

Summary of Rwanda Country experience – implementing PNC home visits

1. Background

A *National Roadmap to Accelerate the Reduction of Maternal and Infant Mortality* was adopted by the Rwandan Ministry of Health in 2008. The *Roadmap* outlines approaches to reducing maternal and newborn mortality, and includes strategies for improving the quality of facility-based primary and referral care, the availability of kangaroo mother care (KMC) and the availability of community-based services for women during pregnancy and in the post-natal period. The *Roadmap* builds on the National Reproductive Health Policy (2003), the National Child Health Policy (2008) and the Strategic Plan for Acceleration of Child Survival (2008-2012). All program activities are implemented in the context of the Economic Development and Poverty Reduction Strategy of Rwanda (EDPRS 2008-2012) and the National Health Sector Strategic Plan (HSSPII 2009-2012).

General approaches to implementing community-based activities are outlined in the National Community Health Policy of Rwanda (2007). The health system in Rwanda is decentralized to the district level. The country is divided into 4 provinces and the City of Kigali, 30 districts, 416 sectors, around 9,000 cells and 15,000 *Imidugudu* (villages). A system of community-based health insurance in the form of mutual health insurance was established in 1996. Since 2006 Rwanda has implemented a Performance Based Financing (PBF) model to provide incentives to facility- and community-based health workers. The PBF approach provides quarterly remuneration to health workers based on performance measured by defined indicators.

2. Policy/strategy adoption – early PNC home visits 2008-2011

2.1 Process of introduction

Introduction of community-based maternal and newborn health care built on a strong existing community-based structure. This structure includes three categories of Community Health Workers (CHWs): (i) Binomes - who work on primary health care, nutrition and c-IMCI (2 in each community); (ii) Animatrice de Sante Maternelle (ASM) in charge of maternal and newborn health care (1 in each community); and (iii) CHW in charge of social affairs (1 in each community). At the cell level one of the CHWs is elected to coordinate community health workers activities. Each health facility has a dedicated staff person allocated to oversee community health workers in their catchment area, and each district has a community health supervisor. At the central level, the MOH has established a Community Health Desk, under the unit of maternal and child health. This unit is responsible for overseeing planning, coordination and monitoring of all community health activities. In addition, in order to strengthen coordination, a community-health committee has been established under the maternal and child health technical working group. The community health committee meets monthly and includes representatives of the MOH and development partners. The group helps to coordinate activities of all partners, mobilize partner resources and develop guidelines and materials. Recommendations on key issues from this group are submitted to the MCH technical working group and then to senior management for approval. Once endorsed by the senior management

committee, the community health committee can take action to implement activities on the ground in collaboration with partners.

Process of implementation

PNC home visits are implemented as a component of a home-based Maternal and Neonatal Health Care Package (HB-MNHCP). Implementation has therefore focused on the overall package.

- Implementation of HB-MNHCP was recommended by the unit of Maternal and Child health, and the Community Health Desk. The concept was developed from the global HB-MNC approach advocated by WHO and UNICEF and was adapted to the country context as a strategy to reduce maternal and neonatal deaths.
- A coordinating committee composed of MOHP and key partners was established to support consensus building, review and adaption of materials, development of tools, and to plan the implementation process. Key development partners and MOH staff were involved in the decision to begin implementation – support to districts was divided between development partners and the MOH – and coordinated with district health teams and community health supervisors. Early PNC home visits has not yet been incorporated into the reproductive health or child health policies, however it is being implemented as a strategy that has been endorsed for national implementation.

The early process of adoption of HB-MNHCP was supported by WHO and UNICEF, who convened a Regional African Workshop and conducted a training in CMNH using materials adapted from the Malawi program. Adaptation of HB-MNHCP materials for Rwanda was coordinated by the community health desk in collaboration with UNICEF, WHO, MCHIP/JHPIEGO, EIP, and Lux Dev.

2.2 Content of policy/strategy

HB-MNHCP is implemented by the Community Health Workers in charge of Maternal and newborn Health Care - Animatrice Sante Maternelle (ASM). The standard guidelines recommend that ASMs identify pregnant women and then conduct home visits during pregnancy and in the postnatal period as shown in the ASM home visit schedule table on page 3 - 3 during pregnancy and 3 in the postnatal period. If the baby is low birth weight then an additional 2 home visits are recommended. Mothers and newborns are screened at the same time. The training package includes the 7 core competencies recommended by WHO and others – in order to deliver key maternal and newborn interventions¹. In addition, ASM guidelines recommend that ASMs refer pregnant women for ANC, accompany women to health facilities for delivery, and refer mothers and newborns for PNC.

¹Core PNC competencies: Promotion of NB care (early/exclusive BF, warmth, hygiene); Promotion of optimal care for mother (nutrition & family planning); Promotion of care-seeking for mother & newborn; Identification of danger signs in mother + referral; Identification of danger signs in newborn + referral; Support for breastfeeding; Care of low birth weight infant (feeding, skin-to-skin contact)

ASM home visit schedule – Rwanda ASMs

During pregnancy: Three home visits

- Pregnancy visit 1: as soon as pregnancy is confirmed
- Pregnancy visit 2: Five – six months of pregnancy
- Pregnancy visit 3: between eight –nine months of pregnancy

After birth: If birth weight is normal, three home visits :

- Visit 1: day 1 after discharge from health facility or within 24 hours for a home delivery
- Postnatal visit 2: between day 5-7 after delivery
- Postnatal visit 3: day 28 after delivery

If low birth weight (small baby), five home visits:

- Postnatal visit 1: when the mother arrives at home or within 24 hours for a home delivery
- Postnatal visit 2: day 5 after delivery
- Postnatal visit 3: day 7 after delivery
- Postnatal visit 4: day 14 after delivery
- Postnatal visit 5: 28 day after delivery

2.3 Supporting policies/strategies

A national policy of facility-based deliveries by a skilled provider has been adopted. Health facilities should have at least one delivery room. Skilled providers in Rwanda include: doctors, nurses, midwives or auxillary midwives.

Kangaroo mother care has been incorporated into the national child health policy as a strategy for managing pre-term and low birth-weight babies. KMC guidelines have been incorporated into the national EmONC and IMNCI training guidelines. EmONC and IMNCI have been adopted as the primary training packages for facility-based health workers. CHWs are trained in CCM of sick children – and are permitted to treat malaria, diarrhea, pneumonia and to refer sick newborns with danger signs to health facilities - the package does not allow CHWs to treat sick newborns.

Lessons learned: Adoption of the HB-MNHCP strategy

- A designated community health desk has been important for adoption – staff are responsible for overseeing and coordinating implementation of community-based activities, including development of guidelines and materials.
- A community health coordinating committee has been essential for mobilizing technical and financial resources. Key stakeholders make decisions together, have consensus on materials and guidelines; and share implementation costs and responsibilities.

- Policy guidelines and field experience from other settings in Africa have been useful for providing guidance on local approaches.
- Having designated staff at district and health facility levels who are responsible for overseeing community-based activities – and an existing system of community-based workers, made it feasible to consider a HB-MNHCP strategy using local resources.
- Having a PNC home visit policy formally adopted is not essential for beginning implementation of the approach – provided there are mechanisms for ensuring that all key MOH and other stakeholders are involved in the decision-making process and have input.
- The HB-MNHCP approach is expected to increase referrals for facility-based deliveries, suspected maternal and newborn danger signs, and for low birth-weight babies. It is therefore essential that policies and guidelines for improving quality of delivery care including EmONC, managing sick newborns, and managing low birth weight babies, be adopted in tandem with the HB-MNHCP approach.

3. Selection and training of community health workers

3.1 Characteristics of community health workers

The HB-MNHCP approach is implemented by ASMs. Criteria for selection of ASMs include:

- Female
- At least a primary education
- Ability to read and write
- 20-50 years of age
- Live in the village where they work
- Available to conduct home visits
- Integrity/respected in the community

ASMs are selected by village chiefs who consult with community members. Their participation is on a voluntary basis. The selection is guided by local community leaders and discussed with the health worker responsible for community health at the local health facility. A meeting of village leaders and the community health supervisor is held to finalize the selection. ASMs receive 6 days basic training in HB-MNHCP. On average ASMs are responsible for 100-150 households. Each pregnant woman is given a mother's and baby card at the first ANC visit – this is kept by the mother and used to record and track all contacts. ASMs record all pregnant women and home visits in a community register – data from the register are summarized each month and submitted to the health facility community supervisor. Referral notes are given to all women and babies referred to facilities. Each ASM receives a kit containing essential equipment and supplies (see section 4.2).

A system of performance based monitoring (PBF) is in place nationally. This system provides incentive payments for selected performance indicators, including: the number of women

referred by ASMs for ANC in the first 4 months of pregnancy, the number of women accompanied by ASMs to the facility for delivery; the number of women referred by ASMs for PNC and vaccination of newborns. The system is managed by a sector steering committee for PBF. Funds are dispersed from the central level to a facility account managed by the steering committee, based on indicator performance. Funds are divided – 70% returning to the CHW cooperative and 30% being given to the ASMs as incentive payments. The cooperatives can use the funds raised to support facility services and other local health activities. Funds for PBF are from a central government allocation.

A workshop on approaches to community mobilization was conducted in November 2011 by the MOH Community Health Desk and MCHIP. This was conducted with national MOH staff and district community supervisors. The workshop focused on the Save the Children community action cycle approach – and proposed using existing community groups such as health and hygiene clubs to coordinate community participation activities. Facility health committees will be expanded to include community representatives, in order to better represent community perspectives. This approach has is still under development. In 2012, training guidelines will be adapted and tested, and training of ASMs is proposed in selected districts.

Lessons learned: ASMs

- ASMs are well liked and respected in communities. The selection process involves communities and has been well accepted. Because ASMs are required to live in the communities they serve they are effective communicators to local women.
- ASMs appear to be able to complete all HB-MNHCP tasks without difficulty, including counseling using counseling cards, home visits, and completing community registers. Because they do not have other program responsibilities, they generally have enough time for home visits.
- ASMs do not believe that they miss significant numbers of pregnant women – when serving a population of 100-150 households. Because they are known in the village pregnancies are usually reported to them by families. Delays in identifying pregnant women can occur because of a cultural tendency for women not to report pregnancies in the first 3 months.
- Because ASMs are required to accompany women to facilities for deliveries, they are notified by women at the onset of labor. Because they are aware of the delivery, they are more likely to follow-up with the woman at home to provide early PNC.
- ASMs report that the PBF is an important motivator. It is functional in all areas visited, although payments in some areas are delayed.
- Referrals for PNC are not currently included in the PBF mechanism – including PNC visits could help increase referrals.

3.2 Training of CHWs

Counseling messages and materials were reviewed and adapted at a BCC review workshop in April 2008. HB-MNHCP training materials were adapted and tested in early 2010 by the MOH Community Health Desk and the development partners including UNICEF, MCHIP/JHPIEGO, EIP and Lux Development. Materials used for the local adaptation were the WHO/UNICEF *Caring for mothers and newborns at home* training materials for community health workers, that had been pre-tested in Kenya, Philippines, India and Malawi in 2009. Feedback from this first local training was used to further adapt the guidelines. Training of ASMs using the adapted guidelines was begun in early 2010. All partners implementing HB-MNHCP used the same adapted training materials. A cascade method of training has been used. National trainers have been trained, as well as 3 HB-MNHCP trainers and 2 health center community supervisors in each implementation district. Facility community supervisors train ASMs in their catchment area – usually at the health center. The duration of the training is 6 days – and includes 2 half days of field practice (one for the mother and one for the newborn), as well as role plays, case-studies and exercises. All training costs have been covered by development partners in the districts for which they are responsible. In areas where the Rapid SMS alert system has been introduced CHW training was coordinated with training in this system.

Lessons learned: training

- Cascade training has worked well because of the presence of dedicated community health supervisors at districts and health centers – these staff have taken responsibility for training and have developed local training plans. Local plans help ensure that training is done efficiently and that staff are not missed.
- Central support has been useful to help address problems and answer questions, particularly in the early phases, before district and community staff have experience.
- The training materials appear to be appropriate for the education level of ASMs. ASMs report that the training gives them the skills they need to do their job effectively. They report that the length of the training and the amount of field practice is adequate. The counseling cards are clear and easy to use. They also report that community registers are clear and easy to complete.
- Follow-up after training is conducted by community health worker supervisors – although visits are often not made. Some ASMs and other CHWs report that they would like refresher training and more regular updates.
- Training costs are shared between the MOH and development partners.

4. Implementation

4.1 Training coverage

Preparations for training in the HB-MNHCP package began in early 2010. Early implementation was proposed in districts already receiving support to develop facility-based services by UNICEF (including roll out of the rapid SMS alert system) and the MCHIP project. Facility-based activities in these districts include training and systems strengthening to improve the quality of delivery care, EmONC and KMC.

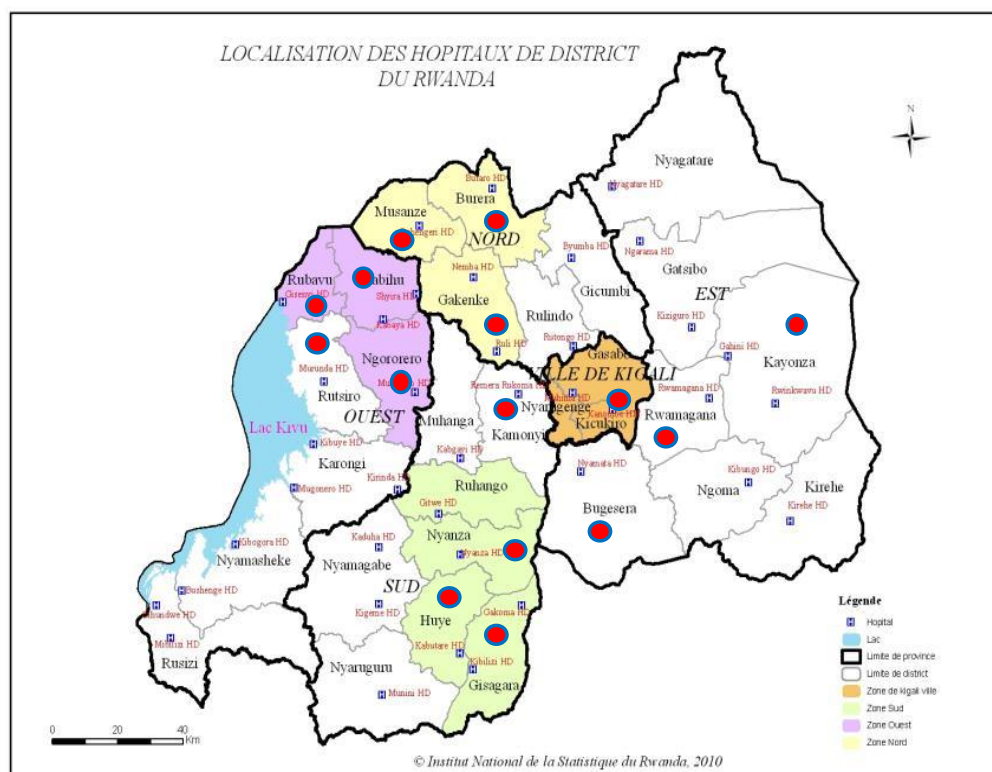
By December 2011 a total of sixteen districts had begun implementation of the CMNH approach – and a total of 7823 ASMs had been trained. Six districts had trained ASMs in place for between 1 and 2 years, and the remaining nine districts have had trained ASMs in place for less than one year.

In MCHIP/UNICEF areas, training began in 3 districts (Gakenke, Musanze and Nyabihu). By the end of 2010 all ASMs these districts had been trained (a total of 1692 ASMs) and this was extended to ASMs in the remaining 3 early implementation districts (Rubavu, Ngororero and Nyanza) by the end of 2011. By December 2011, a total of 3903 ASMs had been trained, representing 100% of ASMs in the 6 early implementation districts, and approximately 62% of the ASMs in the 13 UNICEF/MCHIP supported districts. In addition, by December 2011, all community health supervisors at district and health center level (211) had been trained in the 6 early implementation districts. Figure 1 and Table 1 summarize the implementation districts and supporting partners.

Table 1: Districts implementing the HB-MNHCP Package, Implementing Partner and Date ASM training was Completed, Rwanda, December 2011

No	District	Hospital	Implementing Partner	Date ASM Training Completed
1	Gakenke	Ruli	MCHIP	Jun-10
		Nemba	MCHIP	Jun-10
2	Musanze	Ruhegeri	UNICEF	Sep-10
3	Nyabihu	Shyira	UNICEF	Sep-10
4	Rubavu	Gisenyi	UNICEF	Feb-11
5	Ngororero	Muhororo	UNICEF	Jan-11
		Kabaya	UNICEF	Feb-11
6	Rwamagana	Rwamagana	MOH/Lux Development	Jun-11
7	Kayonza	Gahini	MOH	July 2010
		Rwinkwavu	PIH/MOH	July 2011
8	Burera	Butaro	PIH/Save the children	July 2011
9	Gisagara	Kibirizi	MCHIP	August 2010
		Gakoma	MCHIP	August 2011
10	Huye	Kabutare	MCHIP	Sep-11
11	Ruhango	Gitwe	MCHIP	June -11
12	Kicukiro	Masaka	MCHIP	Sep-11
13	Rutsiro	Murunda	MCHIP	Sep-11
14	Nyanza	Nyanza	MCHIP/UNICEF	Oct-11
15	Bugesera	Nyamata	UNICEF	Nov-11
16	Kamonyi	Remera Rukoma	MOH/Care International	Dec-11

Figure 1: Map of HB-MNHCP implementation districts, December 2011



4.2 Trends in coverage indicators: 2005-2010

Key MN indicators along the continuum of care have shown steady improvements nationally in the last 5 years. These improvements preceded widespread implementation of the HB-MNHCP approach – and are likely to be associated with a number of health systems inputs, including an increased allocation of national budget to health, and increasing uptake of national health insurance which is likely to have improved access to services. Population-based DHS indicators are summarized in the Table at the end of the summary. Trends in key indicators are shown in Figure 2.

National level DHS data: 2005, 2007/8, 2010 (preliminary data)

ANC

A high proportion of women receive ANC from a trained provider (98% 2010). ANC 4+ coverage rose from 13% to 35% between 2005 and 2010. In 2010 98% of women received ANC from a trained provider. Data from the 2010 DHS show that 38% of first ANC visits were made in the first 4 months of pregnancy, compared with 22% in 2007/8. Several aspects of ANC quality have shown improvements over the same time period, including the proportion of women who received iron (73% in 2010) and who slept under an ITN the previous night. A high proportion of newborns are protected against NN tetanus (79% in 2010). The 2010 DHS survey

showed that a very high proportion of women were given information on pregnancy complications/danger signs during their last ANC visit (72% compared with 6% in 2007/8). Overall, ANC coverage has generally increased; and a number of elements of quality of ANC care have shown improvements.

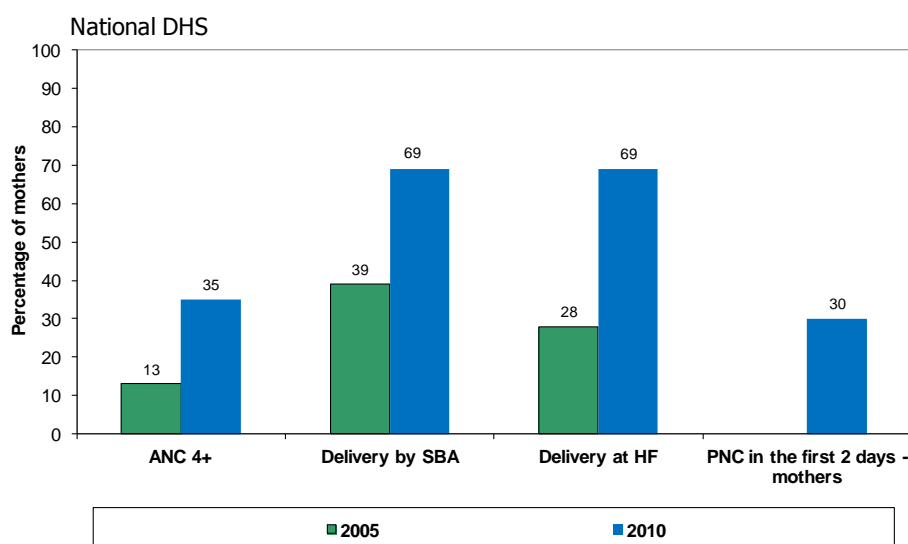
Delivery care

The proportion of women delivering with a skilled birth attendant rose from 39% to 69% between 2005 and 2010. This rise has been mostly due to an increase in facility-based deliveries and a decline in household deliveries. DHS 2010 data show that 69% of women delivered at their babies at a health facility compared with 28% in 2005. In 2010 18% of women reported a PNC contact within 2 days of delivery regardless of the place of delivery, a relatively low rate. Since 69% of women deliver with a skilled provider, this data suggests that opportunities to provide PNC are often missed.

Newborn care

The proportion of newborns breastfed in the first hour after delivery has shown an upward trend, rising from 41% to 68% between 2005 and 2007/8. Similarly the proportion of newborns exclusively breastfed has remained high (85% in 2010). The DHS in 2005 and 2007/8 did not collect data on key newborn practices, including drying, wrapping, delayed bathing and cord care.

Figure 2: Coverage of Maternal and Newborn Interventions, Rwanda, 2005 and 2010,



Rwanda DHS 2005, 2010 (preliminary)

Data from ASM community registers; 2010-2011

ASM community register data are not yet available from the majority of early implementation districts. Data are currently being routinely collected in Gakenke district, which was the first to begin ASM training and has been implementing for 2-3 years. Register summaries are compiled by the community health supervisor at district hospitals. More details of the community –based surveillance system are discussed in Section 4.2.

An example monthly reporting summary is shown in Table 2. These are data from one health center catchment area in the district of Gakenke. Absolute numbers are reported; so it is not possible to determine coverage or change in coverage over time. Community-based indicators have been established. The data allow tracking of ASM activities, and tracking of early PNC referrals for newborns delivered at home. The data show that in this catchment the majority of women are delivered at the health center; and that all those who deliver at home are sent for PNC within 24 hours of delivery. In addition, ASMs are accompanying about half of the women to facilities for delivery.

Table 2: Gakenke District, Ruli Hospital, Nyange Health Center: 6 Monthly ASM Report, 2011

Community-based newborn care	Jan	Feb	March	April	May	June
Number of pregnant women registered	108	97	109	109	103	102
Number of pregnant women follow-up	108	97	109	109	103	102
Number of pregnant women sent to HC ANC < 4 months	14	6	8	15	20	16
Number of pregnant women sent to HC for danger signs	2	3	1	5	2	0
Number of pregnant women home delivery	1	1	2	1	2	1
Number of pregnant women delivered at HC	16	16	-	16	22	21
Number of pregnant women accompanied by ASM for HC delivery	7	16	19	8	12	11
Number of home delivered women/newborns sent to health facility within 24 hours of delivery	1	1	2	1	2	1
Number of babies <2 m of age sent to HC with danger signs	0	0	0	0	0	0

Lessons learned: implementation data

- Nationally, improvements in ANC, skilled delivery care and early PNC contacts showed upward trends before widespread implementation of HB-MNHCP. The upward trend in early PNC contacts is associated with increased facility-based deliveries by skilled attendants. Missed opportunities to provide PNC after facility delivery remain common.
- Community register data are not yet available from all early implementation districts – from those areas where data are being regularly collected, data are useful for tracking elements of

community health worker performance. Register data are not yet summarized as coverage indicators – coverage data would be useful for tracking trends over time.

- National DHS surveys have not up to now collected data on a number of key neonatal health indicators, including drying, wrapping, delayed bathing and cord care practices. More data in this area are needed in order to assess quality of ENC and PNC.
- No population-based survey data from HB-MNHCP early implementation districts are yet available – population-based data will allow changes in coverage of HB-MNHCP interventions to be better tracked.

4.3 Program activity areas

4.3.1 **Planning and coordination**

Activities have been planned and coordinated by the maternal and child health unit of the MOH through the Community Health Desk. The Community Health Committee under the Maternal and Child Health Technical Working Group, has also played an important role in ensuring that a single set of technically sound HB-MNHCP materials has been used by all partners. All implementation has been conducted through districts. Because there are dedicated community health supervisors at the district hospital and health center levels, planning and coordination has been made considerably easier. District community health supervisors develop their own local training plans and track training coverage. Because they are in close communication with health center-based community supervisors, they are able to coordinate activities on the ground relatively easily. Costs of implementation have been shared between the MOH and partners. There is no experience so far with implementation of HB-MNHCP through routine district plans – which would require closer coordination at the district level, and allocations from the annual district budget.

The current plan for taking HB-MNHCP to scale is to begin in early implementation districts and to use these districts to learn key lessons. The implementation model is to share financial and technical resources between MOH and development partners. No strategy has yet been articulated for phasing out inputs from development partners and transferring responsibility to districts using routine budget allocations.

Lessons learned: Planning and coordination

- Planning and coordination has been facilitated by having a dedicated Community Health Desk at the central level, and a Community Health Committee to coordinate partners. Both have helped ensure that implementation is conducted systematically, that the same materials are used, and that resources are shared between the MOH and partners.
- Dedicated community coordinators at the district level, and community supervisors at the health center level have been essential for planning and training and support for ASMs.

- HB-MNHCP activities have not yet been incorporated into routine district plans for local funding – since resources have been provided by development partners. It remains to be seen whether HB-MNHCP will continue to be supported through the routine system.
- A strategy for scaling up HB-MNHCP throughout the country – and transferring financial responsibility to districts has not yet been developed.

4.3.2 Equipment and supplies for ASMs

All ASMs receive an essential equipment and supply kit. Costs of the kit are usually divided between the MOH (CHW manual, forms and register), UNICEF (timer, thermometer, MUAC measure, and new-born salter scale equipment), and MCHIP (boots, umbrella and bag). In some areas, other development partners have supported costs of components of the kit. Components of the kit are shown in the Box below. District community coordinators and ASMs report that complete kits are generally available. ASMs report that the kit is essential for them to be able to carry out core activities. In one area, essential equipment has been slow to arrive, and so kits have been issued without weighing scales, thermometer, and timer – limiting what the ASM is able to do during home visits. Since 2/3 of the components of the kit are supplied by UNICEF and MCHIP, ordering and supply is done by district community coordinators through project staff. Currently the MOH does not procure, distribute or fund ASM kits.

Equipment and supplies – ASMs

- ASM manual
- Pregnant Women Register
- Counseling cards
- Mother and baby cards – given to the mother at the first ANC visit
- Referral notes which are given to the family
- Weighing scales (newborn salter scale)
- Thermometer
- Timer
- Boots and umbrella
- Carry bag

Lessons learned: equipment and supplies for ASMs

- Equipment and supply kits are essential to enable ASMs to conduct home visit tasks according to standards.
- Bags and rain gear (umbrella, boots) are essential to facilitating home visits.
- How ASM kits will be procured, supplied and funded in the long term will still needs to be determined. Currently all most of the costs are covered by development partners – including supply and distribution to districts.

4.3.3 Supervision

District community coordinators supervise health center-based community supervisors. Health center-based supervisors are responsible for supervising ASMs in communities. Supervisory guidelines recommend 4 monthly supervisory visits. A 3 day training on supportive supervision or supervisors has been developed by the MOH and MCHIP – and an integrated supervisory checklist. Costs of supervision come from district MOH funds – there is a general supervision budget for all supervisory activities, not specific for community-based supervision (in selected areas, for example those supported by Lux Development, costs of community supervision are supported by the partner organization). Supervisors report that district funds for supervision are inadequate to cover all costs, and that visits often do not take place at district and facility level. Supervisors also report that checklists are too long – and difficult to complete at each visit. Generally supervision is not coordinated between different technical sections – for example supervision of ASCs who provide CCM is not linked with supervision of ASMs. Many supervisors reported that better integration of community-level supervision would better use available resources.

The presence of a dedicated community supervisor also helps ensure that ASMs have direct supervision and a resource if they have questions. After facility deliveries, facility staff are supposed to send mothers back to their villages with referral forms for the ASMs – to ensure that the ASM is aware of their return and continues to make home visits. The district community coordinator reports that facilities often do not give mothers referral forms after facility deliveries – and are often not aware of the importance of ensuring community follow-up by ASMs.

Lessons learned: supervision

- Dedicated community staff at districts and health centers are available to provide supervision visits – the same staff are involved with ASM training in their own areas, and are therefore familiar with community volunteers in their own areas.
- District supervisory budgets are generally inadequate to cover costs of supervision visits – visits are therefore not always being made as scheduled. Facility-based supervisors do have contact with ASMs when they visit health facilities with mothers, or return motherly reporting forms. Regular visits could be better used to review skills.
- There is little coordination of supervision between different technical areas – better coordination of supervision would use available supervision resources more efficiently.
- Facility-based health staff often do not make efforts to notify ASMs when women are discharged after a facility delivery – to ensure continued follow-up at home.

4.3.4 Care-seeking

Mothers and newborns identified by ASMs as having suspected danger signs are given referral slips – these are given to facility health workers and are intended to help facilitate the process of referral. ASMs report that this process is working. Available data from Gakenke community

registers show that ASMs are referring women and newborns with suspected danger signs to facilities. In some districts community ambulances are available for referral – although their reach remains relatively limited. A number of barriers to effective care-seeking are reported, including lack of transportation, geographic distance and poor roads. Mobile phone coverage is high in most areas of the country, including rural areas, and most villages have access to a mobile phone.

An SMS alert system has been developed and piloted by the MOH and UNICEF in Musanze district. Using this approach, ASMs enter data into mobile phones on new pregnancies identified, ANC visits made, complications of pregnancy, delivery at home or at facilities, and maternal and newborn deaths. Reminders of ANC visits and delivery due dates are sent automatically. The system allows ASMs to notify district and health center staff of women and newborns needing care - efforts can then be made to ensure that these cases reach facilities. In addition, this approach collects data on pregnancies, ANC visits, deliveries and deaths. Field tests show promise. In these areas ASMs are provided with mobile phones, a charging device and telephone airtime. The current plan is to introduce the rapid SMS system into the 6 HB-MNHCP early implementation districts. Plans for training ASMs in use of the system are currently being developed.

Lessons learned: care-seeking

- ASMs are able to identify danger signs in women and newborns and refer them to facilities.
- Referral forms help facilitate care-seeking from communities to facilities
- A number of barriers to care-seeking remain, including lack of transportation, costs of transportation and geographic distance.
- High mobile phone coverage has made a SMS “rapid alert” system possible. This has been piloted in Musanze district and shows promise. It will be further tested in 6 early implementation districts. In addition to improving notification of mothers and newborns, the system has been used for tracking pregnancies and deliveries and providing reminders to ASMs about ANC visits and delivery due dates.

4.3.5 Monitoring and evaluation: Community-based surveillance

ASMs complete community registers for each pregnant women. Registers track contacts along the continuum of care. Register data are entered into register summary forms by ASMs each month. These are submitted to health center supervisors who compile forms from all ASMs in their catchment area – and submit summarized data to district community supervisors. District community data are then sent to the Community Health Desk and to the MCHIP project. Register data are not currently integrated into the routine HMIS – but are submitted as part of a parallel system. Community register data are currently being reported from all hospitals in the 6 UNICEF/MCHIP implementation districts – although not all ASMs and health centers are reporting. Routine reports collect data on ANC visits conducted, home and facility deliveries,

mothers and newborns referred for complications, and the number of women and newborns referred for PNC after a home delivery. Routine reports do not report the proportion of ASMs/facilities reporting. Data are reported as numbers, and not as proportions. District community coordinators report that data are not yet being used for decision-making or planning at any level. In addition, they report that data collection activities are time consuming and can be difficult to complete in time.

Lessons learned: community-based surveillance

- Community registers are a useful job aide for ASMs. They are able to complete registers and summary forms.
- Health center and district supervisors are able to compile summary forms transmit reports to the next level of the system. ASM data are now being reported by all hospitals in the 6 early implementation districts.
- Data collected are not presented as proportions, making it more difficult to assess progress over time. Proportion of ASMs reporting is not included on the summary form. Data are not currently being used by staff at any level.
- Community register data are currently being managed as a parallel system to the routine HMIS. Staff report that completing forms is time consuming and can be difficult to complete in a timely fashion.

4.3.6 **Financing: HB-MNHCP**

Implementation has been shared by the MOH and development partners. Cost sharing with the MOH increases the likelihood that activities will continue in the longer term without external inputs. The MOH covers all staff costs, costs of forms and registers and costs of routine supervision in many areas. In addition, the routine health budget funds most of the costs of routine facility-based primary and emergency care. Development partners cover all training, material development and printing costs, and most of the costs of ASM equipment and supplies. Never-the-less, district community coordinators report that district budget allocations are inadequate to cover regular supervisory visits. The PBF approach, which provides incentive payments to ASMs is funded from a central budget allocation which receives contributions from several development partners. An approach to ensuring that recurrent costs currently covered by partners can be picked up by district in the longer term is needed.

Increasing population coverage by ASMs is likely to increase pressure on facilities to provide ANC, delivery care and emergency care for mothers with complications and sick newborns. System costs at all levels are likely to increase over time – including an increased demand for human resources. Quality of care at first and referral level facilities will be increasingly important.

Program inputs into development, testing and implementing HB-MNHCP in the 6 early implementation districts have not been costed. It would be useful to quantify total costs in order

to plan for further expansion of the approach – and to advocate both within and outside the MOH for resources.

Lessons learned: Financing

- Sharing of recurrent costs of HB-MNHCP between the MOH and development partners may help ensure that activities are sustainable in the longer term. A plan for transferring costs currently covered by partners to districts is needed.
- The PBF approach appears to work as an incentive mechanism for ASMs. If this approach is to be used nationally, as HB-MNHCP is expanded, then commitments to long term support of this mechanism are needed.
- Increasing coverage with HB-MNHCP will increase facility use. System costs at all levels are likely to increase and should be taken into account when planning. An increasing focus on quality of facility-based care will be needed.
- A cost analysis of HB-MNHCP is needed, in order to quantify total resources required for implementation – at all levels. Future program activities should have costing built in up-front, to ensure that costing information is collected.

5. Sustainability

Long term sustainability of the HB-MNHCP approach is promoted by:

- Strong ownership of the program by the MOH – and the development of national standards, guidelines and materials based on international norms.
- Coordination and management by a staffed Community Health Desk.
- A Community Health Technical Working Group that helps coordinate all stakeholders and allocate resources appropriately.
- A strong community-based system with community coordinators allocated to district level, and community supervisors to each health facility.
- Acceptance of the community volunteer model in villages – and a tradition of community organization.
- Cost sharing between the MOH and all partners – a proportion of recurrent costs are currently paid by the MOH.
- A PBF scheme to provide incentives to ASMs.

Long term sustainability of the CMNH may be made less likely by:

- Continued reliance on development partners for a high proportion of recurrent implementation costs – including training materials and costs of training, equipment and supplies and on-going staff inputs to support the community surveillance system.
- No data on the costs of implementation –and a costed implementation plan for further expansion.

- Difficulty sustaining routine supervision visits to ASMs in the villages where they work.
- A clear strategy for improving the capacity and quality of facility-based services for ANC, deliveries, EmONC and management of sick newborns – since demand is likely to increase as ASM coverage increases.

Indicator Table: PNC home visit review - Rwanda

		NATIONAL LEVEL			
Objective/ Result	Indicator	2005 DHS	2007-8 DHS	2010 DHS	Target
IR1: Increased availability of and access to key MNC services	Proportion of mothers who received at least 4 ANC visits	13%	24%	35%	
	Proportion of mothers who received TT2+ during pregnancy	22%	31%		
	Proportion of newborns protected against NNT at birth	-	72%	71%	
	Proportion of deliveries by skilled birth attendants	39%	52%	69%	
	Proportion of deliveries at a health facility	28% Home = 70%	45% Home = 49%	69%	
	Proportion of rural pregnancies having a c-section	2%			
	Proportion of mothers who had a care contact in the first 2 days after delivery	4% - home births		18% all births	
	Proportion of newborns who had a care contact within 2 days after delivery	-			
	IR 2: Improved quality of key maternal and newborn care services	Proportion of mothers women who received iron tablets or syrup during pregnancy	28%	41%	

		NATIONAL LEVEL			
Objective/ Result	Indicator	2005 DHS	2007-8 DHS	2010 DHS	Target
	# of pregnant women who took 2 doses of Sp as IPT during pregnancy	0.3%	17%		
	Proportion of babies who had the cord cut with a clean instrument	-			
	Proportion of babies who were dried, wrapped immediately after birth	-			
	Proportion of children age 0-23 months whose first bath was delayed at least 24 hours after birth	-			
	Proportion of mothers who initiated BF within 1 hour of birth	41%	68%		
	Proportion of babies weighed at birth	32%			
IR 3: Improved household level knowledge and attitudes for key essential newborn care and related maternal care behaviors	Proportion of pregnant women who slept under an ITN the previous night	17%	60%		
	Proportion of newborns exclusively breastfed	95%		91%	

		NATIONAL LEVEL			
Objective/ Result	Indicator	2005 DHS	2007-8 DHS	2010 DHS	Target
	Percentage of infants age 0-5 months exclusively breastfed	88%		85%	
	Proportion of children born in the last 5 years who were born least 24 months after the previous surviving child	77%	78%		