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Community Health Desk

***INTRODUCING COMMUNITY-BASED PROVISION OF FAMILY
PLANNING SERVICES IN RWANDA:
A PROCESS EVALUATION OF THE FIRST SIX MONTHS OF
IMPLEMENTATION***

December 2011

With technical support from FHI 360



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FOREWORD

The Government of Rwanda recognizes family planning (FP) as one of the key elements contributing to the socio-economic development of our country and as a strategy to attain the Millennium Development Goals (MDGs). Therefore, family planning is one of the top national priorities. The Government of Rwanda's goal is to achieve 70 % modern contraceptive prevalence by 2012, as stated in the Rwandan Economic Development and Poverty Reduction Strategy (EDPRS, 2008-2012).

Within this framework, the Ministry of Health is currently implementing Community-Based Provision (CBP) of Family Planning Services by Community Health Workers (CHWs). CBP is one of the key approaches implemented to increase the accessibility and uptake of family planning services. As a component of the national community health policy and the family planning policy, CBP of FP services were introduced in late 2010. The services provided include not only counseling but also provision of contraceptive methods such as contraceptive pills, injectables, cycle beads and condoms.

To execute this program, the Ministry of Health opted to implement it in phases. The first phase covered three districts: Rusizi, Gatsibo and Kicukiro in Western, Eastern Provinces and Kigali City respectively. To document the process and inform the scaling-up of this program, an assessment was carried out in April 2011. The key findings are compiled in this report.

The Ministry of Health acknowledges its different partners, especially FHI360/Rwanda, who contributed to conduct this assessment. Our gratitude is also addressed to the health facilities and CHWs who willingly shared their experiences with us during the assessment.

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Background and intervention

As Rwanda is Africa's most densely populated country, the Government (GOR) has recognized that facilitating rational population growth is key to its economic development. The GOR has set a target of achieving 70% contraceptive prevalence by 2012. Among other strategies, the GOR is working to increase access to modern contraceptive services by bringing them closer to the population. To this end, the Ministry of Health (MOH) adopted a strategy of using community health workers (CHWs) in the delivery of FP services at the village level (*Imidugudu*).

Community-based provision (CBP) of family planning services (including commodities) is a strategy for increasing access to family planning (FP) that has been adopted in many countries, for example, Madagascar, Malawi, Zimbabwe and Ethiopia. Rwanda Ministry of Health (MOH) policies authorize community health workers (CHW) to sensitize their communities about the impact of population growth and provide: condoms, oral contraceptive pills, injectables, and the Standard Days Method. However, CHWs are only allowed to give resupplies to FP clients who have already been initiated on the method by a health provider. CHWs are also trained to refer clients to the health center in the case of any suspected side effects.

CHWs are elected by their communities in Rwanda. Each village has four CHWs including a pair of CHWs (one male and one female) who were trained on CBP. The ten-day training included both theoretical and practical elements. CHWs were required to be certified by qualified trainers before they could officially begin providing counseling and methods. In particular, CHWs were required to correctly provide at least five clients with injectables before being certified. CHWs report monthly on the number of clients served by type of FP method and consumption of stock.

Objectives of the process evaluation

The MOH introduced CBP in three districts in 2010 (Gatsibo, Rusizi, Kicukiro) as a first phase to a national scale-up of these services. In order to document the process of implementing CBP in the first three districts, we carried out a process evaluation with the following objectives:

- (1) Ascertain CHW and Community Health Supervisor satisfaction with the training they received
- (2) Document barriers and facilitators of service provision
- (3) Generate recommendations for scale-up of CBP of FP to other districts

Methodology

Focus groups were conducted with CHWs and their supervisors. We randomly selected two facilities in each of the three districts and then requested supervisors to nominate CHWs (with both large and small caseloads) who could provide a diversity of experiences. A group of supervisors was also randomly selected from each of the three districts. In total, 80 CHWs and 18 supervisors took part in the FGDs.

Trained facilitators and note-takers took detailed notes in Kinyarwanda, which were then translated into French. Due to resource constraints, the content of the FGDs was not transcribed and translated. During a three-day day workshop, the FGD facilitators worked

with MOH and FHI personnel to identify the major themes emerging from the focus group discussions, as related to the objectives of the evaluation, based on the field notes.

CHW focus groups covered the following topics: (1) satisfaction with training, (2) self-perceived competence in providing methods, (3) availability of supplies and commodities, (4) satisfaction with supervision, (5) experience in client recruitment and perception of client satisfaction, (6) religious objections encountered, (7) advice for future CBP CHWs. Supervisors were guided in the same topics, with the addition of questions about community reactions, side effects encountered, and any changes in FP workload at the health centers.

CBP Results

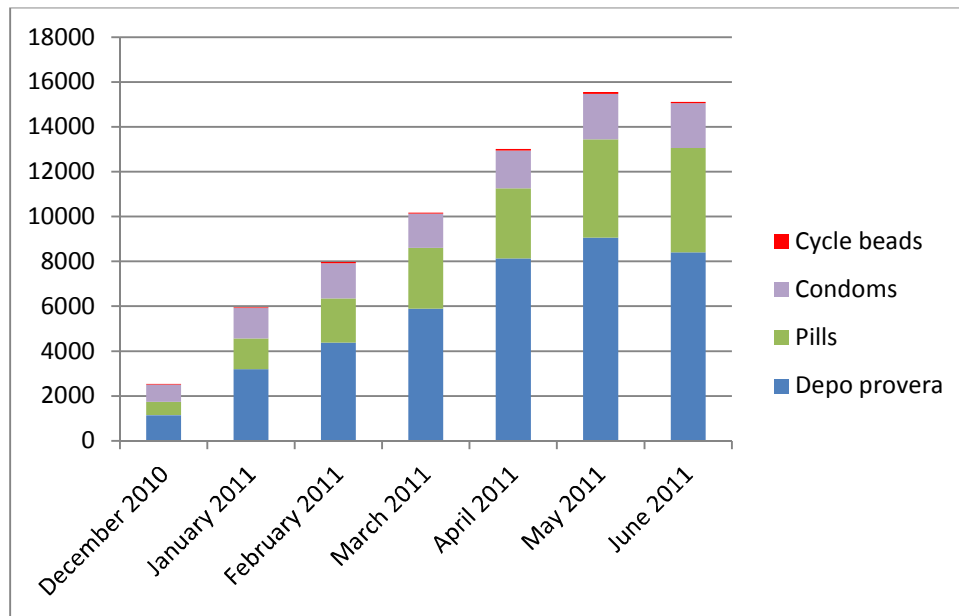
In July 2010, 3061 CHWs were trained in CBP in the three districts. Eighty-two percent of the CHWs trained have been certified to provide injectable contraceptives. Service provision began in December 2010. In the first seven months of service provision 70,308 clients were served with a contraceptive method in the three districts. Over half of clients (57%) received injectables, 27% received oral contraceptive pills, 16% received condoms, and 1% received Standard Days Method (SDM). We would not expect to see many SDM clients, because it does not generally require a follow-up appointment.

When asked whether the volume of clients coming to the health centers for FP had decreased since the commencement of the CBP program, supervisors universally agreed that they had seen a decrease in attendance for FP.

On average, each CHW had 23 clients during the seven-month period. However, this also varies widely by district. In Gatsibo, CHWs had an average of 42 clients, in Kicukiro the average is 13 and in Rusizi the average is nine clients.

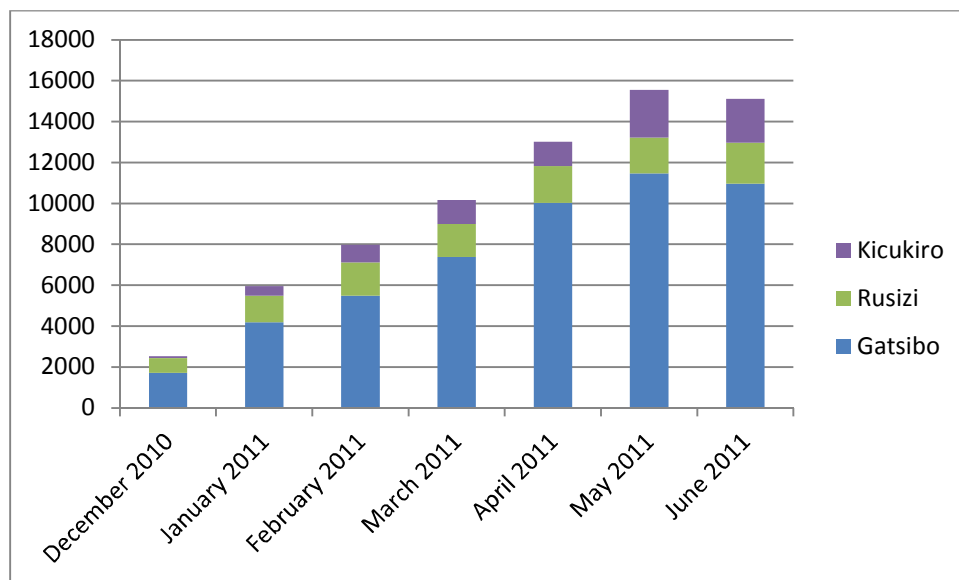
*“Although CHWs are overburdened, here at the health center it’s the opposite.”
– Supervisor*

Figure 1: Evolution of FP service provision in three districts in Rwanda, December 2010-June 2011, by method



When examining the data by district, Gatsibo District is clearly out-performing the other districts. Although Gatsibo has 40% of the total number of trained CHWs, their share of the number of clients served is 73 percent.

Figure 2: Evolution of FP service provision in three districts in Rwanda, December 2010-June 2011, by district



Training

The CBP program was implemented through cascade training. National trainers first trained community health supervisors and FP providers at health centers in a training of trainers (TOT) workshop. This five-day workshop included the following topics:

1. Training methodology for adult learning, including group dynamics in adult training, how to manage difficult situations in training, and a practical session
2. Designing session plans, including administrative elements
3. Teaching techniques, including the coaching of participants in clinical service
4. Technical preparation
5. Teaching aids
6. Evaluation and follow-up of a training activity
7. Review of family planning including anatomy and physiology and FP methods
8. Presentation and discussion the reference manual for CHWs in CBP / FP
9. Data collection tools

Some supervisors requested that the TOT be extended, but they still felt capable of providing the training for CHWs. Supervisors were particularly appreciative of the sessions on training skills and adult learning. CHW Supervisors recommended that they be the ones trained to train the CHWs, rather than FP providers who do not have the time to supervise the CHWs.

The theoretical CHW training was eight days and covered the following topics:

1. The current situation of family planning in Rwanda
2. Advantages of FP methods , rumors about FP methods, when to start using FP methods
3. Male and female reproductive system
4. Infection prevention while providing FP services
5. Health education techniques
6. Counseling in FP
7. Explanation of the existing FP methods in Rwanda, with a focus on the methods allowed to the CHW
8. How to use data collection tools

Following the theoretical training, CHWs underwent practical training. The objective of this training was to allow CHWs to sensitize, counsel and provide FP clients with methods under the supervision of an FP provider. In addition, each CHW would have to provide five injectables under supervision before they could be certified to provide them in the community. Originally the practical training was planned for six hours: one hour of review of information and five hours of service provision. However, many CHWs found that the time allotted was insufficient to see the number of clients they needed to be certified for injectables. This necessitated CHWs having to come back for further practice, which was difficult logistically. Some CHWs and supervisors reported that due to these difficulties, some CHWs did not continue with the process for certification.

Both CHWs and supervisors agreed that the selection of who will be trained is key. In particular, the CHWs should be of reproductive age themselves. The CHW's commitment to providing FP should also be carefully assessed. In some isolated cases, CHWs who had religious objections to FP attended the training and then never implemented the FP services. FGD participants noted no differences between acceptance of male and female CHWs.

In general, the participants were satisfied with the training; however, they did have some recommendations for improvement. Both CHWs and supervisors agreed that the number of

days was insufficient for them to master all the topics. In particular, some CHWs are at a lower level of education and need more time to grasp the subjects.

The practical sessions of the CHW training were acknowledged to be the most important (especially for injectables) and the most complicated to organize. Respondents also wanted more time in supervised practice. Many felt that the practical trainings were disorganized and they did not always feel supported by the FP staff in the health centers. Furthermore, several reported that it was difficult to find enough clients (five are required) to practice on to receive their certification for providing injectables (see above).

“...even people living in other districts who have not yet benefited from this program and are bordering with us come to get their supplies from us.”

– CHW

Nevertheless, most CHWs reported that they had received enough training to effectively provide FP methods. Some participants noted that the Standard Days Method (SDM) is complicated and they did not feel they understood it well enough. CHWs also noted that it was important that they are trained to give counseling on all methods, not just those they can provide. Some supervisors also agreed that there was not enough in-depth information provided about all of the FP methods. Some CHWs said that they had not received sufficient information on side effects. Finally, CHWs said that they did not feel well enough prepared to address the myths and misconceptions circulating in their communities.

“Many people, especially educated people, do not want CHWs to administer injections because they know that they are not medical professionals”

– Supervisor

Community acceptance

FGD participants universally agreed that an official introduction (launch) of the program and the trained CHWs is important to garner community support and confidence in the service. CHWs also recommended that they receive their certificates in a public ceremony to demonstrate directly to the community that they are qualified to provide FP services.

CHWs and supervisors both perceived that clients were generally satisfied with the services they receive as part of the CBP program. Some clients even told the CHWs that they were better at giving the injections than providers at the health center.

CHWs identified several positive factors that increased community acceptance and satisfaction. Having the service available in the community saved clients time and money because they did not have to travel regularly to the health centers. Furthermore, getting methods from CHWs was more discrete than going to the health center. On the other hand, some supervisors thought that community members might be more likely to go to another village or the health center to obtain their method, since they perceived that as being more discrete. Nevertheless, the CHWs served many clients in their communities. One CHW reported that some clients came from other catchment areas to receive FP services.

The support of local authorities and providers at the health center was also perceived to be essential in the community's acceptance of the CBP program. Local authorities allow CHWs

to speak during community meetings, allowing them to make the community aware of the program. The health centers also refer FP clients to the CHWs for their resupplies. CHWs reported that if the local authorities do not support the program, that creates a strong barrier against community acceptance. One means of gaining their support is to hold community meetings before the commencement of the program to sensitize the population about the CBP program. Another idea was to publicize the CBP program via the radio (e.g., *Urunana*).

Despite a general sense of acceptance by the community, CHWs were aware of some community members who were not supportive of community-based provision of FP services. In particular, some referred to CHWs as “charlatans” and claimed that without official schooling they could not be qualified to provide methods, principally injectables. Some CHWs reported that their inability to initiate clients on FP methods was perceived by some community members as a negative reflection on their ability to provide methods. Supervisors were more likely than CHWs to note hesitations among community members.

Religious influences

All the FGD participants acknowledged that there are barriers to FP due to religious objections to modern contraceptives. CHWs stress the advantages of FP to those who object and have seen some clients subsequently accept a modern FP method. CHWs reported that some of their colleagues were actively discouraged by their religious leaders to not provide modern FP methods. In some cases, the CHWs then dropped out of the CBP program.

“At the beginning of the training it was hard to understand, but after the training I had confidence in myself because among my 53 clients no one indicated any problem.” – CHW

Service Provision

Perceived competence

CHWs repeatedly stated that they were proud of the work that they are doing, and that for the most part they feel well accepted by their communities. There was occasional opposition by religious leaders, but CHWs believe that getting political leaders’ buy-in will help to reduce the impact of this.

Several factors gave CHWs confidence that they were providing good services. First, they reported having received no complaints from clients and having observed no method failures (e.g. pregnancies). Supervisors also received no complaints from community members or local authorities about the services being provided by CHWs. In addition, the fact that clients returned to the CHWs in a timely manner for the resupply of their method indicated that clients understood the counseling received and were satisfied with the services they were receiving.

CHWs found some methods more difficult to provide than others. CHWs reported no problems with respect to providing pills or condoms. Supervisors agreed that the CHWs were providing these methods well, but that CHWs did not put enough emphasis in their condom counseling about the benefits of dual protection. Also, some CHWs did not have a penis model upon which to demonstrate correct use to their clients. Supervisors thought that most clients who ask CHWs for condoms are either sero-discordant or are engaging in casual sex.

Some CHWs indicated a lack of understanding of the Standard Days Method. Supervisors also noted this weakness and recommended that the training spend more time on this complex method.

Some CHWs and supervisors reported that they had difficulty drawing all of the content of the injectable suspension, which may have caused them to under-medicate the clients.

Supervisors recommended that CHWs be provided with calendars to help them keep track of client appointments.

“This problem happened to me. One time, two clients came for their injections and I didn’t have any Chlorhexidine. I asked my colleague but he didn’t have any either. It touched my heart – these clients left without receiving the methods...”
– CHW

“I also had this problem for clients who use pills. At the clinic, usually we are only given pills for two people. Recently I had a third unexpected client and I managed the situation by contacting my neighboring colleague...” – CHW

Equipment and supplies

One of the major barriers mentioned by CHWs and supervisors was the difficulty of keeping all the required materials in stock. CHWs reported that since they receive only 2-3 units of each method that they sometimes quickly ran out of stock. A particular problem noted was an insufficient quantity of disinfectant supplied. In rare instances, this even resulted in a client not receiving her resupply on time. As an interim solution, CHWs lacking materials or products often refer the client to another CHW in the same area. However, in some cases the neighboring CHW was also experiencing stock-outs.

CHWs often live far from the health center that resupplies them. CHWs are required to go to the health center to retrieve commodities and consumables, but they are not given a means of transport. Respondents variously suggested that CHWs receive a transport allowance, that they be provided with bicycles, or that they receive a regular salary in order to facilitate travel to and from the health centers. Supervisors also suggested that they could resupply the CHWs during supervision visits, thus avoiding multiple trips for the CHW to the health center.

In most cases, CHWs did not receive their equipment and stock of methods immediately following the training. They reported that this was not a good practice, as much information could be forgotten in the interim period when they are not practicing. Supervisors echoed this sentiment. In addition, CHWs and supervisors both noted that CHWs should be provided

with a separate storage container for the FP consumables and commodities. Some were storing them with their IMCI materials, while one supervisor noted a CHW was storing the FP methods in envelopes.

CHWs reported no difficulties in completing the stock management forms. However, some had not received these forms yet.

Supervision

Nearly all of the CHWs reported having received at least one supervisory visit. (The exception was among some CHWs in Rusizi. CHW supervisors reported that they could not yet supervise the CHWs since they hadn't been trained themselves. Instead, FP nurses received the CBP training.) The policy states that CHWs should be supervised once a quarter; however, CHWs reported that supervision visits took place irregularly. Supervisors variously reported that supervision should happen once a month, once a quarter, or upon request from the CHW. Thus, supervision visits were often prompted by a request from the CHW. CHWs also reported occasionally phoning their supervisors with specific questions. Supervisors reported that it was sometimes difficult for them to conduct the supervision visits, since they lacked transport.

CHWs and supervisors stressed the importance of supervision visits taking place in the CHW's home/village. Not only does this strengthen the CHW's skills, but it also reinforces the credibility of the CHW in the eyes of his/her community. CHWs requested more regular and frequent supervision visits, particularly in their first months of providing services.

Conclusions

CBP appears to be well-accepted by the community, judging by the number of clients who agreed to receive a method from CHWs, although there are still some challenges. The training curriculum appears to be well designed, judging by the lack of adverse events reported by the three districts. However, CHWs and supervisors were nearly unanimous in requesting that days be added to the training. In particular, the practical training was challenging to organize, which appeared to frustrate some of the CHWs.

Although this evaluation was only able to assess competence in terms of supervisors' and CHWs' perceptions, nearly all the participants of the FGDs reported confidence in the CHWs' abilities to provide these contraceptive methods effectively and correctly. As mentioned above, the fact that there were no adverse events reported also implies that the FP methods are being provided correctly. This evaluation was unable to assess if CHWs are referring their clients when appropriate, although supervisors reported receiving at least some referrals for side effects.

“When the supervisor comes, he observes the storage of methods, the registry and the appointments that I made for clients. He simulates a client to see how clients are greeted and if you correctly fix the resupply appointment.” – CHW

“The importance of supervision is that it compares perhaps to a new training because the supervisor reminds me what I had forgotten. Another important element is that it increases the people's trust towards me; there is assurance that I am implementing a government program.” – CHW

The FGDs also could not evaluate client satisfaction beyond the perceptions of supervisors and CHWs; however, the fact that CHWs said that their clients were returning on-time for resupplies of their methods implies some measure of client satisfaction. While religious barriers were acknowledged by the FGD participants, the sheer volume of clients served indicates that it is not a significant issue. However, CHWs recommended that local authorities and health providers make an effort to sensitize and solicit support from religious leaders.

Support of local authorities and the health center personnel emerged as the most important element for gaining community acceptance of this program. The credibility of CHWs was bolstered by community sensitization, CHW participation in community meetings, provider referrals of clients to CHWs, and supervision visits to the community by supervisors. It is also likely that the confidence that CHWs report having encourages the community to have confidence as well.

Nearly all CHWs reported having received a supervision visit and they were perceived as being important for both credibility and reinforcement of skills. In the case where supervision visits did not take place, supervisors reported that it was because FP providers were trained in the CBP program, rather than those people who are charged with supervision of CHWs. FP providers apparently do not feel that CHW supervision is in their mandate, nor do they have the time or the resources to provide this support to CHWs. While most CHWs did receive a supervision visit, they complained that they were often irregular and sometimes unannounced. A regular calendar of supervision should be established and maintained.

The most significant barrier to successful execution of CBP appears to be regular provision of commodities, consumables and equipment to the CHWs. The lack of equipment and supplies directly following training delayed implementation of the program and CHWs reported that this could result in a degradation of CHW skills in the interim. In addition, CHWs regularly reported stock-outs of materials, which hampered their ability to provide services. With such a large number of CHWs, this will remain a serious challenge. The provision of start-up materials and the supply chain for resupply need to be strengthened in the future to maintain CHW effectiveness and community confidence in the robustness of the program.

Barriers and Facilitators

Barriers
Delayed start of program after training due to lack of equipment
Insufficient time during practical training; difficulty in finding enough injectable clients to achieve certification
Stock-outs because they receive a small quantity of supplies and have to go to the health center to resupply, but they are not given transport funds
Facilitators
Local authority buy-in, including allowing CHWs to sensitize the community during community meetings (e.g., <i>umuganda</i>)
Referrals from health centers to CHWs
Supervision not only improves skills, but also reinforces CHW reputation in the community

Recommendations

Below are the strongest recommendations that emerged from the focus group discussions.

- Provide CHWs with equipment and supplies immediately after the training to ensure that they do not lose any of their skills in the interim.
- The program should consider compensating CHWs in the cases where they must use their own resources to perform their jobs (transport to/from training, transport to health centers for resupply, cell phone units for telephone calls to supervisors).
- Provide CHWs with calendars to facilitate managing client appointments.
- Supply CHWs with an adequate stock of supplies to reduce the burden of traveling to health centers for resupply.
- Ensure that the people trained to train the CHWs and implement the CBP program are the people who are responsible for the supervision of CHWs (e.g., Community Health Supervisors).
- Establish a realistic and regular supervision schedule and ensure that supervisors have the resources to carry it out (including being trained and allocated the time and transportation necessary).
- Organize a refresher training for CHWs, since some reported that they have trouble with drawing the entire amount of the solution for the injectable, which could possibly lead to method failure.