Background

The goal of the Maternal and Child Survival Program’s (MCSP’s) maternal health program in Rwanda is to build the capacity and readiness of health care providers working in maternity units to provide quality routine, integrated care for mothers and newborns on the day of birth, and to manage childbirth complications, thus contributing to the reduction of preventable child, neonatal, and maternal mortality in Rwanda.

Rwanda has made significant achievements in maternal health and survival. Tremendous efforts implemented over a period of years have increased the safety of deliveries taking place in health facilities. Currently, 91% of deliveries take place in the health facility. The day of birth is the most dangerous for pregnant women and newborns, with more than 40% of maternal and newborn deaths occurring within the first 24 hours after birth.1 Rwanda recognizes that access to quality care, provided by a skilled birth attendant on the day of birth is one of the key strategies to assure the safety of childbirth, consequently reducing maternal and neonatal mortality. Increasing the quantity and availability of skilled human resources for health through training and continuing professional development of health care providers is a priority of the government of Rwanda, and a key focus of MCSP Rwanda’s maternal health program.

MCSP Rwanda is committed to working closely with and supporting Rwanda’s Ministry of Health (MOH) in the implementation of its Maternal, Newborn and Child Health Strategic Plan to end preventable child and maternal death through the implementation of reproductive, maternal, newborn, and child health (RMNCH) high-impact interventions in 10 districts. Capacity-building of maternal health care providers to provide the high-impact intervention included in provision of basic emergency obstetric and newborn care (BEmONC) is a key component of MCSP Rwanda’s program.

1 Every Newborn, An Executive Summary for The Lancet’s Series, May 2014.
Program Approaches and Interventions

- MCSP supported the MOH to review national guidelines and BEmONC training tools, integrating a locally designed adaptation of the low-dose high-frequency (LDHF) approach to capacity-building. This modularized BEmONC curriculum, integrated with mentoring activities, has been used to build the capacity of health care providers working in maternities in all 10 MCSP-supported districts. Lifesaving skills—including active management of third stage of labor for postpartum hemorrhage (PPH) prevention, PPH management, pre-eclampsia/eclampsia management, and Helping Babies Brief (HBB)—are emphasized in the curriculum.

- Assuring sustainability thorough training of district-based mentors (10 to 15 per district) and working in collaboration with the Rwanda Association of Midwives to reinforce onsite mentorship of health care providers. This approach aims to achieve quality improvement in maternal and newborn care by supporting clinical knowledge, skills, and patient care attitudes/behaviors for midwives and nurses working in maternities in all 10 MCSP-supported districts.

- The culture of data use for decision-making by health facilities has been initiated and supported by MCSP in all health facilities and that contributes to the quality improvement of maternal and newborn health (MNH) services in MCSP-supported districts. Data related to MNH and plans for improvement are also taken into consideration during the monthly mentorship visits done by mentors in all health facilities.

- MCSP supported the First National Stakeholders’ Consultation meeting on Respectful Maternity Care where MOH and stakeholders, including professional associations, civil societies, health facility managers, and health care providers, from the 10 MCSP-supported districts met. At the meeting, participants discussed forms of disrespectful and abusive behavior that exist in maternity care in Rwanda, listed significant contributors or drivers for these types of care, suggested solutions to address these forms of disrespect and abuse in maternity care, and discussed and described the potential role of health care providers, professional associations, and civil society in addressing disrespect and abuse and facilitating respectful maternity care. Respectful maternity care has also been integrated into BEmONC training tools.

- To contribute to the quality of antenatal care (ANC) services provided in health centers, MCSP supported the review of ANC training materials and trained four mentors per district to assure focused ANC (FANC) mentorship is implemented with high quality in all health centers in the 10 MCSP-supported districts.

- MCSP participated in the review of Postnatal Care national guidelines according to World Health Organization recommendations. This has been a good opportunity to integrate the pre-discharge checklist with the national guidelines to ensure that mothers and newborns are staying in the health facilities for at least 24 hours, are being closely monitored by health care providers, and are discharged in safe condition.

- MCSP supports the death audit committees at district hospitals to review maternal, child, and newborn deaths. From the findings, recommendations are made and responses are provided for preventable death, which is done through Society of Obstetric and Gynecology of Rwanda (RSOG) mentorship.

Key Results

- BEmONC/LDHF training coupled with mentorship contributed to the increase in the number of competent health care providers capable of providing quality MNH services. A total of 1,291 health care providers have been trained and 107 BEmONC district-based mentors have been trained to support the continuous monthly mentorship implementation in all MCSP-supported districts.
• This had a positive impact on the increase of uterotonics use in the third stage of labor for PPH prevention.

• Through mentorship on FANC, at least two health care providers working in ANC services per health center have been trained, which contributed to the increase in the number of women who attended the four recommended ANC visits.

The following improvements have also been reported by district-based mentors in terms of MNH services: availability and use of magnesium sulfate (loading dose) in health centers for pre-eclampsia/eclampsia cases before referral to the hospital, effective use of partogram for labor monitoring in health facilities, increase in health care providers’ confidence (including those working in health centers) in terms of management of childbirth complications and timely referrals of complicated cases.
MCSP has also supported obstetric fistula screening and 66 clients have been successfully treated for this devastating condition.

**Lessons Learned**

- The stakeholders meeting and involvement of the health facility managers at the beginning of the program was key in successful implementation of BEmONC/LDHF and mentorship.
- On-the-job BEmONC/LDHF and mentorship contributed to the increase of number of proficient providers on BEmONC in MCSP-supported districts.
- According to feedback from district mentors and health facility staff, BEmONC/LDHF and mentorship have improved teamwork and MNH service delivery.
- Changes and adoption of best practices in maternity, improvement in service organization, availability, and use of protocols in health facilities happened because all providers were trained and have the same understanding.
- Onsite BEmONC/LDHF and mentorship allowed for improvements related to the organization of maternity services and availability and use of protocols in health facilities.
- Well-structured community mobilization, door-to-door identification of suspected cases by community health workers and screenings at the district hospitals allow more clients suffering from obstetric fistula to be screened and repaired.

**Challenges**

- Stock-outs of iron and folic acid in some health facilities presented challenges for the provision of quality ANC services.
- Because of negative cultural beliefs, most women are reluctant to reveal their pregnancies during the first trimester. This makes them miss their first standard ANC visits and consequently their fourth standard visit.
- The busy workload and shortage of health care providers in some health facilities was challenging in terms of availability of providers to be mentored.

**Recommendations**

- The MOH and MCSP technical staff should ensure continuous supervision of monthly mentorship by district-based mentors where BEmONC/LDHF has been implemented. This will ensure the increased retention of lifesaving skills among providers and continuously improve the quality of care in MNH services.
- BEmONC/LDHF should be scaled up in other non-MCSP-supported districts.
- Technical support should be provided to the MOH to update guidelines and training tools by incorporating ANC, managing complications in pregnancy and childbirth, and uterine balloon tamponade for management of PPH due to atony.