



ACCESS Rwanda Quarterly Report April - June, 2009

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 districts¹ have been 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



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

ACTIVITIES PLANNED AND EXECUTED

INTRODUCTION

From April to June, 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.

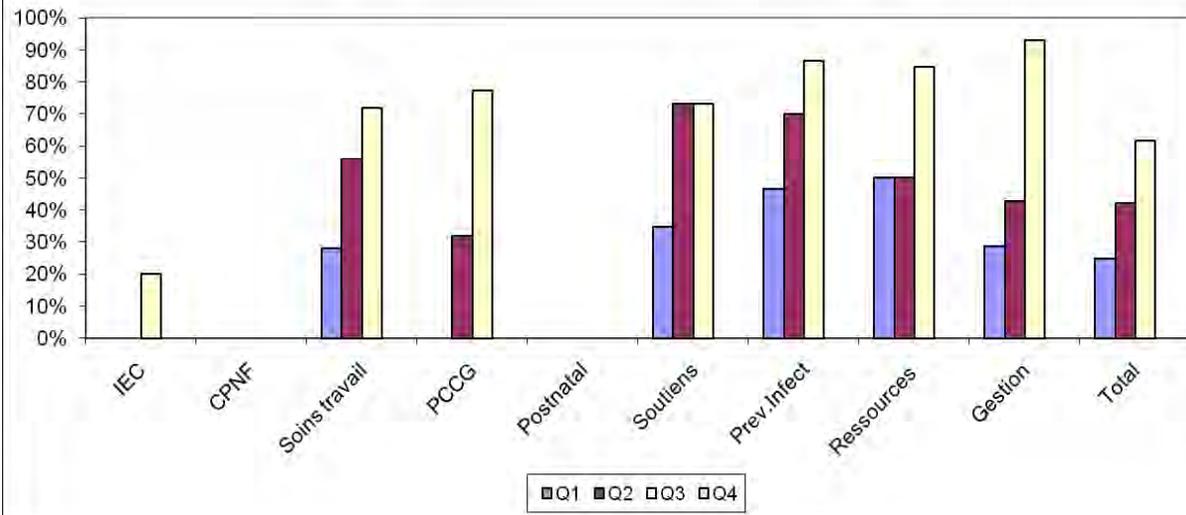
I. SAFE BIRTH AFRICA INITIATIVE

a. STANDARDS-BASED MANAGEMENT AND RECOGNITION (SBM-R) APPROACH

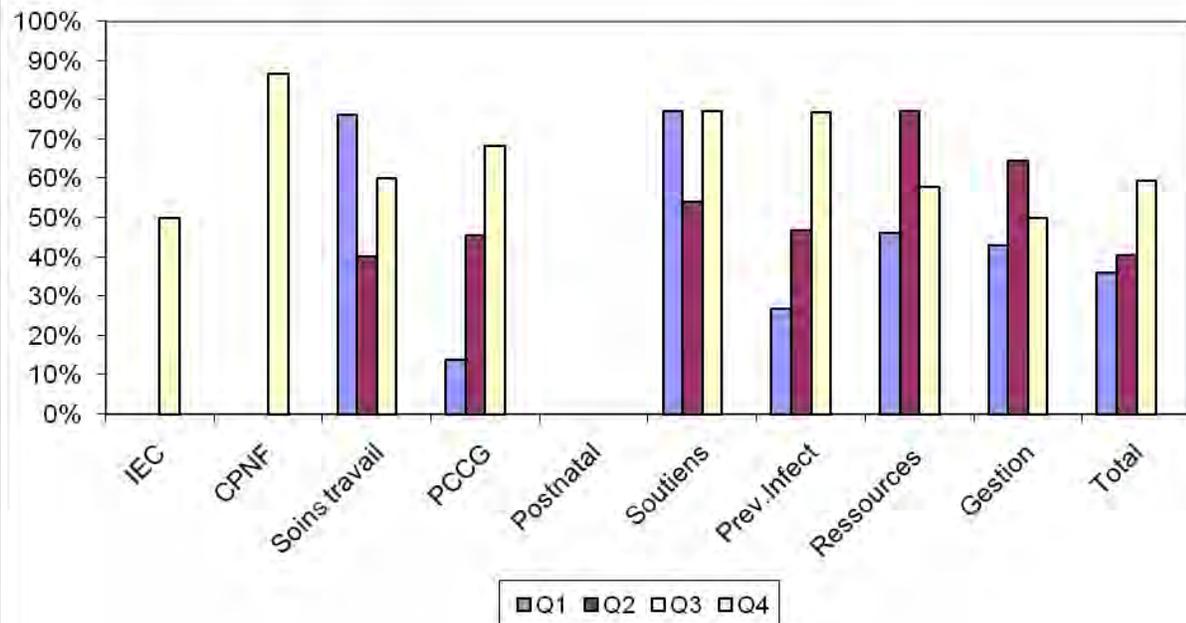
To increase the capacity of clinicians and health workers to provide MNH services, ACCESS followed up our SBM-R work in 6 hospitals: Muhima, Kibagabaga, Kanombe Military Hospital, Nyanza, Kaduha, Kigeme hospitals. Jhpiego evaluated if the action plans elaborated with stakeholders at the respective hospitals in February 2009 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 SBMR 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. Results are presented in the graphs below.

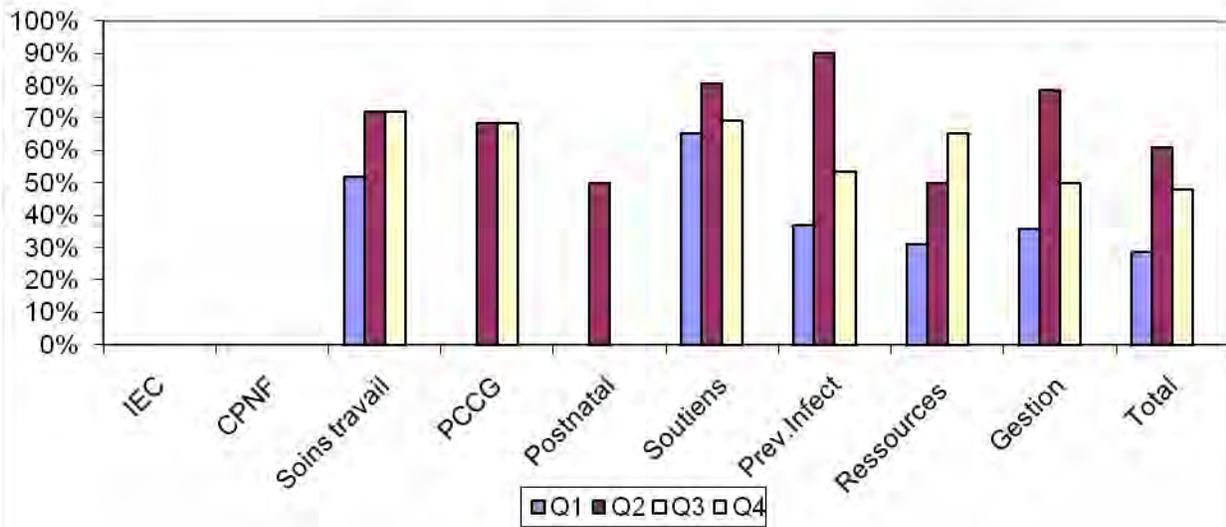
Kibagabaga DH Progress per quarter and intervention



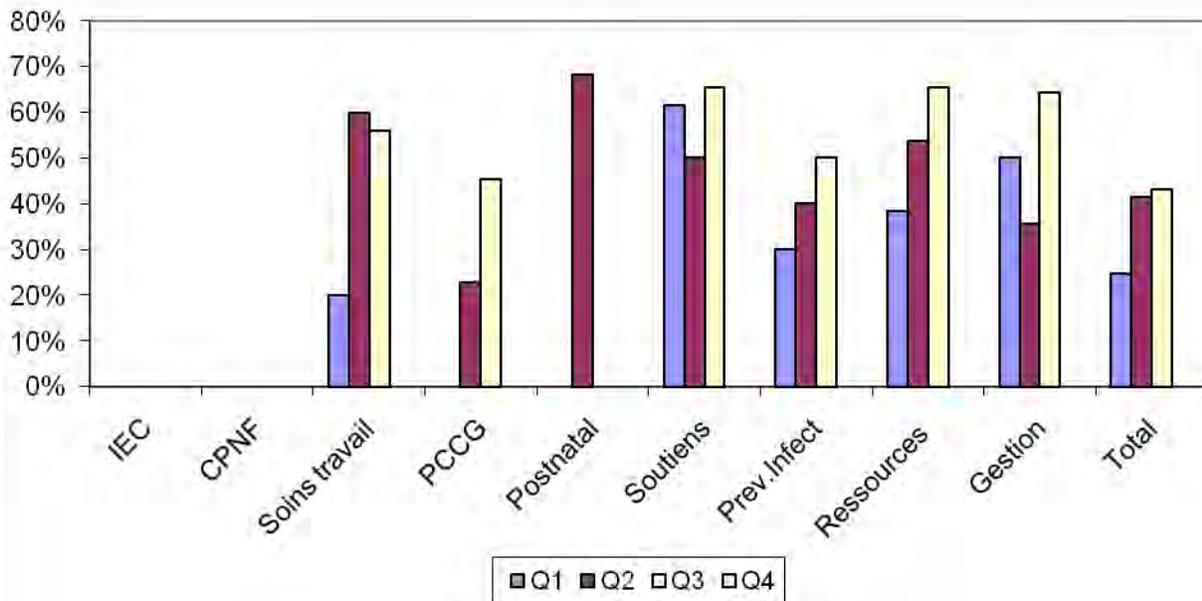
Kanombe DH Progress per quarter and intervention

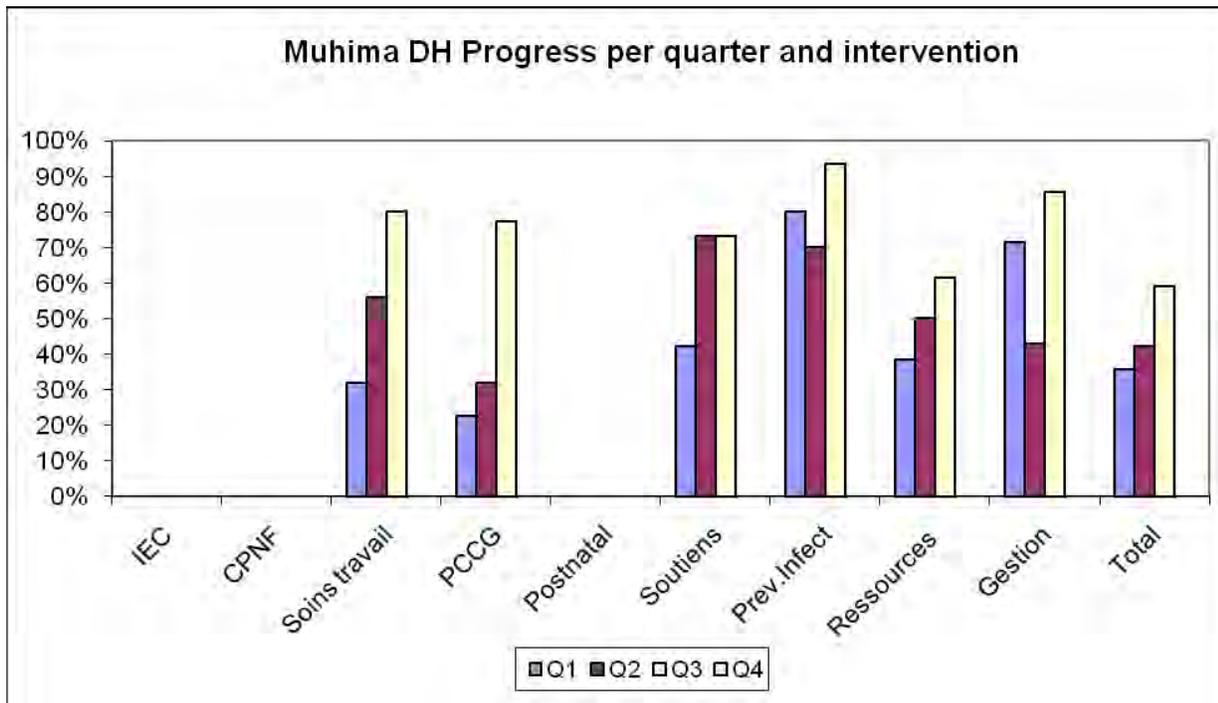
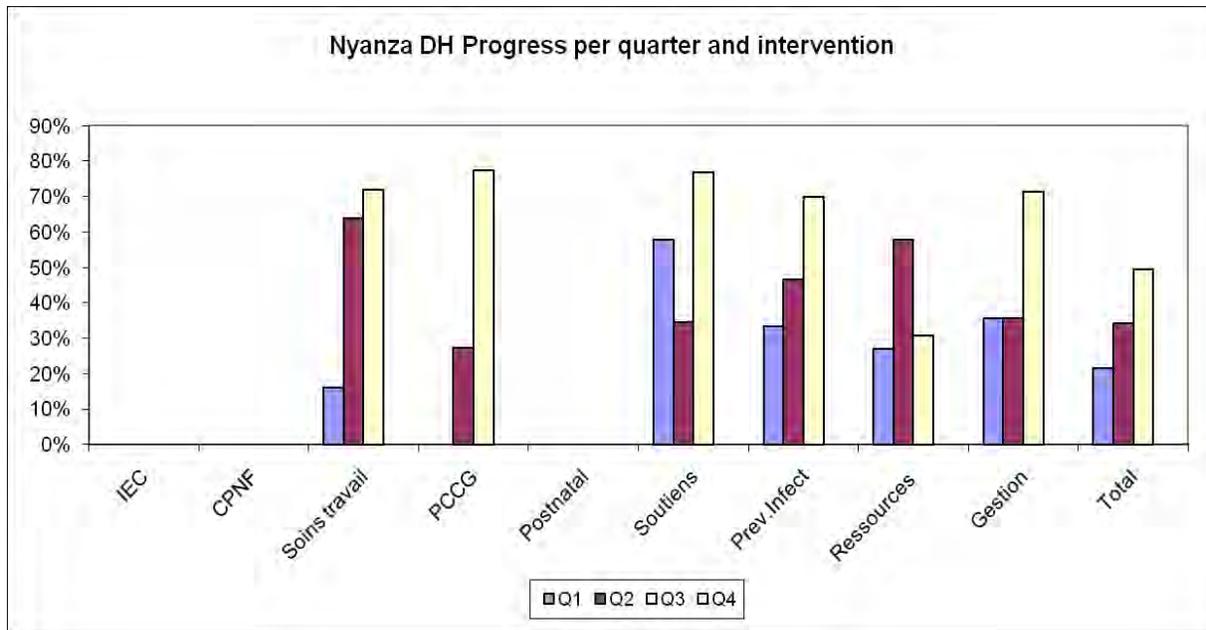


Kigeme DH Progress per quarter and intervention

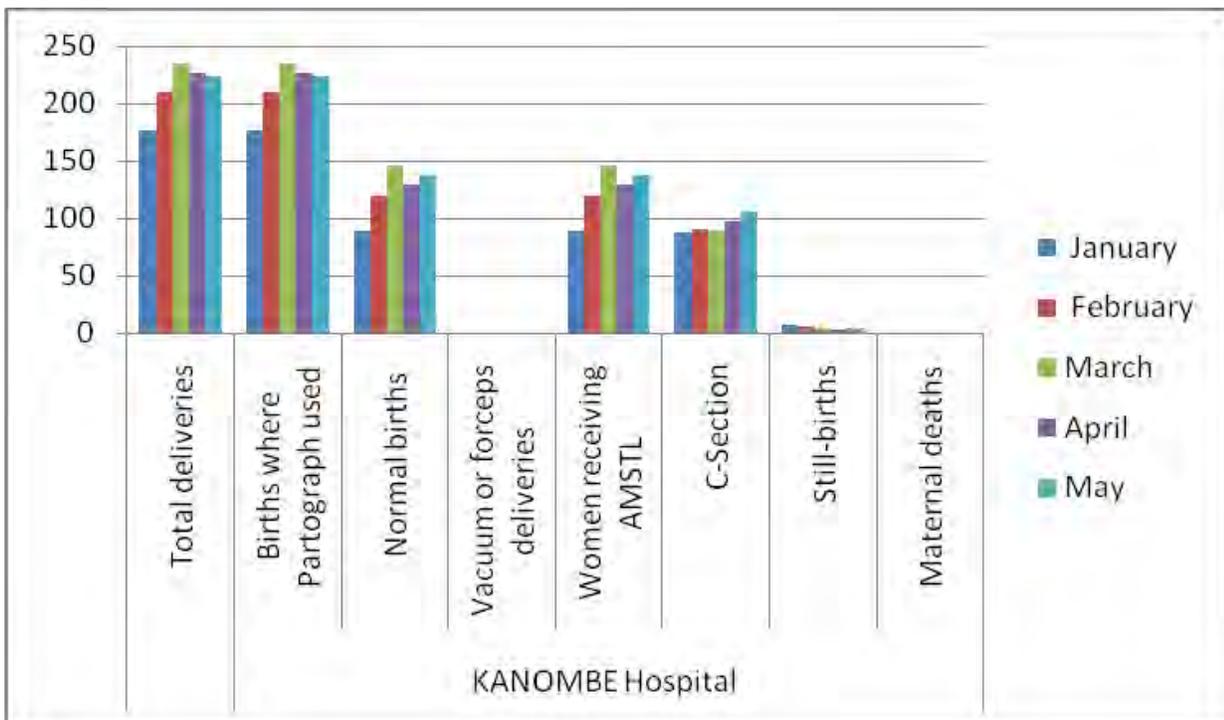
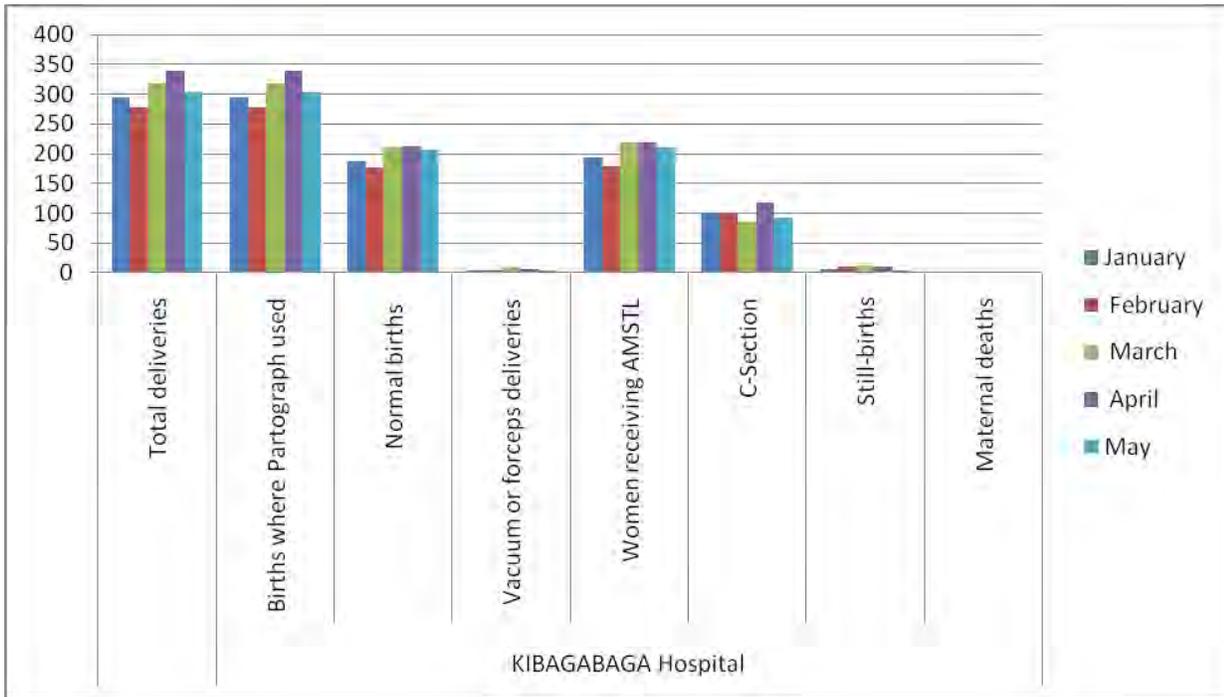


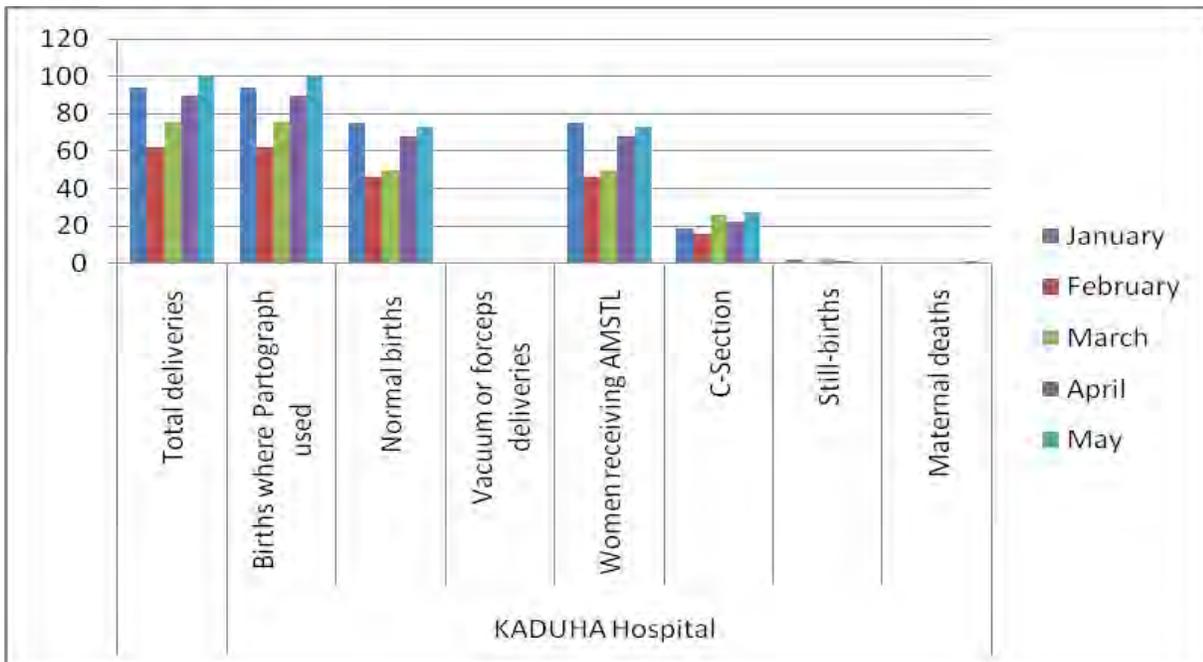
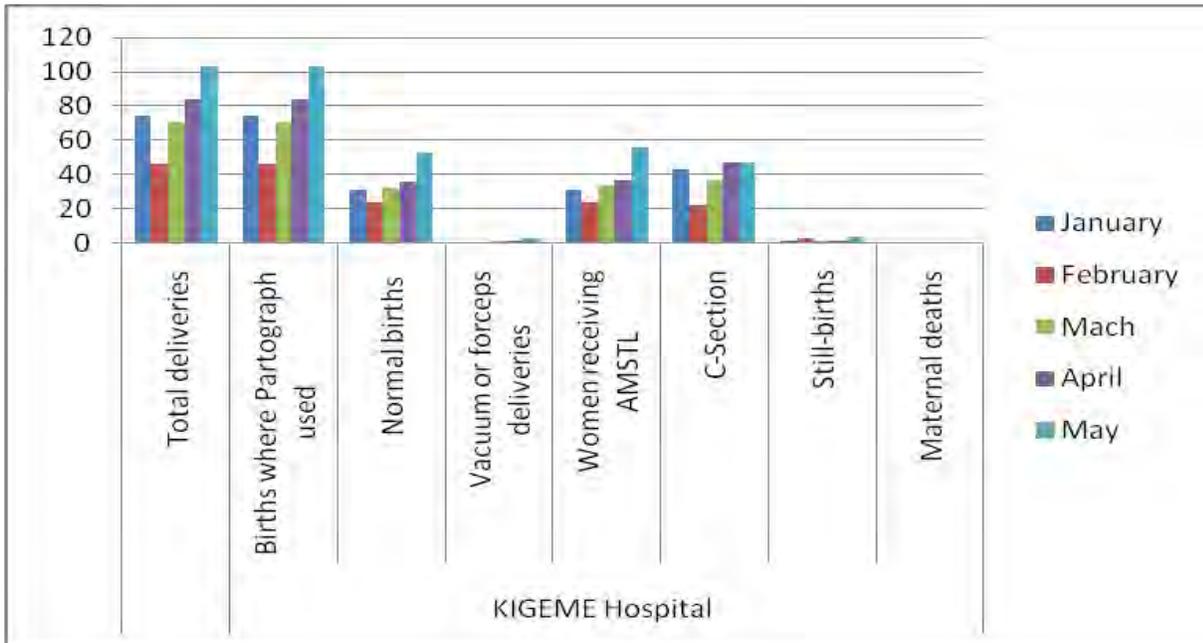
Kaduaha DH Progress per quarter and intervention





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





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 health facilities is increasing in general except 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 health 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

b) FOLLOW UP OF KANGAROO MOTHER CARE (KMC) SITES

In ACCESS' KMC program, a refresher course has been done for Jhpiego staff during two days in April 2009.

In May 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 unit 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 units 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.

Needs:

- Sensitization about KMC and its benefits for all medical staff at hospitals and health centers level because on field it seems that it only KMC unit staff who are 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.

C) Faith Based Organization Activities

- ACCESS collaborated with RCLS (Network of religious leaders against AIDS) 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.
- Printing of sermon guide, 800 copies in Kinyarwanda and 250 copies in English
- Plan to disseminate these sermons guides

Illustrations in the Guide from the Holy Bible and Holy Qur'an

- *A condition like malaria with symptoms of fever, shivering, perspiration, and weakness was mentioned in the Bible, At least twice, Jesus healed people who suffered from it. "And when Jesus entered Peter's house, He saw his mother-in-law lying sick with a fever; he touched her hand, and the fever left her, and she rose and served him." (Mt 8:14-15). A letter from John also tells us about malaria: "So he asked them the hour when he began to mend, and they said to him, 'yesterday at the seventh hour the fever left him.'" (Jn 4:52)*

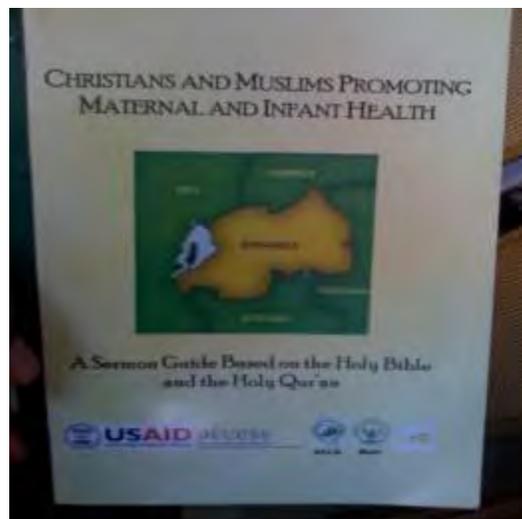
- *Islam requires everyone to take care of his or her body, clothes, and household. In His commandment, God said, “for Allah loves those who turn to Him constantly and He loves those who keep themselves pure and clean.” (Qur’an 2:222) He also asserted, “And thy garments keep free from stain!” (Qur’an 74:4)*

SOME PICTURES FROM WORKING WITH FAITH BASED ORGANIZATIONS



Christians and

Muslims



Together to have this Sermons Guide on maternal and child health

PRESIDENTS MALARIA INITIATIVE

INTRODUCTION

In FY 07, 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 April and June 2009 for the SBAI and PMI activities planned this year in collaboration with the MOH, PNILP, district authorities and other key partners.

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

- Presentation made on the experience of working with FBOs to fight against malaria at the national conference of religious leaders, June 23rd, 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.

TRAINING OF PROVIDERS FROM THE FOLLOWING 8 DISTRICTS IN FOCUSED ANTENATAL CARE:

In total 125 providers in health centers have been trained in FANC. In Huye district 14 providers, Rulindo district 12 providers, Rutsiro district 16 providers, Kicukiro district 7 providers, Munini district 26 providers, Gatsibo district 16 providers, Nyamagabe district 25 providers and Gasabo district 9 providers.

Training has been decentralized to the district level and ACCESS/Jhpiego conducted a total of 5 workshops during this quarter. 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.

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.

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.

THE FOLLOWING TABLE SUMMARIZES TRAINEES BY ORIGIN AND GENDER FROM APRIL TO JUNE 09

Districts	Hospitals	Number of Health centers	Number of providers trained	Gender	
				Female	Male
Huye	Kabutare	14	14	14	0
Rulindo	Rutongo	16	12	9	3
Rutsiro	Murunda	18	16	14	2
Kicukiro	Kanombe	8	7	6	1
Munini	Munini	14	26	16	10
Gatsibo	Ngarama Kiziguro	19	16	13	3
Nyamagabe	Kaduha, Kigeme	17	25	22	3
Gasabo	Kibagabaga	12	9	7	2
8 Districts	10 hospitals	118	125	101	24

II. COMMUNITY HEALTH INTERVENTIONS

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 April ACCESS/Jhpiego conducted 6 workshop sessions for district ASM providers as a key point of contact with mothers and their family members. The activities were done in collaboration with TOT districts supervisors using the manual for maternal and newborn health care at the community level.

The sessions were successfully accomplished. The result of pre and post test is an indicator of successful confirmation of this by comparing the average pre-test and post test.

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).

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.

The following table shows the number of ASM trained

District	Health Center	ASM Supervisors trained from 20-24 April 2009 in Nemba	Number of villages/ FOSA	Number ASM trained/ FOSA	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	Busasama na	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 districts	3 Health Centers	6 ASM Supervis ors trained	134 villages	268 ASM trained	9 sessions	

Some changes noticed after ASM training

- 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

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

III. SOME PICTURES FROM ASM TRAINING







IV. Challenges

- **SBAI**

- Coordination of training activities with partners at district level
- Data collection on MNH indicators at hospital and health centers level
- Providers need to take ownership of the quality performance improvement process
- Need to follow up KMC scale up at national level

- **PMI**

- There is an imperative need to train additional providers in FANC because of the numbers of providers per facility and per district.
- There is a large number of ASM to be trained but available resources are limited.
- Monitoring and evaluation system needs to be finalized.

Next steps

- **SBAI**

- Training of 25 providers in EmONC
- Follow up the utilization of SBMR
- Formative supervision of KMC implementation
- Work with MMR Technical working to discuss about KMC scale up
- Workshop to validate KMC national guide
- Endline assessment

- **PMI**

- 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.