ACCESS Rwanda ANNUAL REPORT OCT, 08 – SEPT, 09

BACKGROUND

Since 2006, Jhpiego through its ACCESS program /Rwanda has been working in partnership with the Ministry of Health (MOH), Twubakane and other central and bilateral partners in Rwanda to support USAID's Safe Birth Africa Initiative (SBAI) and malaria prevention and control targeting pregnant women. The ACCESS program's geographic coverage includes four districts: Gasabo, Kicukiro (Kigali), Nyamagabe and Nyaruguru (South), five district hospitals, 38 health centers and approximately 2000 villages.

In support of SBAI, ACCESS is providing technical assistance in the areas of policy development, service delivery, community involvement, and works with faith-based organizations and religious leaders, and monitoring and evaluation for maternal and newborn health. These program components are primarily focusing on the period from delivery to day three of life and include safe delivery care, active management of third stage of labor, essential newborn care, and emergency obstetric and newborn care. SBAI work in Rwanda is supporting existing programs in the delivery of life-saving interventions for mothers and newborns in low resource settings—especially in the poorest communities, where most of these deaths occur. ACCESS is providing assistance in guiding the MOH and other stakeholders to scale up interventions (and combinations of interventions) in Rwanda, and in integrating them into the country's maternal and child health systems and programs.

ACCESS is collaborating with the President's Malaria Initiative (PMI) and the MOH to scale up Rwanda's new malaria in pregnancy (MIP) policy, which promotes routine focused antenatal care (ANC), sleeping under an insecticide-treated net (ITN) and effective and prompt case management for the treatment of malaria. As with SBAI, ACCESS is working to strengthen skills of health care providers from hospitals and health centers as well as skills of community health workers (Agents de Santé Communautaire – ASM) as a key point of contact with mothers and their family members to prevent and control malaria in pregnancy. Since October 2008 ten (10) additional districts[1] have been

[1] Nyaruguru; Gasabo; Gakenke; Musanze; Nyabihu; Rubavu; Gatsibo; Nyamagabe; Kicukiro; Huye; Nyamasheke; Rulindo; Gicumbi and Rutsiro

selected in collaboration with the MOH in order to strengthen MIP activities at the district level, from health facilities to the community, using Agent de Santé Maternelle (ASM) as a key point of contact with mothers and their family members.

ACCESS/Jhpiego's Geographic & Technical Areas in Rwanda

ACTIVITIES PLANNED AND EXECUTED

INTRODUCTION

ACCESS has been steadily implementing our workplan for SBAI and PMI. We have also continued our collaboration at the national level with various stakeholders and have participated in relevant meetings. The activities reported below represent the progress achieved during the reporting period in collaboration with the MOH, PNILP, district authorities and partners.

I. SAFE BIRTH AFRICA INITIATIVE - SBAI

1- **Participation in the launch of the White Ribbon Alliance (WRA) Chapter in Rwanda**

The WRA chapter was launched on October 13th by the first lady of Rwanda and the Jhpiego/ACCESS, Country Director and WRA board member who gave a speech on behalf of the Global WRA. The contribution of Jhpiego to safe motherhood and especially to the WRA is very important not only through its programs like MNH and ACCESS, but also through the involvement of its staff that has played an important role at the global and national levels. Jhpiego through its staff has been instrumental in the process of establishing the WRA Chapter in Rwanda in collaboration with the MOH and its partners like UNFPA, DFID, USAID, World Bank, Imbuto Foundation, UNIFEM, and Civil Society. The next steps will be to continue to support to set a national structure to coordinate activities at country level.

2- **Attendance in the regional conference on PAC in Dakar**

- ACCESS supported the MNH coordinator's participation with the Rwanda team that attended the regional workshop on post abortion care (PAC) in Dakar, Senegal from 19 – 24 October 2008. This conference allowed the Rwanda team to build an action plan based on the lessons learned from the six countries whose experiences on PAC were presented. ACCESS will support the action plan which focuses on a situation analysis, advocacy and sensitization in order to integrate PAC into other activities in safe motherhood, since PAC can contribute to reducing maternal mortality by 37%.
- In September 09, ACCESS provided financial and technical support to conduct the formative supervision in PAC site in Rwanda (Ruli and Gitwe Hospitals)

3- **Participation in the national workshop on the maternal death audit**

In order to monitor the causes of maternal death, the MOH, in partnership with WHO and UNFPA, has initiated the maternal death audit at all levels. ACCESS attended and contributed to a workshop organized to harmonize tools and update key partners on the importance of the maternal death audit. ACCESS will be able to support subsequent training of providers.

4- **Standards-Based Management and Recognition (SBM-R) approach**

Building on our tradition of health care innovation, ACCESS/Jhpiego has pioneered a process designed to achieve meaningful improvements in health care. Over the last decade, we have developed and refined Standards-Based Management and Recognition (SBM-R), a practical management approach for improving the performance and quality of health services. It is a proactive approach, focusing not on problems but rather on the standardized level of performance and quality to be attained. Through the SBAI Project, this approach has been applied to five districts. The SBM-R steps include:

Step 1, consists of setting performance standards and has been accomplished during the past fiscal year. The goals were to define, in the clearest and most objective terms, the level of performance desired in a specific area of health service delivery (e.g. infection prevention and focused ANC/MIP). These performance standards, which must be based on scientific evidence, show providers and managers, in detail, not only what to do but also how to do it.

Step 2, the most important, involves implementing the standards, by putting them into practice in a streamlined, systematic way. Health managers and providers use standards to develop an assessment tool that they use at the facility level to identify performance gaps that should be reduced or eliminated. In the first quarter, a two-day refresher workshop on SBM-R was organized for 16 new providers from 6 hospitals who joined the standards-based management and recognition SBM-R teams at hospitals, replacing providers who had left. The workshop was necessary to orient the new providers to SBM-R before the teams continue next steps, which include a second assessment of skills against performance standards. The team has not only been updated on the concept of using SBM-R to improve the quality of services, but also trained on the use of the evaluation tool.

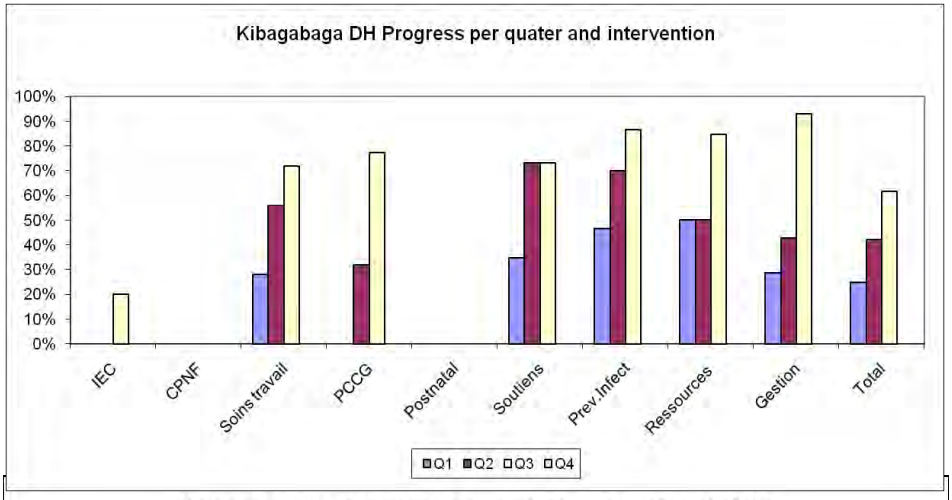
During the month of January 2009, 25 hospital supervisors from the six hospitals (MUHIMA, KIBAGABAGA, KANOMBE, NYANZA, KADUHA and KIGEME) implementing SBM-R, participated in a workshop to analyze the causes of gaps—lack of knowledge and skills, inadequate enabling

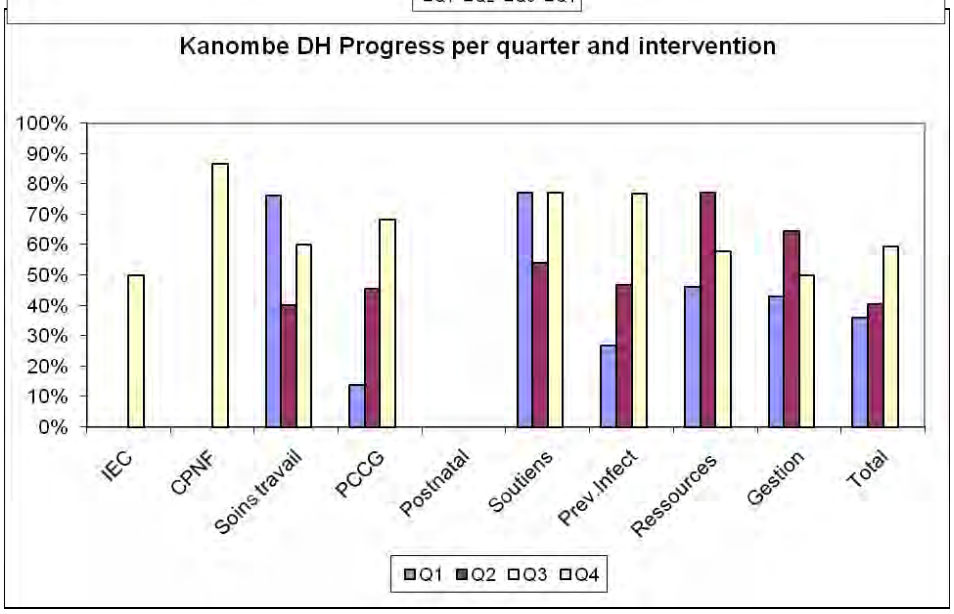
environment (including resources and policies), and/or lack of motivation—and developed action plans including appropriate interventions to close these gaps, which they took back to their hospitals to implement.

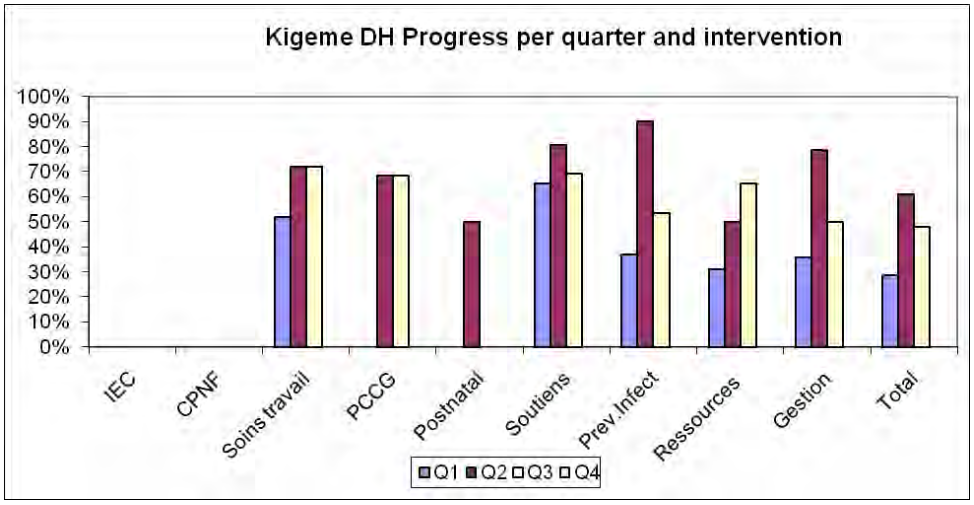
Step 3, will be a continual measurement of progress. A series of assessments –self, peer, internal and external assessments – guides the improvement process toward meeting standards, informs managerial decisions and reinforces the momentum for change. Through continual measurement, managers, providers and communities can monitor the process, assess the success of interventions, identify resistant gaps and make necessary adjustments to their plans. Measurement also gives managers and providers quantitative targets for achievement.
To increase the capacity of clinicians and health workers to provide MNH services, ACCESS followed up our SBM-R work in 6 hospitals: Muhima, Kibagabaga, Kanombe Military Hospital, Nyanza, Kaduha, Kigeme hospitals. Jhpiego evaluated if the action plans elaborated with stakeholders at the respective hospitals are resolving their main problems. In addition, the follow-up aimed to evaluate how the 6 hospitals continue to improve quality care and performance using EmONC standards.

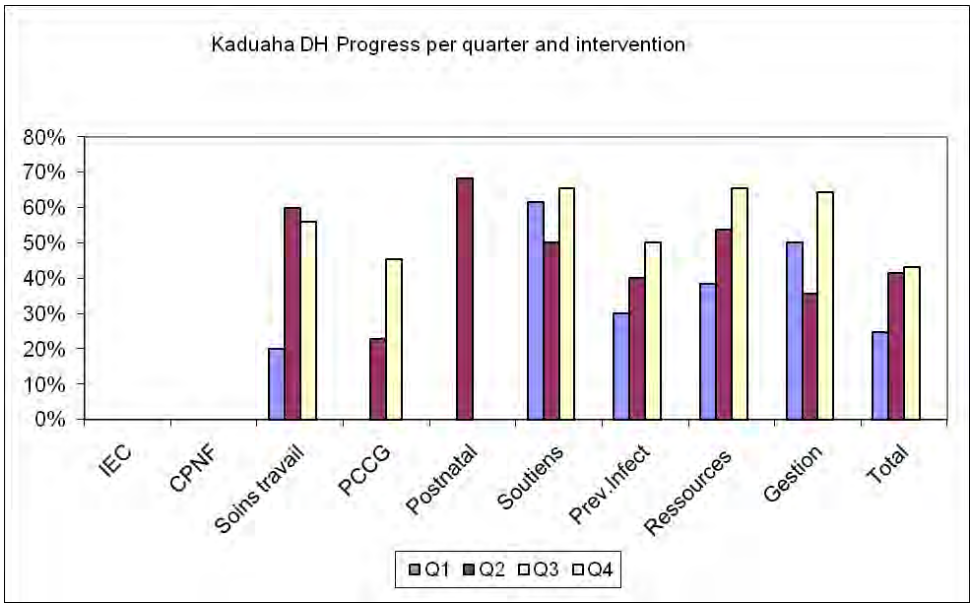
Observations from SBM-R findings show that the practice of IEC, ANC and postnatal care is weak in some district hospitals which means that providers need to be encouraged to integrate it into services provided. From this data, it seems as though there is a need for additional training and increased supervision in the areas of ANC, postnatal care and IEC.
ACCESS, also collected service statistics for facilities applying the SBM-R quality improvement process to delivery care services.

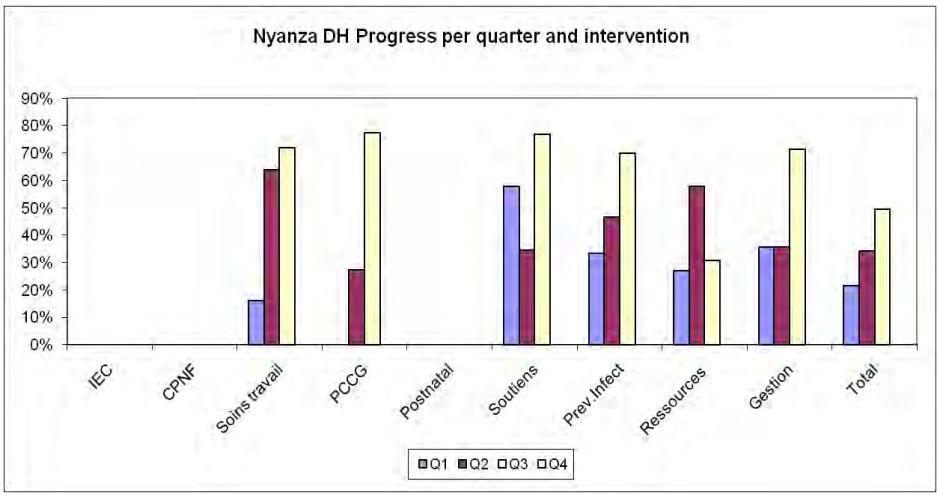
Finally, achievement of standards is rewarded through recognition mechanisms that should involve institutional authorities and the community. These mechanisms include timely and specific feedback, social recognition (commendations, trophies, diplomas, celebrations) and material recognition (monetary or in-kind rewards). The motivational element of SBM-R is critical to its success; because it helps health care workers see that they have something to gain from the process. Workers can take more control over their work, experience personal and professional growth and empowerment, and increase their self-confidence and sense of achievement when they meet their established performance goals. Performance-based financing can play an important role in strengthening this process by recognizing also the quality of work and the progress made. The following tables show the level of performance of each hospital based on the domain of intervention.

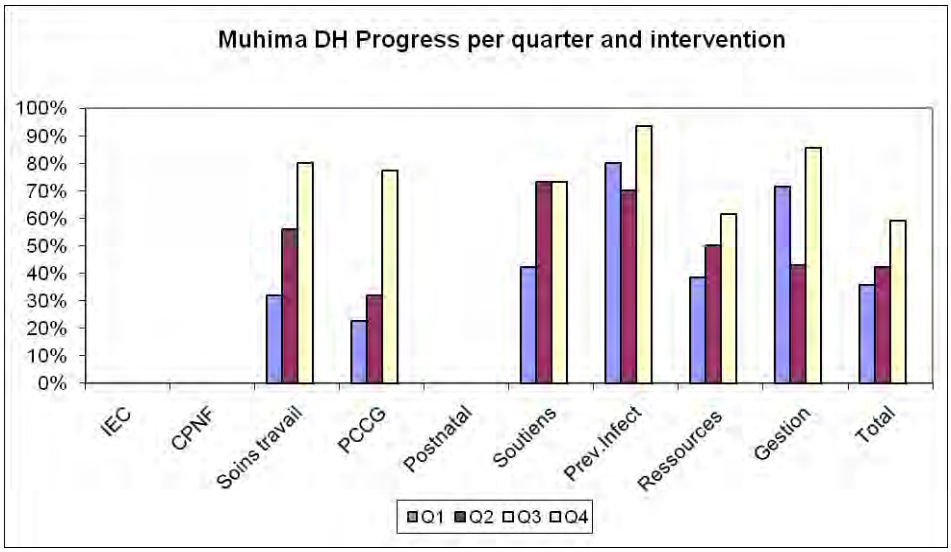

Kibagabaga DH Progress per quater and intervention
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
IEC
CPNF
Soins travail
PCCG
Postnatal
Soutiens
Prev.Infect
Ressources
Gestion
Total
Q1 Q2 Q3 Q4


Kanombe DH Progress per quarter and intervention
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
IEC
CPNF
Soins travail
PCCG
Postnatal
Soutiens
Prev.Infect
Ressources
Gestion
Total
Q1 Q2 Q3 Q4

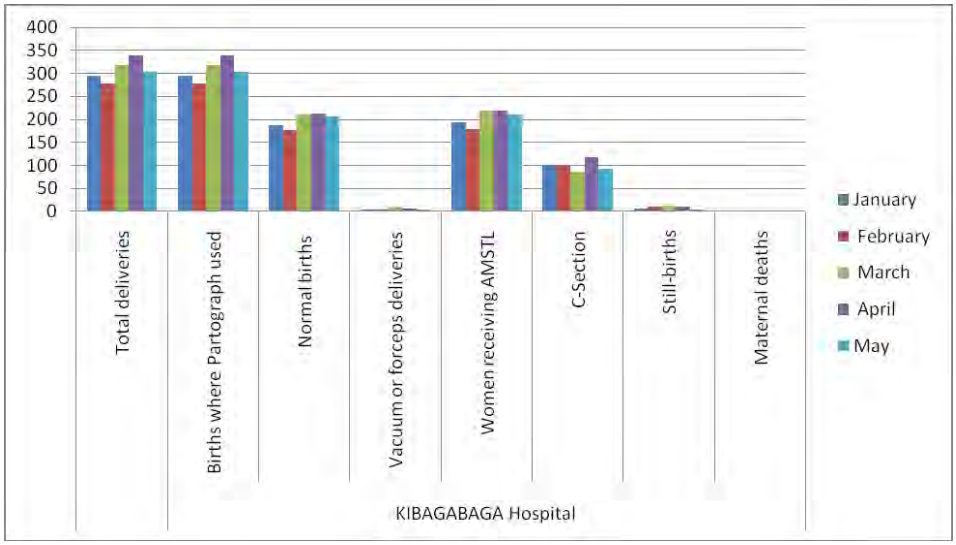

Kigeme DH Progress per quarter and intervention
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
IEC
CPNF
Soins travail
PCCG
Postnatal
Soutiens
Prev.Infect
Ressources
Gestion
Total
Q1 Q2 Q3 Q4

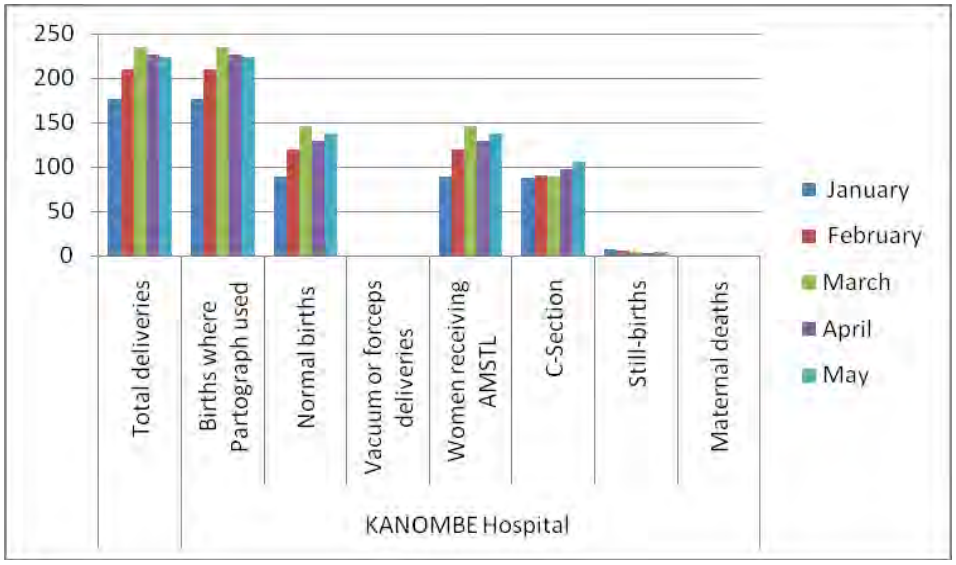

Kaduaha DH Progress per quarter and intervention
80%
70%
60%
50%
40%
30%
20%
10%
0%
IEC
CPNF
Soins travail
PCCG
Postnatal
Soutiens
Prev.Infect
Ressources
Gestion
Total
Q1 Q2 Q3 Q4

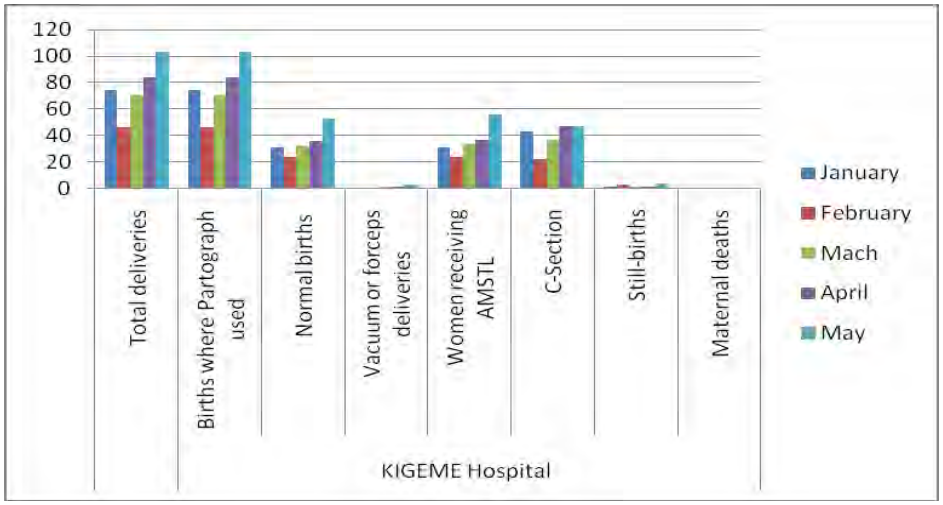


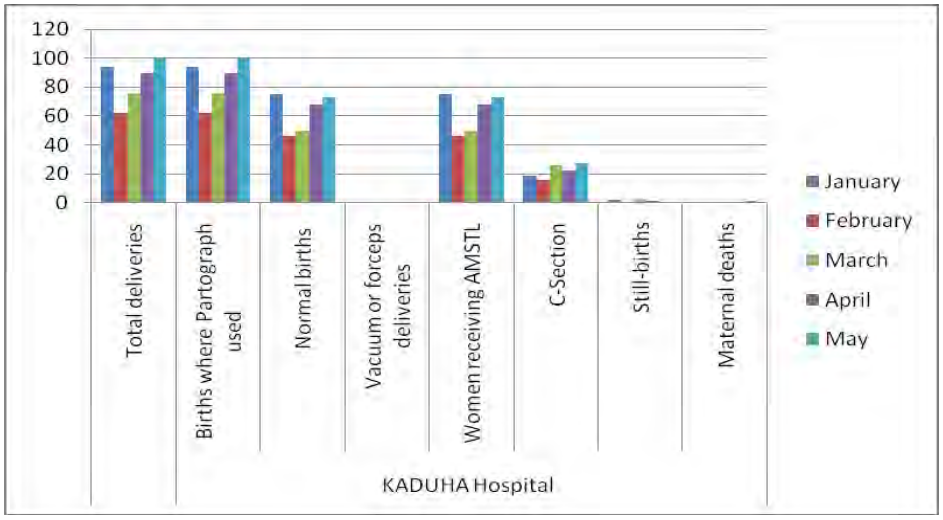


Maternal and Newborn Service Statistics reported from 4 district hospitals for the period of January to May 2009 are presented in the following graphs:


400
350
300
250
200
150
100
50
0
Total deliveries
Births where Partograph used
Normal births
Vacuum or forceps deliveries
Women receiving AMSTL
C-Section
Still-births
Maternal deaths
January
February
March
April
May
KIBAGABAGA Hospital


250
200
150
100
50
0
Total deliveries
Births where Partograph used
Normal births
Vacuum or forceps deliveries
Women receiving AMSTL
C-Section
Still-births
Maternal deaths
January
February
March
April
May
KANOMBE Hospital





Observations from these charts:

- The use of AMSTL (active management of third stage of labor) is 100% among women with vaginal births at the four hospitals monitored (n=2138 vaginal births) this means that appropriate steps to prevent post partum hemorrhage are being taken in all these health facilities.
- The number of deliveries in most of heath facilities is increasing in general expects Kaduha that has almost the same number.

- Vacuum extraction is used in some hospitals and health centers
- The partograph is used at 100% in all heath facilities. This may explain why the number of C-sections appears to be increasing in the five hospitals because dystocia cases are detected early and transferred to the hospitals.
- Service statistics suggest that health practitioners are carrying out their job as trained in all health facilities

5- **Kangaroo Mother Care**

➢ **Follow up of Kangaroo Mother Care (KMC) sites**

In 2008, ACCESS trained 18 providers from 9 hospitals in KMC and collected data. During the first quarter we visited four KMC units (Kanombe, Kigeme, Kibagabaga and Muhima) to provide supportive supervision and project monitoring. At Muhima, we supplied 500 newborn bonnets to the KMC unit. General findings and recommendations are included below:

- At Muhima hospital, from 108 newborns admitted, there were no deaths during 2008 and for this first quarter of 2009, from 4 admitted in January, there are no deaths.
- At Kibagabaga hospital, from 48 admitted, there were 3 deaths during 2008.
- At Kanombe hospital, from 47 admitted, there was 1 death in 2008 and for 2009, from 4 admitted, no deaths.
- At Kigeme hospital, from 98 admitted, there were 21 deaths in 2008. So far in 2009, from 10 admitted, 5 died. We have developed a plan to train providers in this hospital since the death rate is unacceptably high.

Two issues impacting the results are:

1. Many providers who were trained have left the hospitals or KMC Units
2. There were only 2 providers trained per hospital and the hospitals have not made subsequent plans to train other providers.

After considering this data, ACCESS has planned to reinforce the capacity of providers by having a refresher coaching with KMC teams at the hospitals and also increase the number of supervisions visits. An in-depth investigation is needed at Kigeme hospital to understand what contributed to the high rate of newborn mortality. There is also a need to strengthen data monitoring systems by revising registers to have a comprehensive data collection tool for KMC units. The ACCESS team will

also be visiting hospitals to collect data to measure progress in other technical areas, such as number of births assisted, use of a partogram, active management of third stage of labor (AMSTL) and also to measure morbidity and mortality.

- A refresher course has been done for Jhpiego staff during two days in April 2009.

- In May 09, one day training conducted for 13 providers from Muhima hospital (Neonatology ward). Conducted orientation training in KMC program for Jhpiego staff and update of KMC data collection and supervisor tools was done with TA of Dr Winnie for JHPIEGO staff.

- A formative supervision has been conducted in Muhima, Kibagaba, Kanombe, and Kigeme hospitals during June/2009. The orientation in theoretical and practical aspects has been done for KMC unities staff. In general in those 4 hospitals, KMC units are functioning very well but the following aspects need to be improved:

  - To take and register regularly the temperature and feedings for all babies
  - To encourage mothers to use caps for babies
  - To wash hands
  - To separate the registration for KMC unities from the one of all neonatal cases.
  - To document the follow-up of babies after discharge

Nyanza and Kaduha hospitals are not currently implementing KMC although they have received training in the method. This is because they are waiting for the site to be strengthened by UNICEF (in the case of Nyanza and Kaduha had some difficulties obtaining some materials (although this is understood as currently being changed) Kaduha also has a problem of electricity but should be able to implement KMC because it is a low tech intervention that involves the baby being warmed by the mother.

- **Assistance to the MCH Desk for the development of a KMC scaling-up strategy**

In order to help the MCH Desk scale up the Kangaroo Mother Care (KMC) model, ACCESS has developed a draft guide for scaling up KMC at the national level – from health centers to the community level. This plan will be finalized after feedback from the MOH and partners. The purpose of the guide is to provide guidance to district health management teams, health facility management teams – both public and private – on how to establish, implement and monitor KMC services to

improve the survival of low-birth-weight babies. This will contribute to the achievement of the millennium development goal (MDG) 4 which aims to reduce the 1990 under five child mortality rate by 2/3 by the year 2015.

- **Support the MOH to validate KMC national guidelines**

In September 09, The Ministry of Health in collaboration with Jhpiego/ACCESS Program has organized one day workshop for validation of KMC National guidelines. The objectives and benefits of KMC Program to the community were to:

- Have an overview on KMC implementation in Rwanda
- Present the draft of KMC national Guidelines
- Discuss on next steps for KMC scale up in Rwanda

We are still waiting for the approval of the final document of these guidelines from the MoH in order to move forward.

- **Technical Support to Peace Corps**

In August 2009, Jhpiego provided a technical support to the new Peace Corps team of volunteers who was supposed to work in different domain including Health domain at community level countryside to provide them the KMC skills. A one day workshop has been conducted where Jhpiego made presentations, demonstrations and practices on KMC procedures.

Needs:

- Sensitization about KMC and its benefits for all medical staff at hospitals and health centers level because on field it seems that it is only KMC unit staff who is involved with the intervention (need for the various units to be in communication).
- Educating hospital administration that KMC is a LOW TECH intervention in which that minimal material is needed. The perception for the need for many materials was raised by hospitals and centers trying to use the model of Muhima (as the Center of Excellence). The Muhima model, although a good model, is somewhat misleading because administrators from the hospital decided to use more equipment than what would normally be required. Therefore when scaled up, many other hospital administrators also put an emphasis on equipment procurement and not necessarily the skin to skin aspect of KMC.
- Educating staff about how Infection prevention through hand washing is crucial in KMC.

6- **Faith Based Organization Activities**

1. ACCESS collaborated with RCLS (Network of religious leaders against AID) to finalize messages on maternal and child health. The messages were then harmonized with the Holy Bible and Holy Qur'an, resulting in a sermon guide which was translated from French into Kinyarwanda and English and disseminated.

2. Revision of messages from the Behave Model to integrate new messages on MIP. Since the MIP policy changed, there was a need to review messages to provide to women at health center and community levels. These messages are already integrated in the guide for religious sermons that is being prepared in collaboration with RCLS and the MOH.

3. Printing of sermon guide, 800 copies in Kinyarwanda and 250 copies in English

4. ACCESS/Jhpiego collaborated with RCLS to train 38 women and 23 men religious leaders from 4 Christian groups and Muslim on the use of the sermon guide in order to improve maternal and newborn health on their role on fighting against malaria in community. These religious leaders will be able to train others in the use of this sermon guide.

5. Presentation made on the experience of working with FBOs to fight against malaria at the national conference of religious leaders in June 09, on their role on fighting against malaria. Take home points include the fact that Jhpiego/ACCESS had a good experience of working with FBOs that resulted to the sermon guide for Muslim and Christians to be used to promote maternal and child health.

6. ACCESS will also explore ways of incorporating use of the guide into the on-going community health work of the Church and develop with RCLS sermon guide utilization and monitoring process.

Challenges

- Coordination of training activities with partners at the district level
- Data collection on MNH indicators at the hospital level
- Ownership of the performance and quality improvement process by providers
- Need to follow up KMC scale up at the national level

Next steps

- Follow up the utilization of SBM-R
- Formative supervision of KMC implementation
- Work with MMR Technical working to discuss about KMC scale up

II. PRESIDENTS MALARIA INITIATIVE - PMI

INTRODUCTION

In FY07, ACCESS/Jhpiego provided technical assistance to the MOH to strengthen prevention and control of malaria targeting malaria in pregnancy (MIP) programming.

Since October 2008 ten (10) additional districts have been selected in order to strengthen MIP activities at the district level, from health facilities to the community, using ASM as a key point of contact with mothers and their family members.

OBJECTIVES

- Support rollout of the new national policy MIP implementation at both national and district levels;
- Increase utilization of focused antenatal care (ANC) services, especially in the first trimester of pregnancy;
- Increase use of insecticide treated nets (ITN), including long-lasting insecticide treated nets (LLIN), among pregnant women and children under five; and
- Improve community awareness of comprehensive maternal and newborn health services, with a focus on MIP.

The activities reported below represent the progress achieved between October and June 2009 for the PMI activities planned this year in collaboration with the MOH, PNILP, district authorities and other key partners.

I. Community Health Interventions

1. Assistance to the Community Health Desk for the development of ASM training manual, job aid and strategy

- Two senior staff members from the ACCESS partner Save the Children (Winifride Mwebesa and Joseph de-Graft Johnson) met with the local ACCESS team, MOH and partners to review and finalize training materials.

- The counseling materials had been adapted to include messages identified from the April 2008 BCC workshop.

- The ASM manual and counseling cards were translated into Kinyarwanda before training district supervisors. This was useful not only to pretest the use of local language during the training, but also to familiarize participants with new terminology, for which there was not always a translation in the local language.

- The ASM counseling card has been printed and packaged in a special laminated box that will help protect it from rain during the rainy season and other natural intemperate (500 counseling cards printed).

2. Training workshops

- Training of the national pool of trainers on the use of ASM manual on MCH care. The national TOT workshop was held in November 2008. The training was attended by 20 participants from districts, project partners and 5-6 observers from MOH headquarters. The workshop was facilitated by Dr. Winifride Mwebesa, Jeremie Zoungrana, Dr. Joseph deGraft Johnson, Emile Sempabwa and Dr Ferdinand Bikorimana (MOH). The workshop lasted six days and included theoretical and practical sessions. During the training, the team learned that the current supervision of ASMs is being revised and a new cadre of supervisors (hygienist) is being added to lead the supervision of community level activities including ASM and ASC activities. According to the workshop evaluation, participants were highly satisfied with the content, training methodology (engagement of trainees as facilitators) and facilitation of the workshop.

The pre-test results ranged from 11 - 88% with an average of 49%. Post-test results showed an impressive improvement with results ranging from 60 - 100% with an average of 85%.

- The process of capacity building at the community level follows the MOH system which first trains national trainers, district supervisors and health facility supervisors. This is the same system ACCESS used for the training in maternal and newborn health care at the community level. From March 2-7, 2009, ACCESS conducted a workshop for 21 district supervisors from 10 district hospitals in Rwamagana to update them on the manual for maternal and newborn health care at the community level. District supervisors will go on to train ASM supervisors in Kinyarwanda. 4 New staff of the Community Health Desk attended this workshop.

- From April, 09 ACCESS/Jhpiego conducted 9 workshop sessions for district ASM providers. The activities were done in collaboration with TOT districts supervisors using the manual for maternal and newborn health care at the community level. ACCESS supported training of 268 ASM: 134 mudugudu from 3 health centers in 3 districts (Rubavu, Gakenke, Nyamagabe) in 9 sessions. The training is pro-active and lasted 9 days that is not concurrent in order to give time for trainees to practice what they have learned before continuing with next steps. ACCESS noticed the mobilization that such training raised at district as well as sector and umudugudu level with the high commitment of people to make it successful.

<u>The following table shows the number of ASM trained</u>

District	Health Center	ASM Supervisors trained from 20-24April 2009 in Nemba	Number of villages	Number ASM trained	Timeline	Observation
Gakenke	Cyabingo	2	34	68	May 7- 27/ 2009 Cyabingo	All ASM trained in 2 sessions
Nyamagabe	Nyarusiza	2	21	42	May 4 - 23/2009 09 Nyarusiza	All ASM trained in 2 sessions
Rubavu	Busasamana	2	79	158	First 4 sessions: June 8-27/2009	All ASM trained in Five sessions The activities were conducted in

						collaboration with MOH and local districts authorities
Total : 3	**3**	**6**	**134**	**268**	**9 sessions**	

- **Formative supervision**

All ASMs trained have received continue formative supervision in order to make sure that ASMs are implementing their skills and knowledge learnt during the training.

During the formative supervision conducted by Jhpiego/ ACCESS in collaboration with MOH, they noticed that the mobilization that such training raised at district as well as sector and umudugudu level with the high commitment of people to make it successful. Some changes noticed after ASM training during formative supervision:

- Registration of all women in reproductive age at each Umudugudu level
- Registration of pregnant women at Umudugudu level
- All pregnant women registered have received at least one visit from the ASM
- All ASM have at least use the counseling card to counsel women in pregnancy
- ASM and ASC work closely to harmonize messages about pregnant women
- A song related to the job description of ASM has been developed and used during their monthly meeting
- A role play has been developed by ASM during the training and is used now for community sensitization
- Number of deliveries at health facilities have increased after training of ASM and those women were accompanied by ASM to delivery to health center.

3. **Support PMI activities at national and district levels**

Presentation made during the mother and neonatal survival conference, May 27th, on the Contribution of Community-Health Workers in the Promotion of Maternal and Newborn Survival in Rwanda. Take home points include the fact that Community health workers can contribute to promote maternal and newborn survival if:

- Ensuring a specific training for them
- Ensuring quality supervision

- Providing additional equipment : boots, umbrellas, torch to facilitate their work
- Securing ownership by all levels (district, sector, cell and Umudugudugu)
- Ensuring health facilities are ready to receive women and newborns – addressing supply side

INDICATORS TO BE COLLECTED FOR BCC ACTIVITIES

- Number of session's discussion per ASM per Month
- List of topics developed by ASM during the month
- Number of people sensitized per month per type of topic
- Number of households with pregnant women that own LLINs
- Percentage of Pregnant women who report sleeping under an ITN the previous night
- Percentage of Pregnant women registered who are visited by the ASM per month
- Number of Pregnant women accompanied by ASM at the HC for ANC
- Number of Pregnant women accompanied by ASM at the HC for delivery
- Percentage of Pregnant women referred by ASM to the HC for danger signs per month
- Percentage of women newly delivered who received ASM visit within 02days after delivery
- Percentage of women newly delivered who have been referred by ASM for danger signs
- Percentage newborns with low birth weight for which KMC is used and they are followed by the ASM

Below are tables showing the results from the Formative Supervisions

Nyarusiza Health center – Nyamagabe District has been visited from 20-22 October, 2009

	Before ASM Training			**After ASM Training**			
Period	**March**	**April**	**May**	**June**	**July**	**August**	**September**
Fréquentation de la fosa							
CPN1	28	30	20	20	14	15	19
CPN2	26	33	26	26	17	29	25
CPN3	54	53	27	33	33	32	18
Visites standards	3	0	14	6	9	9	9
Distribution de MII	0	0	0	0	0	0	0

Pendant la période prénatale							
Nombre de femme enceintes identifies par les ASM				131	70	56	54
Nombre de femmes enceintes visitées par les ASM par période de grossesse				119	70	56	54
Nombre de femmes enceintes referees par les ASM au centre de santé pour la CPN				30	0	10	16
Nombre de femmes enceintes ayant un plan d'accouchement complete par l'ASM				35	24	22	23
Nombre de femmes enceintes identifiées par les ASM présentant les signes de danger				3	3	0	1
Nombre de femmes enceintes référées à fosa par l'ASM pour les signes de danger				3	3	0	1
Nombre de femmes enceintes présentant les signes de danger accompagnées à la fosa par ASM				0	0	0	0
Pendant la période d'accouchement							
Nombre d'accouchements à la fosa	29	24	33	32	22	16	23
Nombre de femmes enceintes accompagnées par l'ASM à la fosa pour l'accouchement	0	0	0	8	7	15	16
Nombre d'accouchements à domicile	0	0	0	2	5	4	6
Nombre d'accouchements en cours de route vers le CS (En presence de l'ASM)	0	0	0	2	1	2	2
Pendant la période post natale							
Nombre de femmes récemment accouchées ayant allaités leurs enfants avant la première heure de naissance et qui n'ont rien donné à leur nouveau né				36	28	21	31
Nombre de femmes accouchées à domicile qui sont transféré à la fosa pour une prise en charge immédiate				3	3	3	4
Nombre de NN né à domicile référés à la fosa avec leur mère endéans 2 jours après la naissance				0	0	0	0
Nombre de femmes récemment accouchées qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM				0	0	1	1
Nombre de NN qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM				0	0	0	3
Nombre de femmes qui sont mort par suite de la grossesse				0	0	0	0
Nombre de NN qui sont mort après leur naissance avant 28 jours				0	0	0	2
Nombre de femmes qui sont mort pendant et après l'accouchement				0	0	0	0
Planification familiale (nouvelles inscrites)	44	61	49	50	49	45	
Utilisatrice fin du mois	562	647	688	751	684	643	

Cyabingo

		Avant la formation des ASM			Après début la formation des ASM		
Période en mois	**Février**	**Mars**	**Avril**	**Mai**	**Juin**	**Juillet**	**Aout**
Fréquentation de la fosa							
CPN1	5	6	10	11	16	12	11
CPN2	0	2	13	10	2	5	10
CPN3	0	1	7	6	4	7	3
Visites standards	11	6	7	7	2	2	3
Distribution de MII	52	45	28	35	22	0	0
Pendant la période prénatale							
Nombre de femme enceintes identifies par les ASM				137	130	103	92
Nombre de femmes enceintes visitées par les ASM pendant la grossesse				128	111	82	74
Nombre de femmes enceintes referees par les ASM au centre de santé pour la CPN				121	92	67	62
Nombre de femmes enceintes identifiées par les ASM présentant les signes de danger				3	6	3	4
Nombre de femmes enceintes référées à fosa par l'ASM pour les signes de danger				3	5	3	4
Nombre de femmes enceintes présentant les signes de danger accompagnées à la fosa par ASM				3	5	3	4
Pendant la période d'accouchement							
Nombre d'accouchements à la fosa	17	19	20	41	21	25	18
Nombre de femmes enceintes accompagnées par l'ASM à la fosa pour l'accouchement				23	17	14	15
Nombre d'accouchement à domicile	9	2	1	3	3	1	4
Nombre d'accouchements en cours de route vers le CS (En présence de l'ASM)				0	0	0	0
Pendant la période post natale							
Nombre de femmes récemment accouchées ayant allaités leurs enfants avant la première heure de naissance et qui n'ont rien donné à leur nouveau né				41	21	25	18
Nombre de femmes accouchées à domicile qui sont transféré à la fosa pour une prise en charge immédiate				0	0	1	3
Nombre de NN né à domicile référés à la fosa avec leur mère endéans 2 jours après la naissance				0	0	0	1
Nombre de femmes récemment accouchées qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM					0	0	0
Nombre de NN qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM					0	0	0
Nombre de femmes qui sont mort par suite de la grossesse		0	0	0	0	0	0
Nombre de NN qui sont mort après leur naissance avant 28 jours		0	0	1	0	0	1
Nombre de femmes qui sont mort pendant et après l'accouchement		0	0	0	0	0	0

Busasamana

	Avant la formation des ASM			Après début la formation des ASM		
Période en mois	**Mars**	**Avril**	**Mai**	**Juin**	**Juillet**	**Aout**
Fréquentation de la fosa						
CPN1	45	20	33	44	37	27
CPN2	24	18	94	16	19	32
CPN3	36	16	35	27	31	18
Visites standards	20	19	19	20	29	16
Distribution de MII	0	0	0	0	0	0
Pendant la période prénatale						
Nombre de femme enceintes identifies par les ASM				709	552	407
Nombre de femmes enceintes visitées par les ASM par période de grossesse				626	389	392
Nombre de femmes enceintes referees par les ASM au centre de santé pour la CPN				433	232	182
Nombre de femmes enceintes identifiées par les ASM présentant les signes de danger				6	4	4
Nombre de femmes enceintes référées à fosa par l'ASM pour les signes de danger				5	3	4
Nombre de femmes enceintes présentant les signes de danger accompagnées à la fosa par ASM				0	0	0
Pendant la période d'accouchement						
Nombre d'accouchements à la fosa	153	112	127	120	136	158
Nombre de femmes enceintes accompagnées par l'ASM à la fosa pour l'accouchement				68	103	121
Nombre d'accouchements à domicile		22	25	21	25	13
Nombre d'accouchements en cours de route vers le CS (En présence de l'ASM)				2	12	13
Pendant la période post natale						
Nombre de femmes accouchées à domicile qui sont transféré à la fosa pour une prise en charge immédiate				6	17	9
Nombre de NN né à domicile référés à la fosa avec leur mère endéans 2 jours après la naissance				1	7	2
Nombre de femmes récemment accouchées qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM				0	0	0
Nombre de NN qui sont référées à la fosa pour les signes de dangers identifiées par l'ASM				0	0	0
Nombre de femmes qui sont mort par suite de la grossesse	0	0	0	0	0	0
Nombre de NN qui sont mort après leur naissance avant 28 jours	4	2	3	1	3	5

SOME PICTURES FROM ASM TRAINING

II. Focused Antenatal Care and Malaria in Pregnancy

i. **Field visit to meet with key decision makers from districts**

(Mayor, vice Mayor, Health director and District director) to exchange on activities planned for this fiscal year in order to involve district stakeholders in the process of planning malaria in pregnancy activities at the district and community levels, ACCESS has initiated field visits to meet mayors, vice mayors, directors of health and directors of hospitals. ACCESS has been able to meet with decision makers from seven districts out of 14 districts and all have been very cooperative and interested to work with ACCESS to prevent and treat malaria in pregnancy. This was not only an opportunity to share activities with decision makers but also to do advocacy and sensitize some of them on the need to support malaria in pregnancy activities in their districts.

ii. Support partners in the training of trainers on FANC

ACCESS provided technical assistance to the Intrahealth Capacity Project during the training of 20 providers on Focused Antenatal Care (FANC). There is a huge need to update providers on the new policy especially at the pre-service level in order to prepare students with updated information and we will work with the Capacity Project to facilitate the revision of the curriculum.

iii. Training of Providers in Focused Antenatal care

The purpose of the training is to strengthen service providers' skills in counseling pregnant women on malaria prevention and case management and in providing prevention and treatment services using the most holistic approach of focused ANC.

In total 244 providers including 199 women and 45 men in health centers from 14 districts (Huye, Rulindo, Rutsiro, Kicukiro, Nyaruguru, Gatsibo, Nyamagabe, Gasabo, Gicumbi, Musanze, Rulindo, Rubavu, Gakenke, Nyamasheke) have been trained in FANC.

Training has been decentralized to the district level. Most of the providers trained are health center chiefs and each district health center was represented at the training workshops.

Trainees are expected to 'share' their knowledge or mentor/orient their colleagues at the health facilities based on the training they received.

After the training, all providers are followed up regularly to make sure that they are implementing their skills and knowledge learnt during the training and at the same time technical assistance is provided to those who met some difficulties.

iv. Partner reporting and Performance Management System

In order to initiate and to make partners familiar with "**partner reporting and performance management system**" MEMS organized different workshops where JHPIEGO was represented. Three staff from Jhpiego participated to the training and PMI Jhpiego data base and narrative report was shared with MEMS

Challenges

- There is a need to update all providers on the new policy on malaria in pregnancy
- Huge number of Community Health Workers (CHWs) to be trained compared to available resources
- There is an imperative need to train additional providers in FANC because of the numbers of providers per facility and per district.

- Monitoring and evaluation system needs to be finalized.

Next steps

- Elaboration and printing of job aid for providers in FANC.
- Conduct district advocacy workshops to sensitize stakeholders on MIP and MCH.
- Monitoring of FANC activities in the fourteen target districts.
- Supportive supervision to ASMs.
- Support the FBO/RCLS to implement their action plan on MCH.

~~1.3~~Endline assessment

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This study was conducted by the ACCESS Program, which provides support to the Ministry of Health in Rwanda and is financed by the United States Agency for International Development (USAID). The study was carried out as part of the joint work of the ACCESS Program and Twubakane, the local USAID bilateral program, under USAID/Washington's Safe Birth Africa Initiative (SBAI).

This study was conceptualized and designed by ACCESS Program staff, including Patricia Gomez and Barbara Rawlins. The study was carried out by JHPIEGO, an affiliate of Johns Hopkins University (JHU), and the ACCESS Project in Rwanda under the supervision of Mr Jeremie Zoungrana and the coordination of Dr. Aline Umubyeyi. They contributed to the adaptation of the research tools, the training of data collectors/ supervisors, supervision/coordination of data collection, supervision of data entry, quality control of data, analysis and writing of this report.

Purpose of the Evaluation

ACCESS has conducted an endline facility assessment in four districts in Rwanda where the program conducted a baseline facility assessment in 2007 and where ACCESS has subsequently implemented EmONC training at the health center level and applied SBM-R for emergency obstetric and newborn care (EmONC) at the hospital level. The four districts are: Kicukiro, Nyamagabe, Nyaruguru and Gasabo.

The purpose of this facility assessment was to gather information related to the availability and utilization of EmONC services, as well as quality of care and facility readiness to provide EmONC services with respect to supplies and equipment.

At the time of the baseline facility survey in 2007, EmONC training had not yet been rolled out to the health center level, so the baseline assessment serves as a pre-training baseline measure for those facilities. At the hospital level, all but one hospital (not included in the baseline) had received EmONC training prior to the survey.

2. METHODOLOGY

2.1 Study sites

This facility survey has included a census of four government and faith-based organization (FBO)-affiliated hospitals in the three SBAI program districts and a random sample of six government and FBO health centers with maternity services in two of the three SBAI program districts. These two districts were purposively selected to include one urban district (Kicukiro) and one rural district (Nyamagabe). Nyamagabe was chosen as the rural district since the SBAI interventions have been implemented there since the start of the program.

Four of the five hospitals and all the health centers to be included in the endline were also included in the baseline survey, which will allow the ACCESS Project to make comparisons of knowledge and performance of EmONC at the beginning and end of the project. The six government and FBO health centers with maternity services to be included from Kicukiro and Nyamagabe, were randomly selected (n=3 facilities/district).

The following table displays the facilities selected:

Table 1: Surveyed Facilities

District	Health Center	Facility Type
Gasabo		
	Kibagabaga	Hospital
Kicukiro		
	Kanombe	Hospital
	Kicukiro	Health center
	Masaka	Health center
	Kabuga	Health center
Nyamagabe		
	Kigeme	Hospital
	Kaduha	Hospital
	Cyanika	Health center
	Mbuga	Health center
	Nyamagabe	Health center

RESULTS

Jhpiego/ACCESS succefully conducted the endline assessment in 3 districts(Kicukiro, Gasabo and Nyamagabe) covering 4 district hospitals and 6 health facilities to assess the availability of services and providers skills. The findings of this endline assessment :

The final sample included the following numbers of providers, by data collection instrument:

Table 5: Number of Providers Interviewed by Data Collection Instruments

Type of service observed	Total # of providers observed	Number of providers observed at hospitals	Number of providers observed at health centers
1. Antenatal (ANC) care skills observation checklist	13	5	8
2. Normal delivery skills observation checklist	22	12	10
3. Newborn resuscitation skills observation checklist	22	12	10
4. Manual removal of placenta skills observation checklist	22	12	10
5, Postpartum care checklist	20	12	8
6. Equipment and supply audits for ANC and PNC	10	4	6
7. Equipment and supply audits for Labor and Birth	10	4	6
7. Record review	10	4	6
8. Maternity provider interview	22	12	10
9. Knowledge of EmONC	22	12	10
10. Postpartum hemorrhage case study	22	12	10
11. Partogram case study	22	12	10

3.1. Care and Documentation in the ANC Clinic

☞ **Comments on antenatal care consultations:**

- ✓ All staff in both hospitals and health centers prepared the examination area, equipment and documents prior to the patient's visit. When comparing endline to baseline results, there is an important improvement regarding the preparation of the examination area, surveyed facilities came from maximum 80 % to 100%.

- ✓ During the evaluation, care provided to the women in general is improved, all health center and hospitals staff welcomed the woman kindly and with respect, encourages women to ask questions, provide correct answers to the questions and explain all procedures before executing them. Only one out of three hospital staff introduced themselves, when comparing these results to the baseline, there is 30% improvement in hospitals staff but a need for improvement is necessary.

- ✓ Danger signs are more and more asked by both Health centres and Hospitals staff. Facilities are at 90-100% in 2009 assessment while in 2007 assessment, they were at 35% maximum.

- ✓ Generally, even though staff tried to look for the In-depth medical history at the first visit and interval histories, some aspects for both health centres and hospitals staff have decreased from the baseline assessment.

- ✓ During the physical exam in 2009, vital signs are always taken in both hospitals and health centres. They were not taken in taken en 2007 because of a lack of equipment. Inspection of conjunctivae and gums for pallor, the breasts and the nipples, examination of abdomen are done by all hospital and health centres staff.There is a significant improvement from the baseline especially for health centres. In 2007, genital inspections were rarely done to detect lesions, secretions etc. Nowdays, in all type of facilities surveyed, there is almost 60% more health providers who inspect genitals.

- ✓ All staff in hospitals and 90% of health centres staff discussed adequately danger signs and appropriate action to be taken. Similarly, Birth preparedness and complication readiness. This proportion was at 33.3 % for both hospitals and health centres during the baseline.

- ✓ All health centres staff and 67% of hospitals staff recalled all the actions, observations, treatments and counseling on ANC Card and/or in the client's file. These proportions were respectively 70% (in health centres) and 67 % in hospitals during the baseline assessment.

- ✓ All hospital and health centres staff agreed on the date of the next visit. There is 15% improvement in health centres when comparing the result to the baseline.

3.2. Care and Documentation in the PNC Clinic

☞ **Comments on postnatal care consultations:**

- ✓ In the baseline assessment, the overall postnatal care consultation was very power, may be because the postnatal care consultation was not offered by facilities. After the EmonC trainings, even though facilities do not offer postnatal care consultation, taken actions during postpartum simulations are very impressive:
- ✓
- ✓

3.3. Infection prevention in ANC and PNC clinics

☞ **Comments on infections prevention:**

3.4 Care, Documentation, and Clinical Decision Making During Labor and Birth

Comments on care during labor and birth:

- ✓ All health centers and hospitals providers prepared place where the examination will take place, welcomed the women kindly. When comparing these results to the baseline especially for health centers, an important improvement regarging the two issues is observed. Less then 30 % of health center providers introduced themselves while only 5% introduced themselves in 2007.
- ✓ More than 90% of health center and hospital providers ask about the actual pregnancy. In 2007 assessment, this proportion in hospitals and health centers was low respectively at 50 and 30%. Coming to previous pregnancies, an improvement was made especially for health centers from the baseline to the endline when looking at the proportion of health providers who asked on previous pregnancies.
- ✓ Almost all providers both in health centers and hospitals took vital signs. However, during the 2007 assessment, only one out of five took vital signs at health centers and less than 20% in hospitals.
- ✓ All providers performed the abdominal and vaginal exams in health centers and hospitals. Coming back to 2007 assessment, 80% of hospital providers performed the abdominal exam while only 65% of health centers providers performed the abdominal exam

- ✓ In 2007, four out of six hospital providers used the WHO revised partogram or other partogram; slightly over half of the health center staff (11 out of 20) used a partogram. In 2009, all providers used the WHO revised partogram or other partogram in hospitals while nine out of ten health center providers did.

- ✓ In hospitals, all providers used the information on the partogram to make appropriate decisions relating to care. In health centers, 4 out of five did. In 2007, those proportions were around 30% for hospitals and health centers.

- ✓ In 2007, half of the hospital providers (3 out of 6) correctly used the partogram and made notes on labor progress whereas 35% (7 out of 20) health center providers did. In 2009, all hospital providers correctly used the partogram and made notes on labor progress whereas 90% (9 out of 10) health center providers did.

- ✓ Generally, care during labor has been improved in health centers and hospitals, providers performed acceptably tasks that they are supposed to do:

- ✓ In 2007, all three steps in the active management of the third stage of labor (AMTSL) were carried out by 20% of providers (17% of hospital providers and 21% of health center providers) after excluding the presence of a second baby. In 2009, that proportion goes to 90-100% both in health centers and hosspitals

    - In 2007, oxytocin was administered within the minute following delivery by 67% (4 out of 6) of hospital providers versus 100% (12 out of 12) of hospital providers in 2009 and 21% (4 out of 19) of health center provider versus 90% (9 out of 10) of health center providers in 2009.

    - In 2009, all hospitals and health centers providers use to controle cord traction whereas in 2007, controlled cord traction was performed by 83% (5 out of 6) of hospital staff and 26% (5 out of 19) of health center providers.

    - In 2007, the uterus was massaged after delivery of the placenta by 83% (5 out of 6) of hospital providers and 26% (5 out of 19) health center staff. In 2009, the uterus massage after delivery of the placenta was performed by 91.7% (11 out of 12) of hospital providers and 90% (9 out of 10) health center staff.

- ✓ In 2007, immediate care of the newborn was inadequate and evaluation for the purpose of resuscitation was very weak. Similarly, encouraging the mother to breastfeed and support of her during the first hour after delivery is non-existent. In 2009, immediate newborn care is significantly improved especially for health centers; required care is given almost by 100% of health centers and hospital providers but the proportion of those who put the newborn in skin to skin contact with the mother remains the same (at 66% in hospitals) but there is an remarquable improvement in health centers where 90% of providers put the newborn in skin to skin contact versus 5 % in 2007.

- ✓ During the 2007 assessment, there were no evaluation by the staff of the immediate post-partum and little counseling is given to the mother about future care and action for the baby. In 2009, most of providers do that assessment only the first ten minute (83% in hospitals versus 100% in health centers). Looking at the overall vaginal bleeding assessment, results are better in health centers than in hospitals. More than 50% of health center and hospital providers give counseling to the mother about future care and action for the baby.

- ✓ In 2007, tasks to prevent infections after each delivery were rarely performed. In 2009, more than 9 providers out of 10 in hospitals perform well tasks to prevent infections after each delivery but only half of them remove the apron and wipe it up with chlorine solution. Among health center providers, the proportion of those performing tasks to prevent infections is between 80% and 100%. Four out five health center providers remove the apron and wipe it up with chlorine solution; this proportion is above the hospital proportion.

3.3. Evaluation of Newborn Resuscitation Skills

3.3.1 Baseline survey

The evaluation of newborn resuscitation skills was conducted at hospitals because health center staff had not been trained in this skill yet. The evaluation was conducted with an anatomic model on which providers were not accustomed to using. Seven hospital based providers were evaluated.

- ✓ According to the results, Kanombe Hospital was the only facility with a provider who was judged to be competent in newborn resuscitation skills (score of 100%). The second

highest score was from also from a provider in Kanombe Hospital who scored 75% (9 out of 12) and from a provider in Kibagabaga Hospital.

- ✓ The lowest score was 8% (1 out of 12 correct answers).
- ✓ The mean score for hospital providers in newborn resuscitation was 55%.
- ✓ Comments that arose during the discussion with the staff that the health facility is lacking in materials to provide newborn resuscitation.

3.3.2 Endline survey

Comments on newborn resuscitation skills

- ✓
- ✓ The evaluation of newborn resuscitation skills was conducted at health centers and hospitals. The evaluation was conducted at 90 % with an anatomic model. Twelve hospital providers and ten health center providers were evaluated:
- ✓ Overall results show that more hospital providers have done required tasks for the newborn resuscitation.
- ✓ In general, newborn resuscitation is well done but some aspects need to be improved both for health center and hospital providers.
- ✓

3.3.2.2 Newborn reanimation competence's scores

Comments on newborn resuscitation competence's scores

- ✓ According to the results, Kigeme Hospital was the only facility with providers who was judged to be competent in newborn resuscitation skills (score of 100%). The second highest score was from also from providers in Kaduha Hospital and Masaka Health center who scored 91.7%.
- ✓ The lowest score was 33.3 % from Kabuga health centre.
- ✓ The mean score for hospital providers in newborn resuscitation was 91.1% versus 66.7%.for health center providers.

3.4. Evaluation of Skills for Manual Removal of the Placenta

3.4.1 Baseline survey

- ✓ The evaluation of manual removal of the placenta was also only conducted at hospitals because health center staff had not been trained in this skill yet. The evaluation was conducted with an anatomic model on which providers were not accustomed to using. Six hospital based providers were evaluated.
- ✓
- ✓ According to results obtained in this evaluation, the highest score received by a provider surveyed was 82% (18 out of 22 questions).
- ✓ Two providers answered 0 out of 22 questions correctly.
- ✓ The average score among the six hospital providesr evaluated was 41% (9 out of 22 questions).
- ✓ Staff at the health centers state that they do not have the necessary skills to perform the manual removal of the placenta; they always refer these cases to the hospital. They also state that they do not have adequate equipment.

3.4.2 Endline survey

3.4.2.1 Placenta Manual Removal provider's competence

Comments on placenta removal skills

The evaluation of placenta removal skills was conducted at health centers and hospitals. The evaluation was conducted with an anatomic model. Twelve hospital providers and ten health center providers were evaluated:

- Overall placenta removal tasks are acceptably done by hospital and health center providers.
- Some tasks are more practices by health centre providers than hospital providers.
- All hospital providers prepare fourniture and equipements for placenta removal; at health centres, 90 % of providers do so.
- Some importants tasks for placenta removal skills need to be improved:

- Most of providers don't give anesthesia for placenta removal. Only 40% of hospital providers and 20 % of health centre providers give anesthesia.
- Only half of providers both in hospitals and health centers give antibiotics to prevent infections
- Only half of hospital providers and 30 % of health centre providers explore the uterin caevity to check if there are placentary rests.
- Ocytocin is rarely given after placenta removal. Only half of hospital providers give ocytocin whereas in health centres, it was given only by 20% of providers.

3.4.2.2 Placenta Manual Removal competence's scores

Comments on placenta removal scores

- ✓ According to the results, Kigeme Hospital was the only facility with providers who was judged to be highly competent in placenta removal skills (score of 90%). The second highest score was from providers in Kaduha Hospital, Masaka, Cyanika and Mbuga Health centres who scored 85%.
- ✓ The lowest score was 55 % from Kabuga health centre.
- ✓ The mean score for hospital providers in placenta removal was 83.8% versus 77.1%.for health center providers.