

MCSP Community Health Contributions Series: Rwanda

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Background

The Maternal and Child Survival Program (MCSP) was a global, \$560 million, 5-year cooperative agreement funded by the US Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. To support community health structures in countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers (CHWs), and supporting community infrastructure in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and to identify how the community health approaches implemented by the project have contributed to changes in health service uptake and behavioral outcomes.



Community health workers in Nyabihu District in Rwanda welcome guests at a community event. Photo by Mamy Ingabire, MCSP.

Between 2014 and 2018, MCSP implemented reproductive, maternal, newborn, and child health (RMNCH) interventions in 10 districts in Rwanda.¹ Specifically, MCSP worked in conjunction with the Rwandan Ministry of Health (MOH), the Rwanda Biomedical Centre (RBC), and the Rwanda Health Communication Center (RHCC) to increase coverage and utilization of high-impact, low-cost RMNCH interventions and to strengthen the MOH's capacity to manage and scale up select interventions. MCSP enhanced impact through community engagement. Interventions were scaled up in stages. In the second year, MCSP initiated implementation of community engagement in four districts while supporting the MOH at the national level to update guidelines, tools, and implementation approaches. In the third year of the project, MCSP expanded to six additional districts. For RMNCH activities, focus districts were chosen with the MOH and in collaboration with USAID Rwanda using the following criteria: burden of disease based on key maternal, newborn, and child health indicators (i.e., maternal, newborn, and child mortality) and high unmet need for family planning; absence of a partner implementing key RMNCH and malaria programs; and high population density. Additionally, in Nyaruguru District, MCSP collaborated with the RHCC to develop and implement

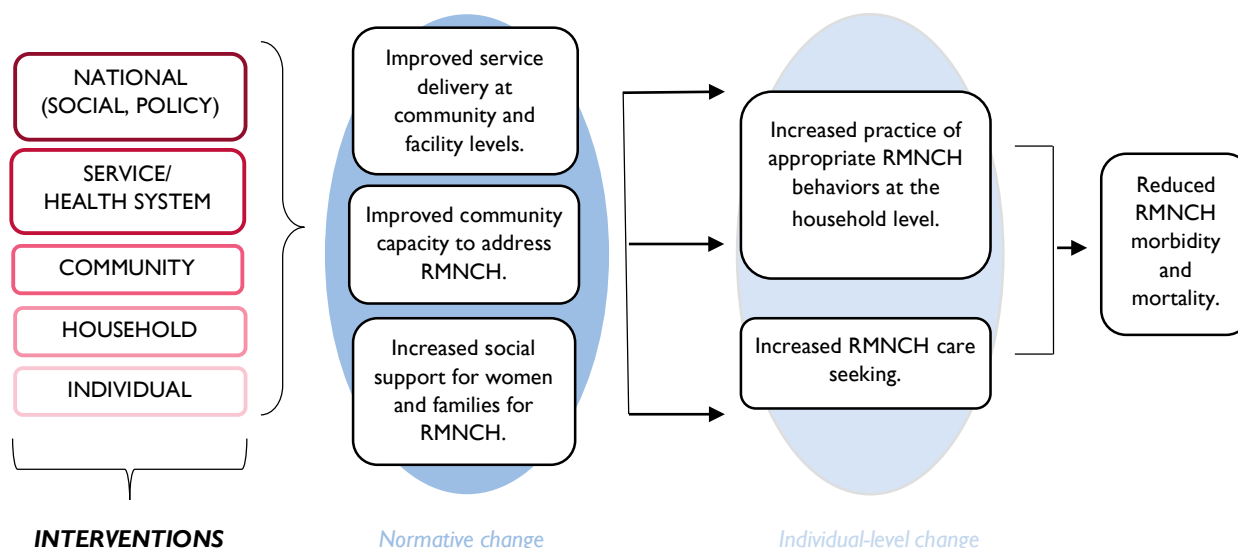
¹ The 10 districts that MCSP Rwanda implemented RMNCH activities in were Huye, Gatsibo, Kamonyi, Musanze, Ngoma, Nyabihu, Nyagatare, Nyamagabe, Nyaruguru, and Rwamagana. Activities targeted the entire population of the 10 districts with facility- and community-level interventions.

the National Community Mobilization Framework. The framework is guided by a number of objectives aimed at creating demand for and improving access to equitable health services. MCSP supported the implementation of the strategy primarily through implementation of the Community Action Cycle (CAC) in Nyaruguru District (only).

Community Health Focused on Maternal and Newborn Health

MCSP’s community health approach in Rwanda combined community service delivery with community capacity strengthening and social and behavior change, with an aim of institutionalizing and supporting RMNCH services. Figure 1 outlines the project’s community health conceptual framework, while Table 1 categorizes activities implemented by MCSP in Rwanda by the type of approach at the community level. The overall approach included meaningful community participation and ownership in planning, implementing, monitoring, and evaluating community-based interventions. It was built off of national strategies, policies, and tools² focused on community health workforce programs and community mobilization. Additionally, MCSP collaborated with the RHCC to develop and validate a National Community Mobilization Framework for mobilizing communities for social and behavior change. The framework is guided by a number of objectives aimed at creating demand for and improving access to equitable health services, in alignment with two objectives of the national Community Health Strategic Plan: to strengthen the capacity of decentralized structures to allow community health service delivery and to strengthen the participation of community members in community health activities.

Figure 1. MCSP Rwanda community health conceptual framework



RMNCH = reproductive, maternal, newborn, and child health

² Rwanda Ministry of Health’s Health Sector Strategic Plan, July 2014–June 2018; National Community Health Policy, 2015; Community Health Program Handbook, 2015; Government of Rwanda’s Vision 2020; Economic Development and Poverty Reduction Strategy, 2013–2018; National Community Health Strategic Plan, 2013–2018.

Table 1. Three pillars of MCSP’s community health approaches and activities in Rwanda

Service Delivery	Capacity Strengthening	Social and Behavior Change
<ul style="list-style-type: none"> Worked with Rwanda Biomedical Centre (RBC) staff to analyze community health worker (CHW) workload in Rwanda using MCSP’s CHW Coverage and Capacity tool.³ Assisted the Ministry of Health (MOH) to establish protocol and specifications on what needs to be done and when at health facility and community levels to ensure improved postnatal care (PNC) and attendance. Worked with the RBC to integrate postpartum hemorrhage protocols and follow-up procedures into training provided to <i>animatrices de santé maternelle</i>. Supported quarterly CHW technical coordination meetings organized at each health center. 	<ul style="list-style-type: none"> Facilitated the Community Action Cycle⁴ process (only in Nyaruguru District, in all 332 villages). Assessed home-based PNC and updated existing capacity-building materials, including job aids. Supported training, equipment provision, and supervision of CHWs. Provided mentoring and built district and health center capacity to plan for and coordinate integrated service delivery by CHWs. Strengthened capacity of health providers through training for increased community awareness of and response to gender-based violence. Supported the MOH to review and update the community-based maternal and newborn health modules and tools for CHWs for consistency with the 2013 World Health Organization recommendations on PNC of the mother and newborn. Strengthened capacity of MOH-supported CHWs to use the RapidSMS system and DHIS2 dashboards (both digital data collection tools) to improve data quality and use in decision-making. Trained CHWs on the prevention of fistula and how to implement verbal autopsies. 	<ul style="list-style-type: none"> Supported the Rwanda Health Communication Center (RHCC) and Health Promotion Technical Working Group to strengthen district- and sector-level capacities to implement and coordinate community engagement and social and behavior change activities. Facilitated sensitization sessions with stakeholders and partners about the provision of fistula services and other reproductive, maternal, newborn, and child health (RMNCH) interventions. Supported the RBC and RHCC in developing documents for community mobilization and social and behavior change materials for RMNCH. Assisted with the development and implementation of district communication plans in 10 districts. Engaged community leaders, CHWs, and women’s groups to improve home-based care of newborns and mothers. Strengthened linkages between facilities and homes with improved referral systems.

Achievements

Overall, MCSP’s community health interventions reduced barriers to accessing health services and contributed to changes in RMNCH behaviors. In particular, the project improved planning and coordination of integrated services delivered by CHWs, reinforced community mobilization, and strengthened the capacity of the community to plan and fashion its own solutions. In total, MCSP supported 4,780 *animatrices de santé maternelle* (ASMs)⁵ and 9,560 *binômes*⁶ in all villages of the 10 targeted districts to offer maternal, newborn, and child health services, and reached 516,090 people through home visits, community dialog, and community radio. The *binôme* facilitated integrated community case management and community-based family planning activities. These efforts and MCSP’s ongoing mentorship approach (see below) contributed to improved management of childhood illness, provision of family planning services, and quality of maternal and newborn health care services, along with increased demand for health services by the community and data use for continuous quality improvement at both facility and community level.

³ This is an Excel-based tool that models options for CHW allocation and engagement. More at: <https://www.mcsprogram.org/resource/community-health-worker-coverage-and-capacity-tool>.

⁴ The CAC model reinforces the capacity of communities to resolve their own health-related challenges, particularly around uptake of high-quality health services and healthy behaviors at household and community levels. The CAC process comprises seven phases: prepare to mobilize, organize communities for action, explore and set priorities, plan together, act together, evaluate together, and prepare to scale up.

⁵ ASMs are CHWs who are identified by the communities and trained, equipped, and supervised by health center-level providers. They are volunteers and not part of the MOH payroll. However, they do receive some monetary incentives following the performance-based financing mechanism in place in Rwanda, and they benefit from membership in CHW cooperatives.

⁶ A *binôme* is a male and female pair of CHWs who are multidisciplinary, polyvalent health agents.

Demand Creation and Quality Improvement

To increase demand for RMNCH services, MCSP worked closely with the MOH and RBC to strengthen the capacity of frontline health workers to improve diagnosis and referral for the management of sick and small babies using the newborn protocol. Additionally, MCSP supported the RBC in initiating community health mentorship by developing mentorship guidelines and tools, facilitating training of the mentors, and following up with the mentees (CHW) at community level. The community health mentorship component strengthened the knowledge and skills of the CHWs. Working in the community and with CHWs, MCSP helped mobilize participation and create demand for health services.

Community Action

As part of the National Community Mobilization Framework, the MOH, with MCSP, adapted and contextualized the CAC process to mobilize the community in improving RMNCH indicators in Rwanda. The CAC is a community mobilization approach that fosters individual and collective action to address key health program goals and improve health outcomes. In Rwanda, the CAC process was used to reinforce the capacity of communities to resolve their own health-related challenges, particularly around utilization of high-quality health services and healthy behaviors at household and community levels. Using a phased approach, the CAC process was scaled up to all villages in Nyaruguru District (only) under the leadership of multisectoral, subdistrict teams. Community action plans were developed in all 332 villages within Nyaruguru District and implemented using different strategies, such as household visits and/or meeting with existing community platforms. The findings suggest the CAC approach contributed to the uptake of health services, including postnatal care (PNC) services, and strengthened the capacity of communities to identify health issues, prioritize health activities, and plan and monitor health interventions independently in Nyaruguru District.

Contributions to Maternal Health

MCSP prioritized fistula screening and repair through household visits and linking women to socioeconomic support and screening for surgical repair eligibility. Within the 10 selected RMNCH districts, CHWs conducted household visits to identify fistula cases, resulting in more than 500 women being referred for screening and repair.

Contributions to Newborn Health

The project also emphasized integration of newborn care with maternal care while strengthening health services through the household-to-hospital continuum of care. In particular, the project emphasized facility births and predischarge PNC, followed by PNC provided by ASMs. Overall, available data indicate an improvement in the utilization of the PNC services by women and newborns in all MCSP RMNCH districts from January 2017 to March 2018. See the MCSP brief, *Strengthening the capacity of communities to increase utilization of postnatal care services at scale in Nyaruguru District, Rwanda*, for more information.

Conclusion

Rwanda has been hailed as among the few sub-Saharan nations on track to reducing child and maternal mortality according to the Sustainable Development Goals. The country achieved the fourth and fifth United Nations Millennium Development Goals in 2015. Such a spectacular change was made possible by the government's commitment to and prioritization of RMNCH. The key achievements of the community health component of MCSP in Rwanda included increasing capacity-building of the MOH staff at central and decentralized levels, planning and coordinating integrated services delivered by CHWs, and reinforcing community mobilization and the capacity of the community to plan and find solutions for its health issues.

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