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Maternal and Child Survival Program

Strengthening the capacity of communities to increase utilization of postnatal care services in Nyaruguru district, Rwanda

A Case Study

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Background

The postnatal period is a critical time for newborns and their mothers and timely, high quality postnatal care (PNC) is crucial to reduce maternal and newborn mortality. Postnatal care visits represent an opportunity for providers to facilitate healthy breastfeeding practices, screen for postpartum depression, monitor the newborn's growth and overall health status, treat childbirth-related complications, counsel women about their family planning options, and refer the mother and baby for specialized care if necessary.

Photo 1. Rwandan parents hold their newborn son.
Photo Credit: Evariste Bagambiki/MCSP

Rwanda has achieved a 76% reduction in maternal mortality since 1990.[1] However, akin to global trends, there has been a smaller decrease in neonatal mortality with a rate of 39 per 1,000 live births in 1987-1992[2] decreasing to a rate of 20 per 1,000 live births in 2014-2015.[3] Likewise, while the proportion of women who received a postnatal checkup has increased significantly since 2010, in 2015 only 45 percent of women received a postnatal checkup.[4]

[1] Mivumbi et al. (2016). Maternal Mortality in Rwanda. Obstetrics & Gynecology, 127 (131), 76S-77S.
[2] Hong, Rathavuth, Mohamed Ayad, Shea Rutstein, and Ruilin Ren. 2009. Childhood Mortality in Rwanda: Levels, Trends, and Differentials; Further Analysis of the Rwanda Demographic and Health Surveys, 1992-2007/08. DHS Further Analysis Reports No. 66. Calverton, Maryland, USA: ICF Macro.
[3] NISR, DHS 2014-15, Key indicators, April 2015.
[4] NISR, DHS 2014-15, Key indicators, April 2015.

USAID's flagship Maternal and Child Survival Program (MCSP) worked with the Rwandan Ministry of Health (MOH) and the Rwanda Biomedical Centre (RBC) to accelerate the reduction of preventable child, neonatal, and maternal mortality in 10 districts in Rwanda from April 2015 to September 2018. Given that many newborn deaths are preventable through improved care in the postnatal period, MCSP emphasized integration of newborn care with maternal care while strengthening health services through the household-to-hospital continuum of care. In particular, MCSP emphasized facility births and pre-discharge PNC followed by PNC provided by community health workers, known as *animatrice de santé maternelles* (ASM).[5]

Goals and Objectives

Nationally, 45 percent of women and 19 percent of newborns receive PNC within two days of delivery.[6] The proportion of women and newborns who received a postnatal checkup increased significantly since 2010, when only 18 percent of women and 5 percent of newborns had a postnatal checkup in the first two days after delivery. While this significant progress is accredited to strong governmental support for maternal and child health interventions, low PNC utilization in Rwanda appears to be associated with negative perceptions of health system quality, cultural beliefs[7], and a perceived lack of importance in seeking medical attention at delivery and during the postnatal period, among other things.[8]

Thus, an area of programmatic focus for MCSP was to increase utilization of PNC for mothers and newborns. In line with the objectives articulated in the Rwandan Ministry of Health's Community Health Strategic Plan[9], in the ten Reproductive, Maternal, Newborn and Child Health (RMNCH) districts MCSP supported, MCSP aimed to

- Increase the percentage of newborns receiving at least one postnatal visit within the first two days of birth from an average of 18% (MCSP baseline, 2011) to an average of 70% by 2018 at MCSP-supported health facilities; and
- Increase the percentage of women receiving at least one postnatal visit within two to seven days following delivery at an MCSP-supported health facility from an average of 37% (MCSP baseline, 2011) to an average of 65% by 2018.

Overview of the Interventions

MCSP's efforts to strengthen PNC in Rwanda included a range of interventions, including review and development of clinical policy,[10] protocol,[11] and frameworks, as well as simple provider tools and job aids to be used nationally.[12]

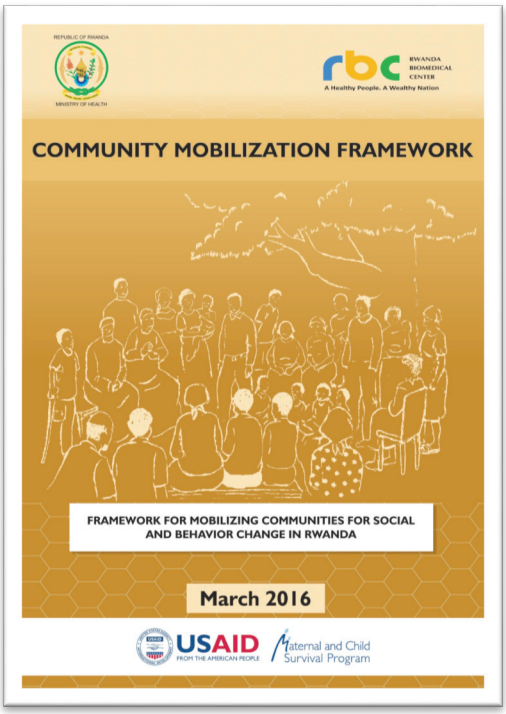
In the 10 RMNCH districts, MCSP trained 455 health facility service providers on how to deliver an integrated package of high-impact PNC interventions for mothers and newborns and how to provide supportive supervision and mentoring to ASMs. At the community level in the 10 districts, 3,873 ASMs were trained on community-based maternal and newborn health care (e.g., breastfeeding, prevention of post-partum hemorrhage, recognition of danger signs and referral, birth preparedness), interpersonal

[5] The ASM are community health workers who are identified by the communities and trained, equipped and supervised by the primary health care level providers. They are volunteers and not part of the Ministry of Health payroll. However, they do receive some cash incentives following the result-based financing mechanism in place in Rwanda and they benefit from membership in CHW cooperatives.
[6] National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International. 2015. Rwanda Demographic and Health Survey 2014-15. Rockville, Maryland, USA: NISR, MOH, and ICF International.
[7] The cultural practice of *kwita izina* discourages both the mother and new-born from leaving the house until the new-born is named at eight days.
[8] Rwabufigiri, B. N., Mukamurigo, J., Thomson, D. R., Hedt-Gautier, B. L., & Semasaka, J. P. (2016). Factors associated with postnatal care

[9] Rwanda Ministry of Health, Health Sector Strategic Plan, July 2014 – June 2018.
[10] MCSP supported policy strengthening for the scale-up of evidence-based high impact interventions such as Essential Newborn Care/ Helping Babies Breathe.
[11] MCSP in collaboration with the MCH Technical Working Group (TWG) conducted in-depth reviews and updated the existing Reproductive, Maternal, Newborn and Child Health (RMNCH) norms and protocols, guidelines and training materials for inclusion of high impact interventions (HIIs).
[12] MCSP supported the MOH to review and update the community-based maternal and newborn health (CB-MNH) modules and tools for consistency with the 2013 World Health Organization recommendations on postnatal care of the mother and newborn. New topics were added including postpartum hemorrhage, Kangaroo Mother Care and postpartum family planning.

communication, and how to use job aids and reporting tools. ASMs were selected by the community they served and seen as key assets in shifting demand for PNC by bridging communities and facilities.

Additionally, MCSP collaborated with the Rwanda Health Communication Center (RHCC) Division of RBC to develop and validate a national Community Mobilization Framework for mobilizing communities for social and behavior change (at right). 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. MCSP supported the implementation of this framework specifically through implementation of the Community Action Cycle (CAC) approach in Nyaruguru district.

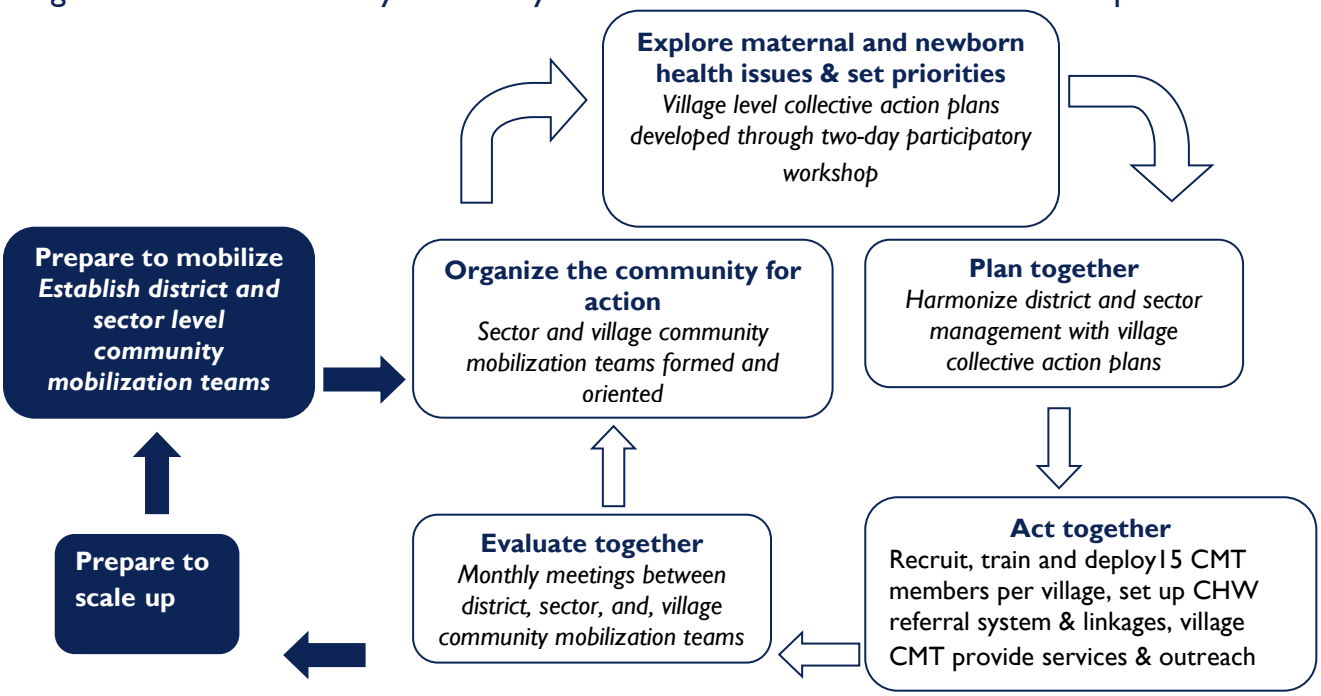


Methodology

Implementation Process

The CAC approach is a proven community mobilization approach that fosters individual and collective action to address key health program goals and improve health outcomes. In Rwanda, the CAC process, as described in the Community Mobilization Framework, was used to reinforce the capacity of communities to resolve their own-health related challenges, particularly around use of quality health services and healthy behaviors at the household and community levels. As shown in **Diagram 1**, the CAC process is comprised of seven phases: i.e., Prepare to Mobilize, Organize Communities for Action, Explore and Set Priorities, Plan Together, Act Together, Evaluate Together, and Prepare to Scale-up.

Diagram 1. The Community Action Cycle Model: Illustrative activities for each phase



RBC and MCSP used a cascaded learning-by-doing model to implement the CAC process. In line with the national Community Mobilization Framework, the approach was cascaded through the decentralized levels of the system as follows:

- The approach began at the **national level** with a training of 14 master trainers, led by the then-Director of the RHCC.

- At the **district level**, MCSP trained 35 district community mobilization team members. The community mobilization team was composed of district management team members such as the Director of Health, social protection officers, and representatives from the National Women's Council, the National Youth Council, and the National Council of Persons with Disabilities.

- At the **sector level**, the community mobilization team was composed of the members of the health committee including the Community Health Officer, Environmental Health Officer, social economic development officers, and various representatives from civil society including faith-based leaders. The sector teams were trained and mentored to facilitate the CAC in each village. In total, 283 sector community mobilization team members were trained. Each sector had a team of 10 community facilitators and each facilitator took on the responsibility to roll-out the process in a certain number of villages. On average, each facilitator covered five communities.

- At the **community level**, community members came together to establish a community mobilization team comprised of approximately 15 members including women, youth, people living with disabilities, and the two types of community health workers (i.e., ASM and binomes).

In Nyaruguru district specifically, 4,845 community mobilization team members were supported under the leadership of the district and sector level officers to identify, prioritize, plan, implement and monitor actions, strengthening their participation in community health activities.

- At initiation, a collective action plan was developed through a two-day participatory workshop that helped identify barriers and facilitators to care seeking practices at the community level. The community mobilization team was in charge of implementing different activities in relation to the action plan such as household visits, community dialogues, public events, real-time monitoring, and tracking pregnant women and mothers with newborns and referring them to ASM and binomes.

- Importantly, 100% of the community mobilization teams from 332 villages in Nyaruguru district demonstrated active participation in the CAC process and, by extension, community health activities, through the development and implementation of action plans. All community committees in CAC intervention areas held monthly meetings to review the achievement of action plan and data. These achievements are indicative of Nyaruguru's commitment to achieving the target outlined in output 2.2 of the Community Health Strategic Plan for 100% of villages to participate in problem analysis.

Data Collected

MCSP was interested in gaining insights on whether the CAC was an effective methodology for improving community leadership and collective problem-solving capacity and whether strengthening the collective problem-solving capacity of communities through the CAC process would increase use of PNC services. To that end, MCSP captured routine monitoring data on the number of women and newborns that received the first PNC visit (in the facility), second and third PNC visits

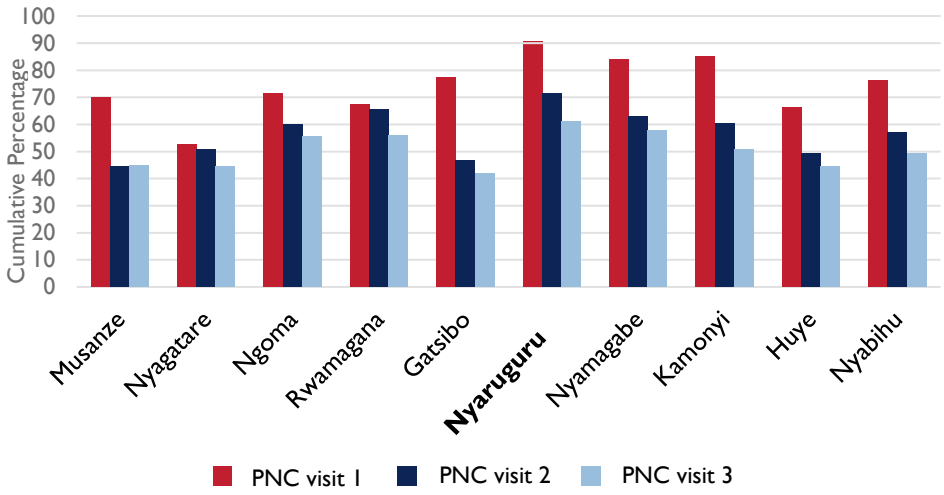
Photo 2. Mayor of Nyaruguru district in official launching of CAC activities in Nyagisozi sector, Nkakwa cell, Kaduha village.
Credit: Benjamin, Bakundukize/Nyaruguru District, Rwanda

(seen by an ASM at home within 3 days for second visit, and 7-14 days for third visit) in MCSP-supported catchment areas implementing community mobilization activities, including Nyaruguru district. MCSP worked with the Nyaruguru District Health Management Team (DHMT) to collect data on CAC implementation. During the visits with the DHMT, discussions were held with Community Management Team (CMT) members from different communities on their daily duties, how implementation of the planned activities were going and challenges they faced in the process.

Results

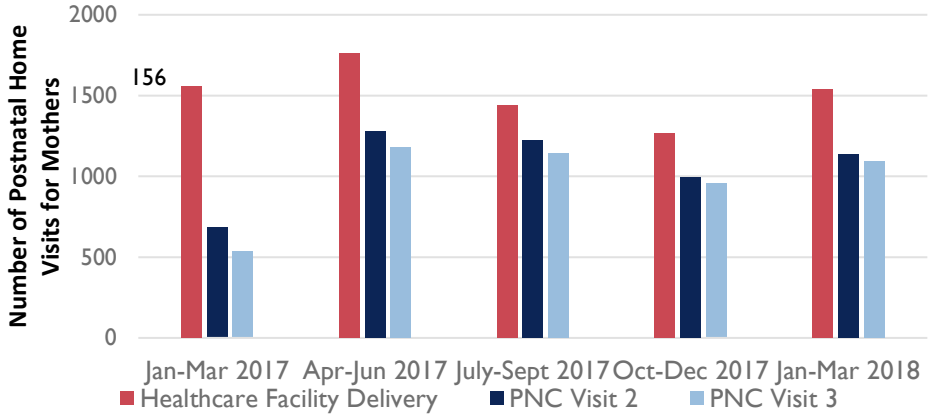
Overall, the data indicate an improvement in the utilization of the PNC services by women and newborns in all MCSP RMNCH districts from January 2017 to March 2018. Notably, Nyaruguru district demonstrated higher cumulative percentage averages for utilization of the first, second and third PNC visits for newborns compared to the other nine RMNCH districts where the approach was not implemented (See **Table 1**). Specifically, 90.4 percent (cumulative percentage) of newborns were seen by a trained health facility service provider or ASM within two days of birth; 74.6 percent (cumulative percentage) of newborns received the 2nd PNC visit within three days (seen by an ASM); and 61.2 percent (cumulative percentage) of newborns received a 3rd PNC visit (seen by an ASM) within 7 -14 days.

Table 1. Cumulative percentage of utilization of first, second, and third newborn PNC visits in 10 MCSP RMNCH districts in Rwanda from January 2017 – March 2018



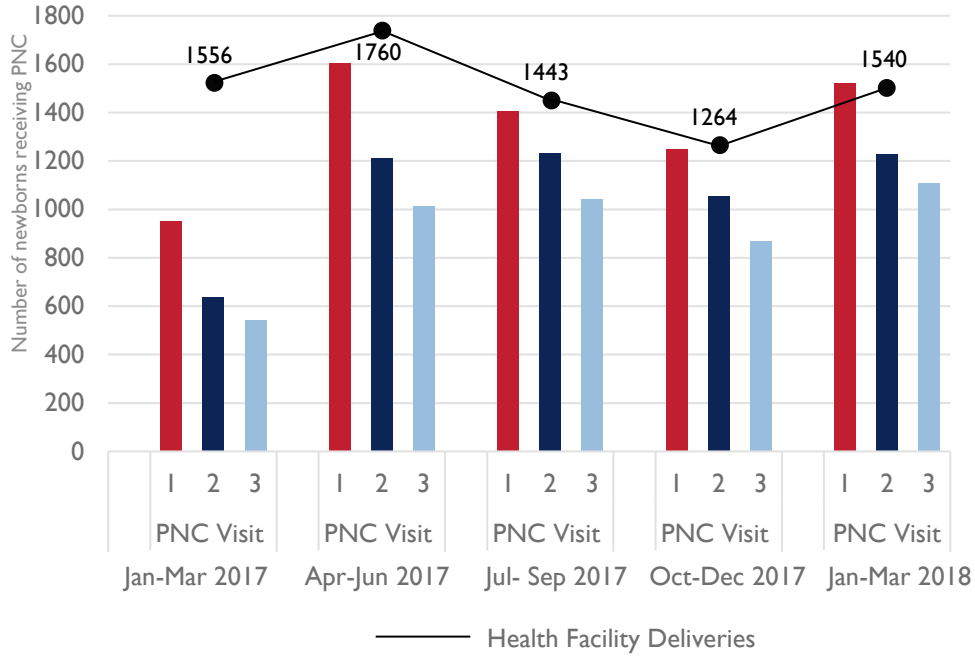
Additionally, the number of women in Nyaruguru district accessing postnatal care at home almost doubled over time (See **Table 2**).

Table 2. Number of women accessing PNC at the community level in Nyaruguru district from January 2017 to March 2018



Meanwhile, the number of newborns receiving at least one postnatal visit within the first two days of birth at MCSP-supported health facilities increased. At the same time, the number of newborns receiving postnatal care at the facility and community level in the Nyaruguru district fluctuated (See **Table 3**). One hypothesis for the fluctuation is attributed to the Program's dedicated efforts to improve family planning services from January to March 2017 that may have resulted in a reduction in deliveries from October-December 2017.

Table 3. Number of newborns receiving postnatal care at the facility and community level in Nyaruguru district from January 2017 to March 2018



With the CAC process, MCSP aimed to complement the work already happening at the community level with the intention that community members would obtain, strengthen, and maintain their capabilities to set and achieve their own development objectives over time. Interviews with key stakeholders from Nyaruguru district indicate that the CAC process did exactly that. As the mayor of Nyaruguru district said:

> *"We have in place different mechanisms, and the community action cycle via community mobilization team, complement other government's approaches such as "parents' evening" (umugoroba w' ababyeyi) and village level juridical mechanism (inteko y'abaturage). These*

platforms give citizens the opportunity to identify their own issues and put in place measures to overcome them. I have no doubt; once the population does the implementation, they provide sustainable solutions. I personally consider CAC as very important approach and hope to see significant changes in lives of Nyaruguru population." - Mr. Habitegeko Francois, Mayor of Nyaruguru District

Additionally, in support of Rwanda's national Community Health Strategic Plan objective of communities fully participating in community health programs, MCSP aimed to strengthen communities' collective problem-solving capacity. Collective problem solving emerges from actions and interactions of many individuals, rather than being driven or organized by a single leader or hierarchy. Mr. Habitegeko also shared the following:

"Nyaruguru District welcomed well the CAC approach, as we always want to see our population playing a significant role to improve their lives. CAC is the approach that gives room to our population to deliberate and prepare their own action plan after assessing the problems they are facing in their respective communities then set priorities and strategies to implement in order to find solutions." - Mr. Habitegeko Francois, Mayor of Nyaruguru District

Discussion

Findings from this activity suggest that community mobilization using the CAC approach successfully promoted the availability and uptake of health services, including 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. District-level officials, particularly the mayor's office, viewed MCSP's community engagement activities as an opportunity to strengthen the likelihood that they would achieve their performance-based contract signed with central-level government, fostering district-level buy in and commitment to the process.

Photo 3. The slogan of the community mobilization teams in the villages is "Our Health in our Hands." Credit: Mamy Ingabire/ MCSP

> Even when donors stop supporting us, we will keep using the CAC approach to develop our village and improve the lives of our community.
>
> –Deborah Ingabire

Strengthening community capacity naturally requires an initial investment of time and resources. The CAC approach relies on quality training, the development of strong partnerships, supportive supervision and mentoring and ongoing monitoring. To improve the sustainability of the CAC approach, the program sought buy-in and support from all levels of the government, community leaders and volunteers early and often. MCSP aimed to work with existing community groups interested in supporting community health and development. Existing groups often require less upfront investment than newly formed groups because they already have experience working together successfully. Additionally, MCSP made an initial investment in easy-to-use tools and learning materials and provided training on the approach. The Program provided more supervision and mentoring in the beginning of the process, which lessened over time as communities took the approach as their own. As communities became more confident and skilled, the speed and ease of the CAC approach increased and the successes built momentum.

Conclusions & Recommendations for Sustainability

The CAC approach is an essential component of the Rwandan National Community Mobilization Framework that aims to address the Community Health Strategic Plan's objective to strengthen community participation in community health. As this experience has shown, the CAC approach is effective in increasing demand for and use of health services. MCSP offers several recommendations for the continued sustainability of the approach in Rwanda.

First, it will be important to formalize the institutional home within RBC's Rwanda Health Communication Center, who can continue to advocate for, plan, budget and support implementation of community engagement activities. In the case of Nyaruguru, the Rwanda Health Communication Center was at the forefront in ensuring proper design, adaptation of material and coordination. MCSP recommends reinforcing institutional linkages given the government's decentralized structure, the municipalities' and mayors' key roles in planning, budgeting, and implementation at district level, and the Community Health Strategic Plan's stated objective to strengthen the capacity of decentralized structures in community health service delivery.

Secondly, as outlined in the Community Health Strategic Plan, MCSP recommends considering the health center (HC) catchment area as a unit of implementation. Rather than having each village in each district have its own CAC trainings and develop action plans, having the health center as the coordinating unit effectively creates economies of scale. This clustering would aim to reduce the cost of initial and recurring investments in the approach.

Lastly, to increase community mobilization teams' confidence in tracking and reporting community mobilization outputs, MCSP recommends providing guidance on community mobilization indicators and monitoring systems as part of routine training. While the data MCSP collected indicate an improvement in the utilization of the PNC services by women and newborns, the Program collected data for approximately one year only. To show sustainability, it will be important to track outcome data over a longer period. Similarly, data use for decision-making at the community level will be another important area of focus going forward. A "quick win" for sustainability and institutionalization is to empower communities to analyze their own data and use this information to inform collective action for social and behavior change. As outlined in objective 4 of the Community Health Strategic Plan, the national program aims to strengthen M&E and coordination of community heath activities at central, district, health center and community levels. Accordingly, MCSP recommends that data use for decision-making is woven into each decentralized level's M&E plan.

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