

## **ACCESS Rwanda Quarterly Report January - March, 2009**

### **BACKGROUND**

Since 2006, ACCESS/Rwanda is working in partnership with the Ministry of Health, Twubakane and other central and bilateral partners in Rwanda to support USAID's Safe Birth Africa Initiative (SBAI). ACCESS is providing technical assistance in the areas of policy development, service delivery, and community involvement, liaison with faith-based organizations which deliver over 40% of health services, 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 program geographic coverage includes four districts: Gasabo, Kicukiro (Kigali), Nyamagabe and Nyaruguru (South), five district hospitals, 38 health centers and approximately 2000 villages. Also since 2006, ACCESS is implementing malaria in pregnancy activities supported by funding from the President's Malaria Initiative (PMI), in the same four districts as SBAI. ACCESS is collaborating with the PMI and the Ministry of Health in Rwanda to scale up Rwanda's new 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. Since October 2008 ten (10) additional districts 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 ASM as a key point of contact with mothers and their family members. The total districts covered by ACCESS's malaria in pregnancy activities are: Nyaruguru; Gasabo; Gakenke; Musanze;

Nyabihu; Rubavu; Gatsibo; Nyamagabe; Kicukiro; Huye; Nyamasheke; Rulindo; Gicumbi and Rutsiro.

## **ACTIVITIES PLANNED AND EXECUTED**

### **Introduction**

The activities reported below represent the progress achieved during January through March 2009 for the SBAI and PMI activities planned this year in collaboration with the MOH, PNILP, district authorities and partners.

### **I. Safe Birth Africa Initiative**

#### **1) 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, including four Twubakane districts where we implement activities together. 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 how to do it.

The 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. During the month of January 2009, 28 hospital supervisors from the six hospitals (MUHIMA, KIBAGABAGA, KANOMBE, NYANZA, KADUHA and

KIGEME) implementing SBMR, 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.

The 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. Step 3 will occur during the next quarter, April through June 2009.

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.

At this point performance-based financing can play an important role 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.

### **1) MNH data collection at health facilities and hospitals**

At the beginning of the quarter, key indicators related to safe delivery and essential newborn care have been collected in order to ensure the practice by the providers of skills learnt from the trainings. The same tool has been used to collect data from health centers. There is an

improvement in the use of partogram, but there is a need to insist on the consistent use of active management of third stage of labor.

2) The following table shows some results from 4 hospitals during 2008.

## **2) Follow up of Kangaroo Mother Care (KMC) sites**

In 2008, ACCESS trained 18 providers from 9 hospitals in KMC and collected data. There was a need to conduct regular supervision with these units. During this quarter we have been able to visit four KMC units. Some of the findings and recommendations are included below:

- KMC is functional in 4 hospitals( Kanombe, Kigeme, Kibagabaga and Muhima )
- 500 newborn caps were donated to Muhima KMC units
- Supervision was conducted in KMC units in 4 hospitals; results reveal the following:
  - At Muhima hospital, from 108 newborns admitted, there were no death during 2008 and, for this first quarter of 2009, from 4 admitted in January, there are no deaths. This compares to 2007 data that from 66 admitted, there was 1 death
  - At Kibagabaga hospital, from 48 admitted, there were 3 deaths during 2008. There is no data yet for 2009
  - At Kanombe hospital, from 47 admitted, there was 1 death in 2008 and, for 2009, from 4 admitted, no death
  - At Kigeme hospital, from 98 admitted, there were 21 deaths in 2008, WHAT IS REALLY HIGH and the data does not mention the cause of death. So far in 2009, from 10 admitted, 5 died.

Two issues impacting the results are: 1. Many providers who were trained have left the hospitals or KMC Units and 2. . There were only 2 providers trained per hospital which was not enough to impact on others 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.

### **3) Support the MOH to draft KMC national guidelines**

At the request of the MOH, ACCESS drafted KMC guidelines to provide guidance to district health management teams and 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 millennium development goal (MDG) 4, which aims to reduce the 1990 under-five child mortality rate by 2/3 by the year 2015. We are still waiting for their feedback on the draft guidelines in order to move forward.

### **4) Faith Based Organization Activities**

- **Translated Muslim sermon guides into Kinyarwanda and English**

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.

- **Next steps**

**II.** ACCESS planned to print 1,000 copies and to train religious leaders who will be able to train others in the use of this sermon guide. ACCESS will work with RCLS to explore other partnerships such as UNICEF to access additional resources for dissemination of the guide. 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. **Presidents Malaria Initiative**

**1) Field visit to meet with key district decision makers (Major, Vice-Major, Health Director and District Director) to exchange on MIP activities planned for this fiscal year.**

In order to involve district stakeholders in the process of planning MIP activities at the district and community levels, ACCESS initiated field visits to meet with decision-makers (Majors, Vice-Majors, Health Directors and Hospital Directors) in 12 of the 14 program covered districts. All have been very cooperative and interested in working with ACCESS to prevent and treat MIP. This was not only an opportunity to share activities with decision-makers, but also to do advocacy and sensitize them on the need to support MIP activities in their districts.

**2) To strengthen Reproductive Health and Family Planning Services**

**• Training of additional national trainers in FANC/MIP**

During this quarter, ACCESS collaborated with a master trainer from the PNILP to conduct the first training of trainers in focused ANC. The new FANC/MIP training package was used, which is based on the new MIP policy that excludes intermittent preventive treatment for pregnant woman and places emphasis on early and regular attendance of ANC, use of ITNs and mebendazole and iron folate. This training took place from February 16-20, 2009 in Rwamagana district and gathered 25 district supervisors of health workers from 16 district hospitals.

The purpose of this training was not only to update trainers on malaria prevention and case management using the focused ANC approach, but also to strengthen their skills in the adults training methods. A total of 25 districts supervisors have been trained and are ready to contribute to the training of providers from their respective district health facilities.

The following table summarizes trainees by origin and gender.

Districts	Hospitals	Number of participants	Gender	
			Female	Male
1. Kicukiro	1. Kanombe	2	1	1
2. Gasabo	2. Kibagabaga	2	1	1
3. Nyamagabe	3. Kaduha	1	0	1
4. Nyaruguru	4. Munini	2	1	1

5. Huye	5. Kabutare	1	0	1
6. Gicumbi	6. Byumba	2	0	2
7. Rurindo	7. Rutongo	2	0	2
8. Nyabihu	8. Shyira	1	0	1
9. Rubavu	9. Gisenyi	2	2	0
10. Gakenke	10. Nemba	1	0	1
	11. Ruli	1	1	
11. Nyamasheke	12. Kibogora	2	1	1
	13. Bushenge	1	1	0
12. Gatsibo	14. Ngarama	1	1	0
	15. Kiziguro	2	0	2
13. Musanze	16. Ruhengeri			
		2	2	0
<b>13</b>	<b>16</b>	<b>25</b>	<b>11</b>	<b>14</b>

- **Training of providers from the following 6 districts (Nyabihu, Rubavu, Gakenke, Musanze, Gicumbi, ) in FANC/MIP**

Training has been decentralized to the district level and ACCESS conducted a total of 4 workshops during this quarter. Most of the providers trained are health center chiefs and each district health center was represented at the training workshops.

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 more holistic approach of focused ANC.

For many of the providers, these workshops represented their first in service training in 5 years since they graduated from nursing school. They were interested by the fact that this new approach will change their behavior vis à vis women and also will reorganize their service-to-provider antenatal care every day rather than twice a week. The district and hospital directors, who were involved in this activity from the perspective of capacity building of their personnel, were also satisfied and promised to support activities through regular and formative supervision. Training all providers from health centers, including hospital providers will really bring change to the health system, and will reinvigorate focused ANC and postnatal care which is currently weak in service provision.

The following table summarizes trainees by origin and gender.

Districts	Hospitals	Number of Health center	Number of providers trained	Gender	
				Female	Male
Gicumbi	Byumba	22	22	20	2
Nyabihu	Shyira	15	15	15	0
Rubavu	Gisenyi	10	10	10	0
Gakenke	Nemba	12	12	10	2
Musanze	Ruli	7	7	6	1
	Ruhengeri	9	9	9	0
Nyamasheke	Bushenge	6	6	6	0
	kibogora	12	12	12	0
<b>6</b>	<b>8</b>	<b>93</b>	<b>93</b>	<b>88</b>	<b>5</b>

### **III. Community Health Interventions**

#### **1) Translation of community health worker (agents de santé maternelle - ASM) Manuals into Kinyarwanda**

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.

#### **2) Training of district supervisors**

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, we used for the training in maternal and newborn health care at the community level. From March 2-7, 2009, ACCESS conducted a workshop for district supervisors 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.

New staff of the Community Health Desk attended this workshop.

The following table shows the number of participants, per origin and gender:

N*	Districts	Hospitals	Number	Gender	
				Female	Male
1.	Musanze	Ruhengeri	2	1	1
2.	Nyabihu	Bagbaya	2	1	1
3.	Muhanga	Shyira	2	0	2
4.	Gatsibo	Kiziguro	2	0	2
5.	Gasabo	Kibagabaga	3	2	1
6.	Rubavu	Gisenyi	2	2	0
7.	Gakenke	Nemba	2	1	1
8.	Nyaruguru	Munini	2	1	1
9.	Nyamagabe	Kigeme	2	2	0
10.	Kirehe	Kirehe	2	0	2
11.	Community Health Desk Staff	-	4	2	2
<b>Total</b>			<b>10</b>	<b>25</b>	<b>13</b>

#### **IV. Challenges**

##### **SBAI**

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

##### **PMI**

- The new MIP policy has not yet been disseminated at the national level and there is a need to move forward with updating all providers on this new policy,
- There is a large number of ASM to be trained but available resources are limited.
- Monitoring and evaluation system needs to be finalized

## **SUCCESS STORY: Fighting Malaria in Pregnancy through Community Health Workers in Rwanda**



Through the ACCESS Program, Jhpiego is implementing activities to prevent and treat malaria in pregnancy in Rwanda. Starting in just 4 districts in 2006, the program has now expanded its reach to 14 of Rwanda's 30 districts. Jhpiego uses the community-to-clinic continuum of care approach to reach pregnant women through their communities, as well as health centers that serve them, so that there are no missed opportunities. Jhpiego is strengthening service providers' skills in counseling pregnant women on malaria prevention and disease management and in providing prevention and treatment services. To complement services at health centers Jhpiego is promoting community interventions that reach women at the village level with appropriate messages about preventing and treating malaria, enabling them to become informed actors and not only beneficiaries.

The community approach is based on female volunteer community health workers (CHWs) who in pairs reach women and their families with important malaria messages and encourage them to access vital antenatal care services at clinical facilities where malaria treatment and prevention services are available. CHWs are selected by co-villagers (abaturage) based on criteria like literacy, willingness to volunteer, and acceptability by other women. Rwanda has trained 60,000 CHWs, and the Ministry of Health created the Community Health Desk within its structure to support and coordinate these community activities. The CHW job description establishes a role for CHWs in maternal and newborn health care.

The village's CHW pair is mandated to record all women in a register and monitor their health. Given that an average village (umudugudu) has 150 households, each CHW pair may monitor between 75-90 pregnant women annually. CHWs follow each woman regularly, aided by tools such as a checklist, to make sure that they attend antenatal care, use malaria preventive measures such as insecticide-treated mosquito nets, make a plan for birth and complications, deliver with a skilled provider, and receive information on nutrition, family planning, malaria, HIV/AIDS and danger signs during pregnancy and delivery.

The CHWs are trained by their supervisor at the nearest health center in the local language (Kinyarwanda). They are being assisted through regular meetings by their supervisors and health workers, as well as when they accompany pregnant women to the health centers. A monitoring system has also been put into place to track CHW activities.

Jhpiego has collaborated with ACCESS Program partners, the Ministry of Health and other local partners to adapt behavior change messages for the community, as well as to update CHW training materials and tools for use in the community. By using these materials, Jhpiego is assisting the Ministry of Health to provide in-service training to 300 CHWs this year in its 14 program districts. This activity will cover a population of 4,775,308. Including CHWs in the continuum of care, means that we can begin to count malaria out in Rwanda, right from the village level.

