCT, 5 agents out of 6 were also trained in PMTCT (except for the Gikore Health Center), the agent of the Kansi Health Center was the only one to have been trained in ART, half of the agents were trained in STD treatment, according to the syndromic approach; only one agent was trained in STD etiological diagnosis, and 2 agents out of 5 were trained in counselling patients with regard to STD. The agencies and institutions which have organised these training courses are: Concern, the Ministry of health, and Caritas.

Table 14: Type of trainings conducted in HIV and STD

| Health Centre | PMTCT | ART | VCT | STD (HO) | STD (ED) | STD Counselling |
|-----------------|---------|-----------|---------|---------------------------------|-----------|-----------------|
| KANSI | Yes | Yes | Yes | No | No | No |
| KIBILIZI | Yes | No | Yes | Yes | - | - |
| GIKORE | No | No | Yes | Yes | Yes | Yes |
| KIBAYI | Yes | No | Yes | No | No | Yes |
| MUGOMBWA | Yes | No | Yes | Yes | No | Yes |
| KIGEMBE | Yes | No | Yes | No | No | No |
| Trainers | Concern | MINISANTÉ | Concern | Caritas Concern MINISANTÉ | Concern | MINISANTÉ |

NB: SA : Syndromic Approach; ED: Etiological Diagnostic

An assessment of competence of the VCT staff was conducted in regard to a hypothetical case of a patient at a VCT service. The agent's knowledge was evaluated based on three possible scenarios: 1) patient who comes to get general information on VCT service, 2) patient who comes to have an HIV test, and 3) patient who comes to get his HIV test result. There are three possible scores for each answer: score 1: answered yes without prompting, score 2: had to prompt but answered yes, and score 3: had to prompt but answered no (see appendix 1).

Table 15 summarises the VCT staff scores for the first scenario. There are 14 possible answers and one note that in general only 25% of the VCT staff properly answered

spontaneously, and 63% answered “yes” but had to prompt and 12% did answer “no” after prompting. The agent of the Kansi Health Centre obtained the best score.

Table 15: Average score of the evaluation of the VCT staff (information)

| Health centre | Score 1 | Score 2 | Score 3 | Total |
|-------------------|------------|------------|------------|-------------|
| KANSI | 7 | 5 | 2 | 14 |
| KIBILIZI | 5 | 7 | 2 | 14 |
| GIKORE | 4 | 9 | 1 | 14 |
| KIBAYI | 3 | 8 | 3 | 14 |
| MUGOMBWA | 1 | 12 | 1 | 14 |
| KIGEMBE | 1 | 12 | 1 | 14 |
| Total | 21 | 53 | 10 | 84 |
| Percentage | 25% | 63% | 12% | 100% |

NB: Score1: correct and spontaneous answers , Score 2: answered “yes” after prompting; Score3: answered “no” after prompting

Concerning the second scenario (HIV pre-test), there are 11 answers. Table 16 summarises the results of the scores obtained by the VCT staff: 21% of the VCT agents answered correctly in a spontaneous way, 73% answered “yes” after prompting and 6% did answer “no” after prompting. The agent of the Kansi HC obtained the highest score.

Table 16: Average of scores of the evaluation of VCT staff (pre-test)

| Health Centre | Score 1 | Score 2 | Score 3 | Total |
|-------------------|------------|------------|-----------|-------------|
| KANSI | 5 | 6 | 0 | 11 |
| KIBILIZI | 1 | 9 | 1 | 11 |
| GIKORE | 0 | 9 | 2 | 11 |
| KIBAYI | 2 | 9 | 0 | 11 |
| MUGOMBWA | 4 | 7 | 0 | 11 |
| KIGEMBE | 2 | 8 | 1 | 11 |
| Total | 14 | 48 | 4 | 66 |
| Percentage | 21% | 73% | 6% | 100% |

NB: Score1: correct and spontaneous answers , Score 2: answered “yes” after prompting; Score3: answered “no” after prompting

The third scenario is related to the HIV post test and table 17 below presents the score of the VCT agents in each health centre. Ten answers are possible, and one notices that on the total of all agents, 40% answered spontaneously yes, 48% answered “yes” but after

prompting and 12% did answer “no” after prompting. The agent of the Kigembe Health center obtained the highest score.

Table 17: Average scores of the evaluation of VCT staff (post-test)

| Health Centre | Score 1 | Score 2 | Score 3 | Total |
|----------------------|----------------|----------------|----------------|--------------|
| KANSI | 3 | 6 | 1 | 10 |
| KIBILIZI | 4 | 3 | 3 | 10 |
| GIKORE | 3 | 7 | 0 | 10 |
| KIBAYI | 5 | 4 | 1 | 10 |
| MUGOMBWA | 2 | 6 | 2 | 10 |
| KIGEMBE | 7 | 3 | 0 | 10 |
| Total | 24 | 29 | 7 | 60 |
| Percentage | 40% | 48% | 12% | 100% |

NB: Score1: correct and spontaneous answers , Score 2: answered “yes” after prompting; Score3: answered “no” after prompting

3. Antenatal Clinic (ANC) and children consultation services

General Characteristics

In total, 14 beneficiaries were interviewed during an exit interview about their opinion about the ANC services and children consultation, particularly concerning the transport duration and the time spent in the Health Center, the quality of the service provided, the diagnostic and therapeutic process, and about their knowledge of the danger signs.

All patients who were interviewed stated that the average time of walk from their homes to the health facility was about 40 minutes, varying from 10 to 60 minutes. As indicated in table 18, the average time spent at the health center from the arrival to the departure, amounts to a minimum of three hours and half. The shortest time spent at health center was one hour and the longest time was 7 hours and 30 minutes.

Table 18: Time spent in the health centre

| Health Centre | ANC | Child Cons. | Average (Minutes) | Average (Hours) |
|----------------|------------|-------------|-------------------|-----------------|
| KIRARAMBOGO | 180 | 230 | 205 | 3,4 |
| GIKORE | 224 | 337 | 281 | 4,7 |
| KIBILIZI | 139 | 200 | 170 | 2,8 |
| KANSI | 168 | 128 | 148 | 2,5 |
| KIGEMBE | 60 | 150 | 105 | 1,8 |
| MUGOMBWA | 460 | 245 | 353 | 5,9 |
| KIBAYI | 450 | 240 | 345 | 5,8 |
| Average | 240 | 219 | 229 | 3,8 |

Patient satisfaction

The patients were questioned on their level of satisfaction concerning several aspects of the services provided during their visit, and as summarised in table 19 below, it was noted that, in general, an average of 64% of the patients were satisfied with the services provided. 86% of the patients declared that they were satisfied with the antenatal consultation service, whereas only 43% were satisfied with the children consultation service. The patients estimated that the quality of the time spent with health care staff

was very good (> 85%), in regard to their respect and attitude. The hygiene, the cost, the drugs availability and the explanations provided by the health personnel were ranked as of good quality in over 70%. Half of the patients stated that they were not satisfied with the quality of the follow-up and the counselling provided by the health personnel, with the price of the drugs and the time spent waiting in the Health Center.

Table 19: Patient satisfaction of the health services

| Category | % satisfaction: ANC | % satisfaction: children Consultation | % total satisfaction |
|--------------------------------------|------------------------|---|-------------------------|
| Time spent waiting in the HC | 71% | 57% | 64% |
| Time spent with the Health personnel | 86% | 100% | 93% |
| Hygiene | 100% | 57% | 79% |
| Respect of private life | 86% | 86% | 86% |
| Staff attitude | 100% | 71% | 86% |
| Cost of Services | 71% | 71% | 71% |
| Drugs price | 57% | 57% | 57% |
| Drugs Availability | 71% | 71% | 71% |
| Explanation given by health personal | 86% | 57% | 71% |
| Follow-up and counselling | 71% | 29% | 50% |
| Total services provided | 86% | 43% | 64% |

Cost of health services, performance, and patients profile.

As indicated in table 20, the average amount paid for the consultation is 200 Rwf but the real cost of the services could not be calculated, since the majority of the patients interviewed were members of a health mutual because their co-payment is only a fraction of the full cost.

Concerning the performance of health services, we noticed that the prescribed drugs were available in all health centers and that none of the patients interviewed had received a prescription to go and buy drugs elsewhere, only 14% of children consultation had to process their laboratory test outside of the health centre.

The average age of the patients interviewed is 28 years, the large majority of the patients are women (93%); and that 72% of the interviewed patients were members of health mutual.

Table 20: Costs, performance and patient's profile

| Categories | ANC | children Consultation | All |
|--|-----|-----------------------|------------|
| Amount paid for the consultation (Rwf) | 150 | 250 | 200 |
| % prescriptions to be purchased elsewhere | 0% | 0% | 0% |
| % laboratory examinations to be made elsewhere | 0% | 14% | 7% |
| Average age of the patients (years) | 26 | 29 | 28 |
| % female | 86% | 100% | 93% |
| % member of a health mutual | 43% | 100% | 72% |

Antenatal consultation

The average of age of the pregnancy of patients attending the ANC were about 6 months old (varying from 3 to 8 months), and 43% of women had come for the first time. During this interview, patients were asked if some actions have been taken by the health care provider (as mentioned in table 21 below) during the antenatal consultation. It was noticed that only half of recommended actions (53%) were performed during the antenatal consultation. Weight control and abdomen examination were systematically done. Blood pressure control and foetal auscultation were done in 86% of the cases. The other actions were seldom done, such as measuring the size, gynaecological examination, and oedema examination, or HIV testing. Urine sample was never taken.

Table 21: Percentage of actions taken during the PN Consultation

| Category | Actions taken (%) |
|-----------------------------|-------------------|
| Growth monitoring | 14% |
| Weight control | 100% |
| Blood Pressure Control | 86% |
| Abdomen examination | 100% |
| Gynaecological examination | 29% |
| Foetal examination | 86% |
| Oedema examination | 57% |
| Blood sample | 43% |
| Urine sample | 0% |
| TT Vaccine | 29% |
| HIV Test | 43% |
| The nutritional counselling | 57% |
| Average | 53% |

At the end of the interview, a knowledge assessment was carried out among the ANC clients in regard to pregnancy danger signs that require an urgent medical consultation. As shown in table 22, an average of 53% of the interviewed women declared that they knew danger signs related to pregnancy. 75% of the women spontaneously quoted as danger signs haemorrhage, fever (57%), and the presence of an oedema, dyspnoea and paleness (43%).

Table 22: Knowledge of the danger signs during pregnancy

| Category | Percentage |
|-----------------|-------------------|
| Haemorrhage | 75% |
| Fever | 57% |
| Oedema | 43% |
| Dyspnoea | 43% |
| Paleness | 43% |
| Total | 53% |

Children curative consultation Service

Most of the children (71%) who came for curative consultation were less than 36 months old, as indicated in table 23 below. 57% of the patients had with them their health card and 71 % had their vaccination cards. 71% of the children were weighed during the consultation. When examining the growth follow-up card, one notices that 60% of the children were within the green colour area (good nutrition) while 40% were in the yellow colour area (malnutrition). None of the children were in the red category (severe malnutrition).

Table 23: Characteristics of the patients seen at the curative consultation service.

| Category | Percentage |
|------------------------|------------|
| Child age: < 36 months | 71% |
| Health card | 57% |
| Weight | 71% |
| Vaccination card | 71% |
| Growth follow-up Card | |
| Green | 60% |
| Yellow | 40% |
| Red | 0% |

The most frequent reasons for children consultation (see table 24) are fever and/or malaria (71%), respiratory problems (29%), and less significantly, diarrhoeas and vomiting (14%).

Table 24: Reasons for children consultation

| Category | Percentage |
|--------------------------------|------------|
| Reason for consultation | |
| Diarrhoea / vomiting | 14% |
| Fever /malaria | 71% |
| Respiratory problems | 29% |
| ENT problems | 0% |
| Growth follow-up | 0% |

During this interview, patients were asked if specific actions were performed by the health care provider during the curative consultation of their child, as described in table

25 below. We notice that some of these actions were done frequently such as the physical examination (86%), and the pulse and stools control (57%), while other actions have been less performed such as weight and growth control (29%), hands and nails examination and abdomen palpation (14%). Eyes and oedema examination, and nutrition counselling were not performed for any of the child during the consultation. At the end of the consultation, 71% of the children had received anti-malaria and antibiotics prescriptions.

Table 25 : Percentage of the actions performed during the curative consultation

| | Percentage |
|-----------------------------|------------|
| History taking | 43% |
| Physical examination | 86% |
| Temperature control | 43% |
| Pulse control | 57% |
| Weight control | 29% |
| Growth measuring | 29% |
| Eyes examination | 0% |
| Hands and nails examination | 14% |
| Palpation of the abdomen | 14% |
| Stools Sample | 57% |
| Blood Sample | 29% |
| Oedema examination | 0% |
| Nutrition Counselling | 0% |
| Anti-malaria prescription | 57% |
| Antibiotics prescription | 57% |

A knowledge assessment was done among parents of sick children who came for curative children consultation service, concerning the knowledge of danger signs of a sick child which require an urgent medical consultation. As shown in table 26 below, 100% of parents interviewed stated that they knew the danger signs. 43% of parents mentioned difficulties to drink and/or breast feed and vomiting, and 14% cited dyspnoea, convulsion, and diarrhoea with blood or a worsening disease. Nobody mentioned lethargy and/or unconsciousness as being a danger signs in children.

Table 26: Knowledge of the danger signs of a sick child

| Categories | Percentage |
|---|-------------------|
| <i>Knowledge of the warning signals</i> | <i>100%</i> |
| Difficulty in drinking / breast feeding | 43% |
| Vomiting | 43% |
| Lethargy / unconsciousness | 0% |
| Dyspnoea | 14% |
| Convulsions | 14% |
| Becomes increasingly ill | 14% |
| Diarrhoea with blood | 14% |

B. QUALITATIVE RESULTS

1. Head of health centers

Individualised interviews with head of each one of the health centers of district of Gisagara were conducted in order to inquire about their general impression about the impact of the CSP Concern project, on the performance of the Health Center, and also on the sustainability of the activities at the end of the CSP project.

Activities

The head of the health centers stated that they have noted positive changes since the CSP Concern Project started to operate in the district of Gisagara, especially in the 4 fields of interventions of the project: Malaria, Nutrition, HIV/AIDS, maternal and child health.

Concerning **malaria**, the head of health centers noted that since the beginning of the community based malaria treatment, children death rates have decreased, because children were treated at home before the disease worsens. Impregnated mosquito nets have become available at low prices and also that they are free of charge for pregnant women. Access to the mosquito nets allowed an increase in ANC attendance. They declare that the community understands better the advantage of sleeping under an impregnated mosquito net.

As for **nutrition**, thanks to the introduction of the Nutritional Training and Rehabilitation Centre (FARN) and the Community based weight control (PNBC) of the Concern project, heads of health centers noticed a better follow up of children nutrition in the community. The community health workers were trained to weight and follow-up children and have received the necessary materials to this effect. The PNBC revealed the major nutrition problem in the community and the need to adopt new behaviours with regard to good nutrition. Children growth monitoring is done at the community level, and “role model mothers” played a key role in the nutritional rehabilitation of the malnourished children. The FARN and the PNBC are well accepted by the community

and have made it possible to transfer in time severely malnourished children to health centres.

For **Maternal and Child Health**, the training and distribution of delivery kits to mothers have allowed an improvement of delivery at home, but also increasing transfers towards the health facilities. The net increase in deliveries rate at health facilities is the consequence of that change.

In the field of HIV/AIDS, one notes that many of the health centers which did not have functional VCT and PMTCT services, could now afford one, thanks to the support of the CSP Concern project. At the beginning, the CSP project contributed to transport of blood samples to Kibilizi HC for laboratory analyses and also provided consumables and material for blood samples. Anti-AIDS clubs were created and organised as well as several associations of PLWHA. HIV test acceptance in VCT and PMTCT services increased in a significant way.

It is also necessary to highlight a strong and steady enrolment of the population into health mutual thanks to the promotional activities organised by Community volunteers and local leaders, and the training health committees and health personnel.

Challenges

Even though the use of modern health services by the population has appreciably increased these last years, access to care still remains a problem, especially for the poorest. The increased enrolment in health mutual partially solves this problem. The other remaining challenge is the low rate of HIV tests, in spite of strong community sensitisation campaigns. The reinforcement of community based training, public testimonies, and sensitisation by volunteers must be maintained. Until now the health centres do not have nutritional centres. The introduction of nutritional rehabilitation unit at the health center level remains a priority, since the prescribed 12 days for FARN at community level are not sufficient to solve complicated cases of malnutrition.

Among the specific issues or constraints that the CSP Concern project helped to solve, one can particularly mention the distribution of mosquito nets to pregnant women, the Community volunteers training and health staff training, and the help in setting up of health mutual. In one of the health center, it was mentioned the CSP project helped in the construction of a water tank which allows now to have water even during the dry season.

Constraints and difficulties which existed before the beginning of the CSP Concern project and that are persisting today are the weak health mutual enrolment rate due to population poverty level and the management of the lack of nutritional center at the health facilities. In spite of the numerous trainings of TBAs and sensitisation of mothers to deliver at health facilities, the rate of those who deliver at home is still high. The VCT and PMTCT services are not yet established in all health centers, and in addition, transportation of blood samples still poses a problem.

Suggested Solutions

It is urgent to look for financial support in favour of the poor, in order to help them to enrol into health mutual which would give them access to health services. It will also be necessary to reinforce TBA associations and sensitise ANC clients to deliver at health facility level. Thanks to the help of the Global Fund and the Ministry of Health, all of VCT and PMTCT services are now technically and financially supported. The Ministry of Health is in the course of setting up a food support programme in favour of people living with HIV/AIDS which will solve some of the above mentioned problems

Gender

Although the CSP Concern project has organised gender trainings, no notable changes were yet noticed at the ground level. However, we noticed that women actively participate in Community associations and some women were elected as presidents of these associations.

Relation between the Health Centre and associations

The relationship of health centers and Community based associations has become more cordial and professional. Professional meetings and supervisions are more regular. The Community volunteers continues health activities in the community by sensitising and visiting sick people at home, and refer sick patients to health facilities before the disease worsens.

Sustainability

The head of Health Centers are committed to ensure that most of the current activities be maintained even after the end of the CSP Concern project. However, they are worried that delivery kits, mosquito nets, training courses and FARN will be difficult to maintain because of the limited resources at their disposal at the health center level. They suggested having transitional funds that would help the Health centers in maintaining some of these activities.

2. District Management Health Team (DMHT)

A focused group discussion was held with the district management health team (DMHT) of Gisagara district, in order to have their opinion on the management of the health services, their relation with partners and the way they intend to sustain their activities in the district.

Management

Thanks to the support of the Concern project, the management of the health services has improved a lot. Service meetings are more regular and held at least once a week. All members of the DMHT actively participate in these meetings, namely the hospital director, the Administrator, the Supervisors, the Accountant, the Secretary of the District, and the Manager of the Pharmacy. The meetings proceed according to a well defined agenda and the reports are presented and discussed in order to share the research of solutions to the existing problems. It also should be noted that the whole CSP project Team, together with as well as activists regularly participate in meetings with the DMHT and head of health centers.

Each position has a job description, with clear and well defined roles and responsibilities. The activity descriptions of each position were done by the district director in collaboration with all DMHT staff.

Supervisions are planned on a monthly basis and re-examined each week. Field visits allow the DMHT to directly observe activities of the Health Centers, to discuss and find solutions to the problems that are facing the health center staff. The performance evaluation system was established for all DMHT staff. Each staff knows his/her obligations and his/her responsibilities. The performance bonus is based on pre-established indicators and when the performance target is not reached, financial penalties are applied.

Decisions are made in the DMHT meeting, on proposal of the person in charge of the activity. This depends on the importance of the decision. Major decisions are made by

the team. Some decisions are made by the district director or the Administrator in case of emergency.

There is an annual written activity plan, except for the year 2006, due to the territorial changes in terms of demarcation.

Based on the activities to be carried out, the DMHT prepares an annual **plan**, with an implementation plan and budget. This plan is done in collaboration with Concern project team, the Head of health centers, and Health Center representatives, such as priests, nuns and pastors. A self-evaluation is organised each quarter, to assess the progress that has been made.

Several reports are compiled by the DMHT at various intervals. There reports that are made each month (SIS, EPI, FP), or each quarter (PNLIT). At the end of each quarter, a report is submitted to the head of the District in charge of health, Gender and Social Affairs. There is no specific time report for the Ministry of Health.

The Head of Health Centers share and discuss the monthly reports with the DMHT, during the monthly meetings.

Gender

The CSP project organised training in regard of gender issues for all health personnel of the health centers and the District team. The district has a policy that prohibits sex discrimination at work and staff recruitment and promotion is solely based on merit. Generally, in the Health facility there more women than men (for example, there are 5 women on a total of 8 heads of health centers).

Relation with partners

DMHT organises regular meetings (each month) with the provincial health authorities, but also at the central level of the Ministry of health. Several vertical programs and projects regularly meet with the DMHT of Gisagara district in order to evaluate the activities, but also to inform the DMHT of new directives and approaches recommended by the Ministry of Health.

CSP Project helped creating and training Health Committees as well as health mutual committees. Concern Activists are involved in the activity planning with the health center staff and help sensitising the population to subscribe to the health mutual. The CSP project helped to create the District Management Committee, but it is still not yet now functional. The CSP Project helped the District in particular with regard to:

- *Supervision:* Concern availed a vehicle for supervision twice a week. Concern project also helped providing drugs from Kigali. Thanks to that help, no vaccines or drugs went out-of-stock.
- *Immunization campaign:* Concern helped in providing a permanent vehicle during the immunization campaign (Vitamin A, Mebendazole, and Meningitis).
- *Transport:* Each Concern activist has a motor bike and whenever urgent need for transport arose at the Health Center level, the Concern activist was available to help. The CSP project granted a new ambulance to the District. CSP also availed motor bikes which were used during supervisions.
- *Training:* Several trainings were conducted and financed by the CSP project in several fields: Malaria, Nutrition, HIV/AIDS, Communication for a behaviour change, Family planning, antenatal care etc.

All this support has been very useful to the District. The District played a crucial role in the improvement of the quality of health services by regular monthly supervision activities at least once a month and the CSP project helped in the organising and facilitating these supervisions.

Sustainability

At the end of the CSP project, the DMHT envisages continuing most of the current activities, thanks to the following reasons:

- The availability of a vehicle offered by the government and which will be able to help in organising supervision

- Several people from the health staff and volunteers have already been trained, therefore, there will be a limited need for further trainings; and for future trainings government and other projects support is assured
- Home based malaria treatment will be financed by the MOH (Malaria program)
- VCT activities are already financed by the Global Fund project

Achievements, challenges and suggested solutions

Patients' transportation and health services supervision are among the key achievements accomplished by CSP Concern project since its beginning, which is now properly done thanks to the ambulance offered by the CSP project. The remaining constraints are related to the staff motivation and the lack of communication mean between Health facilities. In the future, the improvement can be focused on establishing of communication network between health facilities and establishing a contractual approach.

Technical support of the CSP Concern project

The CSP Concern project brought a technical support in several fields, the most important ones being:

1. *HIV/AIDS*: The CSP project supported two VCT services (Kansi and Kibilizi HC) at the beginning of their activities, by providing all the necessary material, but by now the Global Fund project has taken over its full financing.
2. *Maternal and Child health (MCH)*: the CSP Project organised training courses for TBAs, with emphasis of transferring pregnant women to health centres. It also trained the health personnel as regards family planning and antenatal care. CSP gave delivery kits which helped women a lot to prepare for childbirth. Efforts are made to continue the provision of these delivery kits, but the problem related to its high cost need to be resolved.
3. *Nutrition*: Malnutrition remains the major health problem in the District. The CSP Project implemented the Training and Nutritional Rehabilitation Center (FARN) which helps the community to deal with malnutrition issues. It is an approach to be recommended to other communities, for it is an efficient way of encouraging the community to fight against malnutrition.

4. *Malaria*: The home based malaria treatment (HBM) is one of the successful strategies at the level of District, since the results are remarkable and it is well accepted by the community. The CSP Project supported the HBM together with the support from the Minisanté (PNLIT). In collaboration with the PNILP, it is envisaged to implement HBM activities in all Gisagara sectors. In order to continue the mosquito nets distribution, a contact has been established with PSI which will continue to help the community health workers to provide mosquito nets to the population through sales with small benefit.

3. Community based associations

Focus group discussions were held with each of the 12 associations (4 CHW associations, 4 PLWHA associations and 4 TBA associations) on the several topics, and particularly concerning the activities and achievements made, the relation between the Health facilities and the community, about gender issues, and the issues related to the sustainability of activities after the end of the CSP Concern project.

Description of Community Based associations

The general and common goal of Community based health associations is to promote public health at the community level and also to improve the social and economic development of its members. As shown in table 27 below, most of the associations which we met were established between 2002 and 2004; the average number of members by association amounts to fifty people, ranging from 17 to 120 members. All associations are recognised by the administrative district and have legal representatives. The sources of income are primarily based on the members' contributions and all of them have bank accounts.

Table 27: Community based associations

| Name | Start date | Representative | Members | Source of income | Category |
|---------------------------------------|------------|----------------|---------|------------------------------------|----------|
| Urumuli rw'abaturage (Kirarambogo HC) | 2004 | 10 | 17 | members and Concern Contribution | CHW |
| Duharanire ubuzima bwiza (HC) | 2002 | 5 | 22 | Members and MINISANTE contribution | CHW |
| Turwanye Sida (Kibayi HC) | 2002 | 4 | 23 | Members contribution | CHW |
| Twite ku buzima (Kigembe HC) | 2002 | 8 | 33 | Members and MINISANTE contribution | CHW |
| Abatanyurwa (Kansi HC) | 2002 | 8 | 120 | members and Concern Contribution | PLWHA |
| Abashyizehamwe (Kibilizi HC) | 2004 | 4 | 46 | Members contribution | PLWHA |
| Hora munyarwanda (Mugobwa HC) | 2001 | 6 | 50 | members and Concern Contribution | PLWHA |

| | | | | | |
|-----------------------------------|------|---|----|----------------------------------|-------|
| Akabando ki minsi (Kigembe HC) | 2004 | 5 | 47 | Members contribution | PLWHA |
| Abatabaranumwete (Kirarambogo HC) | 2002 | 4 | 30 | Members and Concern Contribution | TBA |
| Abagirimpuhwe (Gikore HC) | 2003 | 3 | 32 | Members and Concern Contribution | TBA |
| Abatabazi (Mugobwa HC) | 2003 | 5 | 38 | Members and Concern Contribution | TBA |
| Abakorerabushake (Kibilizi HC) | 2003 | 3 | 21 | Members contribution | TBA |

Activities

The main activities of Community health worker associations aim at sensitising the population to support the Ministry of health policy and participate in various programs set up by the health centre such as: national immunization campaign, distribution of mosquito nets and anti-malaria drugs, family planning activities, prevention and voluntary HIV testing, the fight against malnutrition, and the promotion of hygiene.

The associations of People living with HIV/AIDS do a lot of anti-stigmatisation campaigns and educate the population by making public testimonies about HIV. The members help patients at home to do the housework, wash their clothes, cook their food, and accompany them to the health centre when they are very ill.

The traditional birth attendant associations do help mothers and their children by visiting women during pregnancy and after childbirth. They sensitise women for antenatal consultation and to deliver at the health facility, and also when necessary do help in delivery and or transfer them to the Health center.

The CSP Concern Project organised several training courses in favour of community based associations. There were training courses on tuberculosis, nutrition, and health mutual; on how to live positively with HIV/AIDS and also on reproductive health which were very helpful to community volunteers. The members of community associations are

now able to recognise several health conditions and particularly: children with growth and nutrition problems, malaria signs and respiratory diseases, and pregnancy complications. And they can now advise the population with regard to: children growth, , HIV infection transmission means, HIV voluntary testing, malaria prevention and treatment, preparing healthy food, and advising pregnant women.

The most recent referred cases (last 3 months) by community volunteers to health facilities were patients with malaria, persistent cough, persistent diarrhoea, and patients suffering from tuberculosis, children who did not respect their vaccine calendar, and abortions. All these cases were transferred to the nearest health centre because of its proximity to the population of community association.

The most important changes brought by the CSP concern project, which have been useful to the associations, consist mainly in trainings conducted that help them to acquire new scientific knowledge and prevention methods against the most current diseases in their community, and also the reinforcement of team spirit and help among members. The traditional birth attendants do not perform delivery at home any longer, except in emergency cases.

Motivation

The motivation of community volunteers in joining an association is mainly due to the desire to help others, and also for personnel gains that the association provides to its members, especially with regard to acquiring new scientific knowledge but also credits granted to members, and an easy access to ARV drugs for PLWHA.

Community associations held several and regular meetings, and generally on a monthly basis together with the health center staff. These meetings were useful since they allowed people to establish monthly programs and tackle health problems encountered at the community level. During these meetings, HIV/AIDS issues are almost always mentioned and several topics were usually discussed such as: HIV prevention, HIV testing, and sensitisation of those who tested positive to join the associations.

The problems that were encountered during these meetings are absenteeism, which sometimes leads to the cancellation of the meeting when the quorum is not reached.

Relation with the Health Facilities

Each association has a special day to meet with the Health Centre which is usually attended by the head of the health center, and when he is not available, he is represented by a member of his team. The relationship with the Health Center has become more cordial and many changes were noticed, such as referral of patients from the community to the health facility: in the past, a patient transferred by a community volunteer used to pay cash up front before getting treatment but currently a referral note of the community volunteer is enough to get treatment. The Concern project team helped a lot in the improvement of this relationship, by serving as intermediary between the health centre and the associations.

Issues that need to be improved are the motivation (allowances and other incentives) and the lack of necessary material and equipment of community volunteers in order to allow them to achieve their goals.

Programs that were conducted by CSP Concern project and health centre towards associations were very beneficial to community associations especially the trainings which allowed community volunteers to acquire new knowledge on epidemic diseases, the creation of small income generating projects, a support for good financial management of grants received, and the development of internal cohesion among members of the association.

Relationship to the community

At Community level, association members visit patients at home; they also organise health training courses on hygiene, prevention against common diseases and on health mutual. They distribute mosquito nets, anti-malaria and anti-tuberculosis drugs at home, and give public testimonies on HIV/AIDS.

Community based associations are well accepted by the population because the volunteers are rendering many services which are generally free of charge, and also because volunteers are members and are part of the community. There are few formal meetings with other associations, except for few events at national level such as the international day against HIV/AIDS.

Achievements

Associations organised very few co-operative activities for their members except granting few and small credits for income generating activities and this is primarily due to the lack of financial means and materials because the association' main source of income is from meagre members' contribution and sometimes from donor' small grants. Nevertheless, associations have managed to organise notable activities such as: reducing severe malnutrition cases at community level, improving the population knowledge on the common diseases such as malaria and HIV/AIDS, reducing the stigmatisation of People Living with HIV, increasing enrolment into health mutual, and reducing the rate of deliveries at home and consequently reducing the rate of mothers' death. These achievements are primarily due to the training courses received from CSP Concern project, the support from health centre and from local administration authorities, and the members' personal commitment.

Gender

PLWHA members had received trainings on gender issues from CSP Concern project especially on how to take decisions as a couple with regard to sex intercourse and how couples facing difficulties should live together. On the other hand, community health workers and TBAs declared that they had not received any training on gender issues from CSP project.

Community volunteers interviewed stated that they learned a lot of things since they joined their association, as for instance, the respect and unity among association members, management and savings skills. PLWHA especially learned how to live positively with HIV/AIDS, to have a good nutrition, and to protect and avoid infecting

others. TBAs learned how to recognize danger signs of pregnancy and to transfer pregnant women to health center ahead of time and avoid practicing dangerous traditional treatment.

Community volunteers helped their association by paying their contributions regularly, and in caring out several activities of the association activities.

Sustainability issues

After the end of the CSP Concern project, members of the community associations stated that they were willing to continue the activities initiated by the CSP project. They can continue carrying out these activities because they had already acquired the necessary technical skills and also from the income from small income generating projects that they intend to start in the near future in order to enable them to become financially self-sufficient. TBAs, however, demanded to be helped to gain the same status and benefits as community health workers (incentives and other materials such as radios and bicycles) to enable them to perform efficiently their duties. TBAs also stated that they have difficulties to find people to train because the profession has become less attractive to young people.

People living with HIV/AIDS gave several public testimonies, especially during official ceremonies such as the international day against HIV/AIDS and during local elections. These testimonies helped in reducing stigmatisation and in encouraging people to be tested and also encouraged people who were tested HIV positive to enrol into the PLWHA association. In spite of the limitation of accessing anti-retroviral treatments, PLWHAs intend to continue and even intensify these public testimonies in the future.

V. DISCUSSION

The results of the analysis show that the health infrastructures of Gisagara district are old, the majority of the health centers were built in the 1970s and some of them need urgent rehabilitation in order to maintain their status. The number of beds is sufficient and the population served by health center is in the recommended range of the Ministry of health, which are about 20,000 inhabitants per health centre catchment's area.

The number of health personnel by health center amounts to 17 people and this number seems to be sufficient but the number of qualified health professionals such as A1 nurses are still low while the majority of the staff is rather constituted by a lesser qualified staff such A3 and A4 nurses and support staff.

There are sufficient community volunteers in Gisagara district (about 1 300 volunteers) and their number has significantly increased over these last years, undoubtedly due to the support from CSP Concern project.

All health centers have now a functional health committee and the management of health services has satisfactory improved. Some health centers do provide subsidies and discounted tariffs for the very poor people but the exact amount is not well accounted and known. Health centers will not be able alone, at long run, to help all the very poor people and there is a need for targeting the free enrolment of the very poor people into health mutual which is the best alternative solution.

The number of the curative and preventive consultations in all health centers sharply increased (almost three times) during these last 5 years. All health services are functional, except for some health centers for which VCT and PMTCT services are not yet in place. This gap is in the process of being filled thanks to the support of the Global Fund project. The post-natal care service is integrated in the routine consultations and

not a separated unit; this makes difficult to obtain specific data about the post natal care utilization, but still it seems that post natal care consultations are not frequently done.

Efforts have been made to organise health staff training, in the several priority fields, namely malaria, HIV/AIDS, ARI (Acute respiratory infections) and nutrition. Most of the trainings were organised during the last 2 years of the project. The supervisions of the health personnel and Community volunteers have also been regular and much more were conducted during the years 2004-2005. Information concerning the trainings and supervisions made especially in the first years of the project was not always available, because not recorded.

Community volunteers referred more and more patients to health facilities especially complicated malaria and delivery cases, while the counter-referrals were almost non-existent, which seems to be a common practice country wide.

Capacity and quality assessment of VCT services reveals that almost all health centers in Gisagara district FOSA have an operational VCT service, except for in Kirarambogo health center, but the knowledge and experience of the VCT service staff is still not adequate. The majority of the VCT staff obtained low scores during the evaluation, thus advocating for further training and supervision.

Patients' perception of the quality of ANC and children consultation services is very good, however there are some poor quality issues particularly those related to the long time spent at the health facility (between 4-8 hours), the high cost of the drugs and the lack of patients' follow-up. Some of these shortcomings can undoubtedly be improved without additional costs to the health center, and the establishment of good quality assurance strategy can be enough to tackle these issues as recommended by the Ministry of Health.

The clinical practice of VCT and children Consultation services staff was evaluated and it was observed that overall performance was just adequate. We noticed that several key

practices were not systematically performed such as: taking pulse, or give advice for the further follow-up of the patient. Additional trainings and close supervision are necessary. The level of knowledge of some of the patients, during the exit interview, concerning the danger signs of pregnancy or illnesses of sick child was not satisfactory; most of the patients could not cite major danger signs spontaneously.

The heads of centers and the DMHT acknowledged that they have noticed positive changes since CSP Concern Project started to work in the Gisagara district, especially in the 4 major intervention areas: malaria, Nutrition, HIV/AIDS, and maternal and child. The management as well as planning and supervisions of health services have improved and the relationship and meetings with other stakeholders became more regular. However, there are still challenges especially in regard to the lack of access of health services by the poorest people and the slow behaviour change of the population particularly with regard to HIV/AIDS and nutrition. Development of community health insurance schemes and the participation of local authorities, as well as the reinforcement of public awareness campaigns remain among the strategies to be maintained and strengthened.

Community volunteers have organized themselves in associations; they all are unanimous to state that CSP Concern project contributed much in setting up these associations and also helped them to fulfil their duties in the community. Though their associations are still young, the volunteers have been able to carry out noticeable achievements and had positive impacts on their community. Most of volunteers are now able to recognise major signs of the most common diseases in their community and are since referring many cases to the health facilities. The relationship between the community and the health facilities has become more cordial and meetings are more regular.

After the end of the CSP Concern project, heads of health centers, the district management health team and members of the community associations in Gisagara district stated that they are all committed to continue the activities initiated by the CSP project. This will be possible thanks to the technical skills they acquired from the CSP project and

also through the committed support from the national and local authorities. The creation of income generating projects for the volunteers is a way to enable them to become financially independent.

VI. RECOMMENDATIONS AND CONCLUSION

At the end of this study and in regard to the obtained results and constraints noticed, several recommendations can be made:

- Ensure infrastructure renovation of health centers, especially the very old ones, in order to maintain their status
- Recruit additional health personnel, especially qualified A1 and A2 nurses in order to improve the quality and performance of the health services.
- Establish a quality assurance team in all health facilities in order to guarantee a better quality of services to the community.
- Establish VCT and PMTCT services in all health centers in collaboration with the Ministry of Health
- Establish a performance monitoring system and motivation of the health personnel, as it is done in other health (contractual approach).
- Continue to encourage enrolment of the population into health mutual and envisage subsidies for the poorest.
- Reinforce community based associations and envisage establishing a follow-up and evaluation system, and also a contractual approach.

In **conclusion**, the evaluation of the health facility and Community based associations capacity operating in Gisagara district showed that the management and performance of health services have significantly increased since the beginning of the CSP Concern project. However, the quality of the services provided is not yet very satisfactory; specific efforts are necessary to reach the desired level. Although all the health players of the district (heads of health centers, DMHT, and community volunteers) are committed to continue the activities initiated by the CSP project, the sustainability issues remain a challenge which will require, in the short term, transitional support strategies.

VII. APPENDIXES

1. Questionnaires

- 1. Health Facility Questionnaire**
- 2. VCT Questionnaire**
- 3. VCT and children consultation services Questionnaire**
- 4. Community associations and DMHT Questionnaire**

Part 1 : Questionnaire for Health Facility

EVALUATION OF HEALTH FACILITY IN KIBILIZI DISTRICT

NAME OF INTERVIEWER _____

CODE: _____

DATE OF INTERVIEW _____

DAY: _____

MONTH: _____

YEAR: _____

TIME INTERVIEW BEGAN: _____

TIME INTERVIEW COMPLETED: _____

CONSENT TO INTERVIEW

INTERVIEWER: Hello: My name is _____. I am from _____.

We would like to know about the types of services you provide in this facility so that we can seek ways to improve the quality care. Any information you give us will remain strictly confidential. Whether or not you participate in this interview, there will be no negative effect on the facility or respondent. No information will be linked to you or this facility. You may refuse to reply to certain questions, or end this interview at any time.

Do you agree to participate in this interview?

YES, the respondent accepts.....1

NO, the respondent refuses2

| →STOP

NAME OF RESPONDENT _____

POSITION OF RESPONDENT _____

TITULAIRE.....1

SUPERVISOR.....2

ADMINISTRATOR.....3

NURSE.....4

OTHER (SPECIFY _____).....5

COMMENTS:

| NAME | SUPERVISED BY | | EVALUATED BY | | ENTERED BY | |
|------|---------------|-------|--------------|-------|------------|-------|
| | DAY | MONTH | DAY | MONTH | DAY | MONTH |
| DATE | DAY | MONTH | DAY | MONTH | DAY | MONTH |

SURVEY QUESTIONNAIRE

I. General Information

| N° | Variables/ Questions | Responses | Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------------|---|--|--------------------------|------|--------|-------|----|--|-------|-----|--|-------|-----|--|-------------------------|----|--|-------------------------|----|--|-------------------|----|--|-------------------|-----|--|----------------|----|--|---------------------------|--|--|-------|----|--|-------|----|--|--|
| Q1 | Name of Health Facility (HF) | | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q2 | Location of HF | Sector _____ Cell : _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q3 | Category of HF | 1. Public 2. Agrée | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q4 | In what year did this facility open? | Month _____ Year _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q5 | Approximately how many people does this facility serve? | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q6 | Total number of beds of the HF (in good state) | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q7 | Number of health personnel | <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Male</th> <th style="width: 20%; text-align: center;">Female</th> </tr> </thead> <tbody> <tr> <td>1. A1</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td>2. A2</td> <td style="text-align: center;">n =</td> <td></td> </tr> <tr> <td>3. A3</td> <td style="text-align: center;">n =</td> <td></td> </tr> <tr> <td>4. Auxiliaires de Santé</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td>5. Assistantes sociales</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td>6. Nutritionniste</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td>7. Lab Technicien</td> <td style="text-align: center;">n =</td> <td></td> </tr> <tr> <td>8. Travailleur</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td colspan="3">99. Others (give details)</td> </tr> <tr> <td>_____</td> <td style="text-align: center;">n=</td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">n=</td> <td></td> </tr> </tbody> </table> | | Male | Female | 1. A1 | n= | | 2. A2 | n = | | 3. A3 | n = | | 4. Auxiliaires de Santé | n= | | 5. Assistantes sociales | n= | | 6. Nutritionniste | n= | | 7. Lab Technicien | n = | | 8. Travailleur | n= | | 99. Others (give details) | | | _____ | n= | | _____ | n= | | |
| | Male | Female | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. A1 | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. A2 | n = | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. A3 | n = | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Auxiliaires de Santé | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Assistantes sociales | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Nutritionniste | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Lab Technicien | n = | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Travailleur | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 99. Others (give details) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | n= | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | |
|------------|---|--|---|------------------------------|--|----------|------------------------|--|
| Q8 | Number of community volunteers | <p>Traditional Birth Attendants n=</p> <p>Health Animators n=</p> <p>Drug Distributors (malaria) n=</p> <p>PLWHA n=</p> <p>Others (specify): _____ n =</p> <p>_____ n=</p> | Male | Female | | | | |
| Q9 | Does this health facility have a Health management committee (COSA) with members outside of the facility? | 1. yes | 2. no | | | | | |
| Q10 | How often does this committee usually meet? | Weekly | Twice per year | Monthly | Every 3 months | Annually | Others (specify) _____ | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Q11 | Is there a system of exemption for the poor or those who can not afford to pay? | 1. oui | 2. non | | | | | |
| Q12 | What is the type of these exemptions? | Total free service | Reduction in cost of service | Provision of in kind service | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |
| Q13 | Services, Utilization | Does this facility provide this service? | For each service can you please record the total number of patients listed in the register for the last 6 months, starting Dec 2005 to May 2006 | | | | | |
| | | Malaria treatment for children | 1. oui | 2. non | <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | Child growth monitoring | 1. oui | 2. non | <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | Prenatal care | 1. oui | 2. non | <input type="checkbox"/> <input type="checkbox"/> | | | |
| | | Post natal care (mother) | 1. oui | 2. non | <input type="checkbox"/> <input type="checkbox"/> | | | |

| | | | |
|------------|---|--|--|
| | | Facility based delivery - Normal 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> - Assisted (forceps, vacuum) 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> Blood transfusion 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> STI services -Etiologic diagnosis 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> -Syndromic approach 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> -Treatment 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> -Counselling 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS services -VCT 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> -ART 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> -PMTCT 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> 24 –hour emergency care 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> outpatient clinic 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> Inpatient stay 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> Referral services (ambulance) 1. oui 2. non <input type="checkbox"/> <input type="checkbox"/> | |
| Q14 | a. Number of training received during years 2001-2005 | 2001 2002 2003 2004 2005 Deliveries : CPN : VCT PMTCT Nutrition CC Diarrhea Malaria STI post natal cons Mutuelle Family Planning Gender HIV/ SIDA IEC Respiratory diseases Other Autres (give details) _____ _____ _____ | |
| | b. Number of people trained per year 2001-2005 | 2001 2002 2003 2004 2005 | |

| Q15 | Number of supervisions received per year 2001-2005 | 2001 | 2002 | 2003 | 2004 | 2005 | |
|-----|--|--|------|------|------|------|--|
| Q16 | Types et number of supervisions received by health personnel of the HF from Dec.2005 - May 2006 | <ul style="list-style-type: none"> - Deliveries n= - Prenatal cons. n= - Immunization n= - AIDS n= - Nutrition n= - Curative Consultations <ul style="list-style-type: none"> Malaria n= STI n= Diarrhea n= | | | | | |
| Q17 | Type et number of supervisions done by health personnel of HF from Dec.05 - May 2006. (see supervision book) | <ul style="list-style-type: none"> - Animateurs de santé n= - TBA n= - Distributors of anti malaria n= - Mamans lumières n= - Comités de mutuelle n= - Volontaires n= - Others n= | | | | | |
| Q18 | Number of transfers and contre références from Dec.05 - may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q19 | Deliveries from Dec.05 -may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q20 | Malnutrition from Dec.05 - may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q21 | Respiratory Infections from Dec.05 -may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q22 | Malaria from Dec.05- may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q23 | Diarrhea diseases from Dec.05 - may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |
| Q24 | New born from Dec.05 -may 2006 | <ul style="list-style-type: none"> Referred by AS, Volontaires, TBA n= Transfers to district hospital n= Contre référence n= | | | | | |

II. General Impressions

A. What positive changes have you noticed since concern started working with you ?
(*malaria, Nutrition, AIDS/HIV, Maternal and child health*)

Malaria : (HBM, ITNs)

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Nutrition : (FARN, PNBC).....

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Maternal and child health : (TBAs)

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HIV/AIDS: (PMCTC etc.

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Others (give details) : (Mutuelle etc.)

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B. Which have been the most helpful or made the most difference? Why?

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C. Give your opinion on health services offered in your health facility (strengths, weaknesses, and suggestions for improvements).

What was the big challenge and why ?.....

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What constraints have encountered that Concern help to solve ?

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What are the constraints that were present before Concern started but that are still not solved ?.....

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Solutions proposed?

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D. How did the CSP project activities changed your attitude towards men's and women's roles and responsibilities?What made the most difference.

E. What and how is the working relationship between the health centre and the community volunteers

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F. The project is ending in September, do you think the CSP activities implemented in your health centre will continue after that? Why? If NO, what can be done to make it sustainable?

G. Any other comments that you wish to make?

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Thank you for your collaboration and your help.

HEALTH FACILITY ASSESSMENT

PART 2 – Health staff skills’ assessment

Name of the health center: _____

VCT SERVICES - Interviewer administered VCT protocol

1. Does this health facility provide voluntary counselling and testing for HIV?
YES..1
NO...2 (»next section)

2. Can you please identify a staff person present today who provides VCT?

NAME _____

The following questions should be directed to this person.

3. Can you please tell me your qualifications?

- a. Nurse A21
- b. Nurse A3 2
- c. Auxiliary staff, > 1 yr of training . . . 3
- d. Auxiliary staff, < 1 yr of training . . . 4
- e. Laboratory technician 5
- f. Counsellor6
- g. Other (SPECIFY _____) 7

4. In what year did you complete your studies? **YEAR:**

5. Have you received additional training since you graduated?

- YES..1**
NO...2 (»7)

Can you tell me, for each of the following areas, whether you received additional training and, if so, who organized this training??

- PMTCT
- ART
- VCT
- STI syndromic approach
- STI etiologic diagnosis
- STI (non-HIV) treatment
- STI (non-HIV) counselling
- OTHERS (_____)

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|---|
| 6. Did you receive training in [--]? YES..1 NO...2 (»NEXT) |
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| 6.a. By Whom Concern ...1 MOH/District...2 Caritas...3 Others...4 |
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We would like to understand the process by which you provide voluntary counseling and testing for an adult person who may be HIV positive. We would like to know about everything you do, beginning with the arrival of the patient and ending when the patient goes home. I shall describe a clinical case, and I will ask you a series of questions about activities that you would regularly do for such a case. Are you ready? Now I will read out the case (READ OUT 2 TIMES):

Mrs. Baribwira, a married woman of 32 years, came to this facility alone to find out more information about voluntary counseling and testing for HIV. She does not appear to be pregnant and has no symptoms of any opportunistic infections.

7. What questions do you ask Mrs. Baribwira about her medical and personal history?

FIRST LISTEN TO THE RESPONDENT. ANY QUESTION THAT HE OR SHE MENTIONS SHOULD BE MARKED WITH CODE 1. AFTER THE RESPONDENT IS FINISHED, FOR ANY QUESTION THAT HE OR SHE DOES NOT MENTION, ASK EXPLICITLY IF THIS QUESTION WOULD BE ASKED, AND CODE THE APPROPRIATE RESPONSE:

RESPONSE CODES:

MENTIONED WITHOUT PROMPTING....1

HAD TO PROMPT, ANSWERED YES....2

HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

- | | | |
|----|--|--------------------------|
| a. | Any current illnesses? | <input type="checkbox"/> |
| b. | Any current or previous STI? | <input type="checkbox"/> |
| c. | Understanding about how HIV is transmitted? | <input type="checkbox"/> |
| d. | Age at first sexual intercourse? | <input type="checkbox"/> |
| e. | Number of sexual partners in last 12 months? | <input type="checkbox"/> |
| f. | Had sex under the influence of drugs or alcohol? | <input type="checkbox"/> |
| g. | Condom use during last sexual encounter? | <input type="checkbox"/> |
| h. | Ever had unprotected sex? | <input type="checkbox"/> |
| i. | Has been tested for HIV before? | <input type="checkbox"/> |

- j. Other exposure to blood products?
- k. Existing knowledge about HIV testing?
- i. Recent pregnancy test?
- j. Partner's HIV status?
- k. Ex-refugee/returnee status?

l. autres:.....

8. Mrs. Baribwara states that she wants to be tested for HIV. What do you explain to her before she takes the test?

AGAIN, FIRST LET THE RESPONDENT ANSWER. AFTER HE OR SHE IS FINISHED, ASK EXPLICITLY ABOUT ANYTHING NOT MENTIONED BY THE RESPONDENT.

RESPONSE CODES:

MENTIONED WITHOUT PROMPTING....1

HAD TO PROMPT, ANSWERED YES....2

HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

- a. Meaning of HIV+, HIV-, and indeterminate results
- b. Meaning of the "window period"
- c. When the results will be ready
- d. How the results are given/post-counseling period
- e. Confidentiality of testing and results
- f. Cost of the test
- g. Voluntary nature of testing

- h. Referral and support services available
- i. Availability of ART
- l. PMTCT
- m. Husband to be tested with counselling
- n. Autres:.....

9. Mrs. Baribwara returns to the facility to obtain the results of the test. The test results are negative. How do you proceed with the patient's counselling?

AGAIN, FIRST LET THE RESPONDENT ANSWER. AFTER HE OR SHE IS FINISHED, ASK EXPLICITLY ABOUT ANYTHING NOT MENTIONED BY THE RESPONDENT.

RESPONSE CODES:
 MENTIONED WITHOUT PROMPTING....1
 HAD TO PROMPT, ANSWERED YES....2
 HAD TO PROMPT, ANSWERED NO.....3

READ OUT QUESTIONS ONLY IF THE RESPONDENT DID NOT MENTION THEM.

- a. Ask her how she feels since taking the test
- b. Ask her is she is ready for the results
- c. Discuss the meaning of the results
- d. Discuss repeating the test if exposed to HIV w/in 3 months
- e. Discuss reducing risk/ preventing exposure to HIV in future
- f. Discuss condom use
- g. Discuss partner's HIV status
- h. Discuss sharing the results with partner
- i. Encourage partner to get HIV test

j. Provide condoms

K. Others:

THIS IS THE END OF THE VCT CASE SCENARIO.

Thank you for your participation.

2. Survey Schedule

HF and Association Kibilizi Evaluation: Field visits: Timetable: 12-16 June 2006

| Hours | Monday | Tuesday | Wed | Thursday | Friday |
|------------------|-----------------------|-----------------------|--------------------------------------|--|------------------|
| From 8a.m. to 12 | Kirarambogo HC (T1) | Gikore HC (T1) | DMHT-Kibilizi (T1) | Kansi HC (T1) | Kibilizi HC (T1) |
| From 8 to 12 | Kigembe HC (T2) | Mugombwa HC (T2) | Kibayi HC (T2) PLWHA - Kansi (T1) | TBA-Kibilizi (T2) PLWHA-Kibilizi (T2) | |
| From 2 to 3 p.m. | CHW -Kirarambogo (T1) | CHW -Gikore (T1) | CHW-Kibay (T2) | | |
| From 3 to 4 p.m. | TBA-Kirarambogo (T1) | TBA-Gikore (T1) | | | |
| From 2 to 3 p.m. | PLWHA Kigembe (T2) | PLWHA - Mugombwa (T2) | | | |
| From 3 to 4 p.m. | CHW-Kigembe (T2) | TBA-Mugombwa (T2) | | | |

3. Selection Criteria for Community based associations

LIST OF HEALTH FACILITIES /INSTITUTIONS/ASSOCIATIONS FOR THE CONCERN RWANDA QUALITATIVE SURVEYS

1. HEALTH FACILITIES (7) :

Kibilizi HC
Kansi HC
Mugombwa HC
Kigembe HC
Kibayi HC
Gikore HC
Kirarambogo HC

2. PLHWA Associations (4) in:

Kansi – strong association group
Kibilizi – medium group
Mugombwa – medium group
Kigembe – nascent group

3. Health Organisers (CHW associations (4)

Kibayi – attached to govt
Kigembe – attached to govt
Gikore – semi-private/private (Caritas)
Kirarambogo – semi-private/private (Caritas)

4. TBA association (4)

Kibilizi – training in 2003
Mugombwa – training in 2003
Gikore – training in 2006 (strong TBA assoc)
Kirarambogo – training in 2006 (strong TBA assoc)

5. Institution (1)

Kibilizi Health District Team

CSP evaluation steps

A. Evaluation of PLH associations. Some criteria have been identified in order to qualify an association as being strong, medium, nascent or weak.

These criteria are the following:

1. To have an income generating association (IGA)
3. Total Number of members
4. To have an official approval
5. Duration of the association
6. To have a bank account
7. Rate of Meetings
8. Testimony of People Living with HIV

This table gives more explanation on the choice of associations based on the above mentioned criteria :

| | Mugombwa | Gikore | Kibilizi | Kansi | Kibayi | Kigembe | Kirarambogo |
|--------------------|----------|---------|----------|---------|---------|---------|-------------|
| IGA | YES | YES | YES | YES | ? | NO | YES |
| Number of members | 70 | 42 | 46 | 120 | 32 | 46 | 38 |
| Status | YES | DRAFT | YES | YES | ? | YES | YES |
| Approval | YES | ? | YES | YES | ? | YES | YES |
| Duration | 5 YEARS | 3 YEARS | 2 YEARS | 5 YEARS | ? | 1 YEAR | 4 YEARS |
| Bank Account | YES | YES | YES | YES | ? | NO | NO |
| Meetings frequency | Weekly | Weekly | Weekly | Weekly | Monthly | Weekly | Weekly |
| Testimony | YES | YES | RARE | YES | RARE | YES | YES |

Thus the PLH association of the Kansi Health Centre has been evaluated as strong, Mugombwa and Kibilizi as medium and Kigembe as nascent.

B As for the evaluation of health Organisers associations, it has been done according to the same process; the Kigembe and Kibayi associations have been evaluated as strong among the public health centres. Among the approved health centres, strong Health Organizers associations are found in the health centre of Gikore and Kirarambogo.

C. Evaluation of traditional midwives associations

The team has chosen 2 associations which had benefited from training courses in 2003, namely the traditional midwives of Kibilizi and Mugombwa. Among the remaining associations trained in 2006, we have evaluated Gikore and Kirarambogo as strong, once again according to the criteria chosen for associations of PLH.