USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

Improving RMNCH Service Readiness and Quality: Summary Findings from an Endline Analyses of the MCSP Rwanda Program

March 2019

www.mcsprogram.org

MCSP Implementation Research Brief Series

Despite significant achievements in key health indicators in Rwanda over the past 15 years, there is still progress to be made. When MCSP began implementing in 2015, Rwanda still hoped to make strides in reducing maternal and newborn mortality, improving quality of care in maternal/newborn health, family planning and child health, reducing unmet need for FP and improving the health system. MCSP implemented a baseline health facility readiness assessment in MCSP supported facilities and, after implementing for three years, hopes to document changes and improvements in RMNCH domains through an endline assessment. The set of analyses detailed within this brief include an endline health facility readiness assessment, a provider skills assessment and documentation of provider and stakeholder perspectives on the collaboration between MOH and MCSP during the life of the project.

Background

Since 2015, USAID's flagship Maternal and Child Survival Program (MSCP) collaborated with the Ministry of Health (MOH) and Rwanda Biomedical Center (RBC) in Rwanda to implement high impact interventions to address the major causes of maternal, newborn and child mortality and to improve the quality of health services from the community level to hospital level. The primary approaches to achieve these objectives included strengthening the national health policy environment and health system components, building and maintaining capacity and skills of healthcare workers, mentoring and implementing quality improvement activities at facilities. This brief provides an overview of the program interventions, a summary of the findings from the facility and mentorship assessments, and recommendations for future programming.

MCSP Rwanda Key Facts

- Project start date: June 2015
- Project end date: March 2019
- Geographic focus: 10 districts (Musanze, Nyabihu, Kamonyi, Nyamagabe, Huye, Nyaruguru, Nyagatare, Gatsibo, Rwamagana, & Ngoma)
- Project Scope: 172 facilities, including 160 health centers and 12 hospitals
- Assessment scope: 52 health centers and 12 hospitals

Key Program Approaches

Aligning Program Approaches with National Priorities

To ensure program approaches and technical guidelines were rooted in global evidence and aligned with Rwanda MoH/RBC priorities, MCSP worked through national technical working groups to adapt to Rwanda context and avail tools, training, and guidelines for program implementation and monitoring. At all levels, MCSP helped foster a culture of data-based decision making and supported the MOH/RBC to develop, update, print, and disseminate data collection tools to health facilities. MCSP helped the MOH/RBC to revise HMIS indicators, data management and use guidelines and conduct capacity building and supervision in the 10 project-supported districts. In addition, MCSP supported the development of data dashboards and trained national level data managers on data use. MCSP also supported and encouraged scale-up of malaria prevention, treatment, and case management, as well as immunology surveillance. At the request of USAID Rwanda and MoH/RBC, MCSP also facilitated a collaborative multi-stakeholder process to develop 7 year strategies for Family Planning (FP)/Adolescent Sexual Reproductive Health (ASRH) and Maternal Newborn Child Health (MNCH). Through this process MCSP successfully advocated for inclusion of MCSP introduced approaches including Postpartum Family Planning (PPFP) into the national health sector strategies.

Box 1: Clinical Mentorship Checklist Service Areas

Maternal Care: B-EmONC

Focused Antenatal care(FANC); labour monitoring with use of partograph; normal delivery; episiotomy/tears repair; breach delivery; vacuum extraction; complicated delivery with shoulder dystocia; management of PPH due to uterine atony, management of PPH due to retained placenta; management of PPH due to cervical tears, management of incomplete abortion; management mother with pre-eclampsia /eclampsia; Helping Babies Breathe

Newborn Care: ENC

Essential newborn care; neonatal care for sick and small babies at district hospital (For RPA Mentorship)

Child Health: IMCI

Management of sick newborn aged from zero to seven days (0–7 days), sick infant aged one week to two months (7 days–2 months) and sick child aged two months to five years (2–59 months), .

Family Planning (FP)

FP consultation (counseling); FP physical and gynecological examination; FP oral contraceptives pills Screening and provision of: combined oral contraceptive and progestin-only pills, injectable, insertion and removal of implants (jadelle/implanon), insertion and removal of Copper IUD in interval, postplacental and early postpartum period [no postabortion?], Counseling and support to use the standard days method (cycle beads) and the lactational amenorrhea method [anything on management of complications/side effects?] PPFP counseling; PPIUD Early Postpartum insertion of the IUD; PPIUD Post placental insertion of the IUD

Capacity building for healthcare workers

To support the health workforce to deliver high quality RMNCH care in Rwanda, MCSP introduced a low dose, high frequency (LDHF) capacity building approach coupled with workplace-based mentorship and supportive supervision. LDHF is a promising, cost-effective and evidence-based approach to building healthcare worker capacity that relies on clinical simulation, case-based learning, hands-on practice with anatomic models, and immediate feedback on performance from supervisors and trainers.[1] LDHF capacity building reduces health worker absenteeism caused by traditional hotel-based trainings, promotes peer-to-peer learning, and results in greater improvement in knowledge and clinical practice compared to traditional, didactic learning approaches.[2]

MCSP collaborated with the MOH/RBC to develop a pool of trainers and mentors to deliver the **LDHF and On the Job training** approach in facilities and conduct follow-up mentorship visits. Providers in

[1] Willcox, M., Harrison, H., Asiedu, A., Nelson, A., Gomez, P., and LeFevre, A. Incremental cost and cost-effectiveness of low-dose, high-frequency training in basic emergency obstetric and newborn care as compared to status quo: part of a cluster-randomized training intervention evaluation in Ghana. Globalization and Health, 13:88 2017.

[2] Ugwa, E. et al. Simulation-based low-dose, high-frequency plus mobile mentoring versus traditional group-based training approaches on day of birth care among maternal and newborn healthcare providers in Ebonyi and Kogi States, Nigeria; a randomized controlled trial. BMC Health Services Research, 18:630. 2018

172 facilities across 10 MCSP-supported districts received appropriately spaced, targeted LDHF training in facility settings on four technical areas, including maternal health services (B-EmONC), newborn health (ENC), child health services (IMCI) and Family Planning (FP).

After delivering the initial LDHF training, MCSP implemented **clinical mentorship** in the 172 health facilities to continually build capacity of providers and promote skills retention through hands-on approaches. MCSP supported development of clinical mentorship guidelines and tools focusing on the four technical health areas listed in Box 1. Mentors were trained through a training of trainers approach to create a cadre of at least 5 mentors per technical area, in each district. MCSP also worked with Rwanda's professional associations (Rwanda Pediatric Association, Rwanda Society of Obstetrics and Gynecology as well as Rwanda Association of Midwives) to provide ongoing mentorship of providers at the district level. During the course of the project, mentors built providers' skills, advocated for appropriate service organization as needed and proper use of equipment and materials, as well as availability of required drugs and other commodities. This was done through direct contacts with mentees and advocacy/feedback meetings with facility leadership.

Facility strengthening through quality improvement

To ensure sustainable quality services, trainings and mentorship were embedded in a broader quality improvement (QI) approach within Rwanda's health system. As part of the national accreditation system, the national QI approach includes use of data to track QI efforts, supportive supervision, development of data dashboards for improved data management, and capacity building for the "Plan-do-Study-Act" (PDSA) QI approach at all MCSP-supported facilities. In addition, a QI supervisory checklist was developed to align QI efforts at the facility level with the national plan and national standards of care.

Assessment Objectives and Methodology

To evaluate the extent to which the program strengthened the RMNCH service delivery and work environment, MCSP conducted a pre/post intervention mixed-methods health facility assessment. The objectives of this assessment were to evaluate health facility readiness to provide RMNCH services, measure health provider competency levels, and document stakeholder perspectives on impact of MCSP program approaches. Though not covered in this brief, the program also collected a range of HMIS data that showed improved coverage and quality at scale of key maternal, newborn, family planning and child health high impact interventions across all 10 districts. These data are captured and described in other related briefs and publications.

Facility readiness to provide RMNCH services was measured in a sample of facilities in October/November 2015 and again in June/July 2018 using an assessment tool adapted from the World Health Organization's Service Availability and Readiness Assessment (SARA) tool, with a new section on "data use for action" added.[3] The RMNCH services covered in the assessment included: reproductive, maternal and newborn services, child health, adolescent services and use of data at the facility level. There are 12 hospitals and 155 health centers in the ten MCSP supported districts. All hospitals (12) and one-third of the health centers (155/3=52) were sampled. The number of health centers sampled per district was proportional to the total number of health centers per district. Each health facility's patient load data (number of deliveries per year per facility) was obtained from the Maternal, Child and Community Health (MCCH) department of the MOH, after which health centers were stratified based on their respective patient load. Then a health center was randomly selected from each stratum until the required number of health centers in a district was reached. The same facilities, representing 37% of all 172 MCSP-supported facilities across 10 districts, were included in both baseline and endline. Box 2 displays elements assessed using the adapted SARA tool. Each composite readiness indicator is comprised of availability of key commodities, equipment, job aids, protocols, and trained staff for each respective service area. Table 1 presents the type and location of all sampled health facilities.

Box 2: Facility Assessment Areas

- Presence of key commodities, equipment, job aids, protocols and trained staff
- Data use for action

[3] Developed by the World Health Organization (WHO) and USAID

Table 1. Health facilities sampled for the assessment

District	Sampled Health Centers	Hospitals	Total Number of Health Facilities Sampled
Musanze	5	1	6
Nyabihu	5	1	6
Kamonyi	4	1	5
Nyamagabe	6	2	8
Huye	5	1	6
Nyaruguru	5	1	6
Nyagatare	7	1	8
Gatsibo	6	2	8
Rwamagana	5	1	6
Ngoma	4	1	5
Total (assessment)	**52 Health Centers**	**12 Hospitals**	**64 total facilities**
Total (supported by MCSP)	**160 Health Centers**	**12 Hospitals**	**172 total facilities**

*MCSP supported all health centers and hospitals in the 10 districts

Health provider capacity was assessed using two methods. First, the number of mentees validated over time were routinely recorded at the 64 assessment facilities to track the number of health providers who met the benchmark for each service area. To validate a mentee, mentors completed a standard mentorship checklist during every mentorship visit (Box 1) which included observations with clients or anatomical models and review of client charts for clients who received care by a given mentee. Mentees are considered validated when they achieve a score of 85% or higher in each competency (EmONC, ENC, IMCI, FP) (see box 1). As many as five visits were conducted and data was routinely collected, at least once or twice per quarter, over a two-year period (June 2016–June 2018).

Secondly, MCSP used the observational mentorship checklist to re-assess a sample of validated mentees to determine if providers maintained high levels of competency by the end of the project. In total, 192 mentees were sampled for the endline assessment, representing 13% (192/1,520) of all nurses and midwives working in MCSP-supported health centers. Three healthcare providers per facility were randomly sampled from each relevant department (maternity/neonatology, IMCI, and Family Planning) at all 64 assessment facilities.

MCSP also conducted a qualitative assessment as program implementation came to a close to gather feedback and experiences from program stakeholders on the different components of the MCSP program approaches from central, district, facility, and community levels in six selected districts. A total of 11 key informant interviews were conducted at the central level and 42 key informant interviews were conducted at district, facility, and community levels with program managers, implementing partner representatives and professional associations, representatives of District Health Management Teams (DHMTs), Director Generals of district hospitals, nurses/midwives in-charge of maternity units at hospitals, nurses in charge of family planning at hospitals, heads of health centers, and nurses in relevant wards. The qualitative data and quotes presented in this brief were gathered from these respondents.

Quantitative data were entered into an MS Access database and reviewed for completeness and spot-checked for consistency with hard copy data collection tools. Cleaned data was analyzed according to key themes and composite indicators. For qualitative data, a codebook was created and analyzed per key themes using atlas.ti and Excel.

Key Findings

The final sample included a sample of health centers and hospitals from all 10 MCSP supported districts. As noted in the methods, the same facilities were included in the baseline and in the endline.

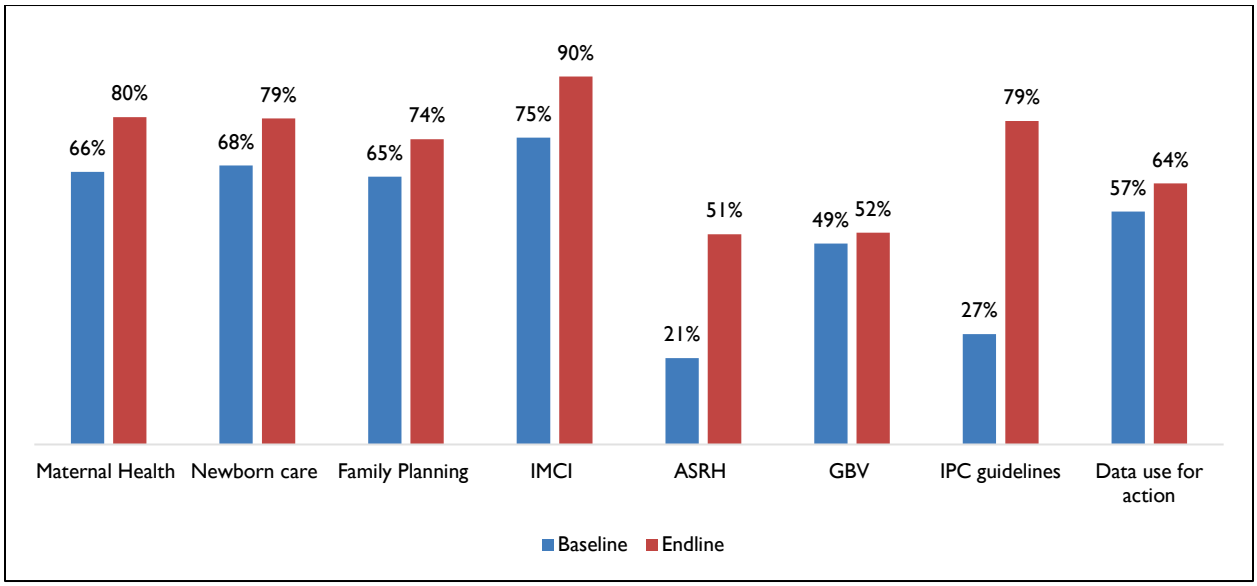
Table 2. Final sample

	Baseline and Endline		Endline only		
	HFA		Skills Assessment		KII
District Name	# of HC	# of Hospitals	# of Providers HC	# of Providers Hospital	# of Participants
Central					11
Musanze	5	1	15	3	4
Nyabihu	5	1	15	3	4
Kamonyi	4	1	12	3	4
Nyamagabe	6	2	18	6	5
Huye	5	1	15	3	5
Nyaruguru	5	1	15	3	4
Nyagatare	7	1	21	3	4
Gatsibo	6	2	18	6	4
Rwamagana	5	1	15	3	4
Ngoma	4	1	12	3	4
TOTAL	**52**	**12**	**156**	**36**	**42**

Facility Readiness

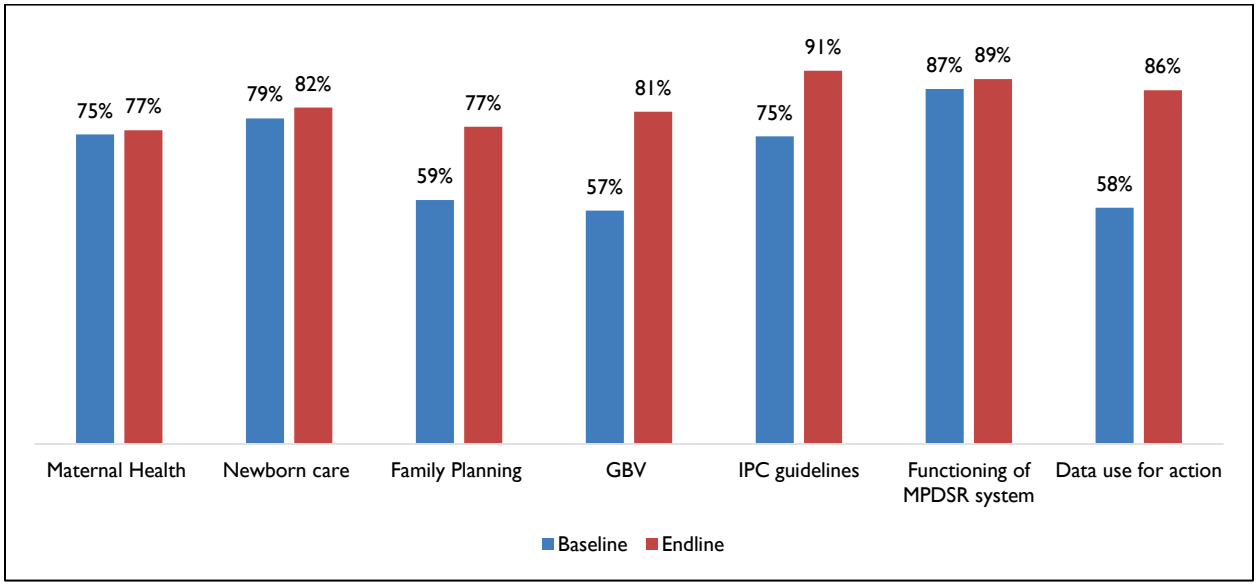
Health facility readiness composite scores in all assessed areas improved at the 52 MCSP-supported Health Centers (Figure 1). This is an important achievement given the breadth of services included under each service area. The composite scores within each service area include the availability of services, trained staff, key commodities, equipment, job aids and visual/auditory privacy to conduct services. Maternal Health includes ANC and L&D, Newborn Health includes ENC, postpartum postnatal care, follow up PNC, Family Planning includes out-patient family planning and post partum family planning, IMCI includes preventative and curative care services for children; ASRH includes the training by providers in all service areas on adolescent friendly services and availability of family planning services to adolescents; GBV includes screening for GBV victims within the setting of other services; IPC covers availability of facility-wide IPC measures; and the data use domain includes data visualization and use, the health facility QI process, district level support for data use/decision making, district level supportive supervision and data dissemination/ community engagement. Availability of IPC guidelines and provision of adolescent sexual and reproductive health (ASRH) services showed the highest increases, probably due to their relatively lower level of availability at the start of the project. The smaller improvement in readiness to provide gender-based violence (GBV) services at the health center level could be explained by MCSP's greater focus on hospital level Isange One Stop Centers, where most GBV cases are referred for comprehensive post-GBV care. Health facility readiness scores also improved at the 12 MCSP-supported hospitals (Figure 2).

Figure 1: Facility readiness to provide RMNCH services improved at all MCSP-supported Health Centers (n=52)



**Composite indicators: the availability of services, trained staff, key commodities, equipment, job aids and visual/auditory privacy to conduct services within a particular domain

Figure 2: Facility readiness to provide RMNCH services improved at all MCSP-supported hospitals (n=12 hospitals)



**Composite indicators: the availability of services, trained staff, key commodities, equipment, job aids and visual/auditory privacy to conduct services within a particular domain

Through qualitative interviews, providers and facility managers spoke of better quality of services and improved efficiencies at the facility level after the support of MCSP. Some providers spoke of improved confidence to manage complex cases of postpartum hemorrhage or newborn resuscitation. One provider noted,

"Before we had no place reserved for maternal emergencies, we did not give much consideration to those emergencies, they shared the same wards with other cases. After training and mentorship, we created a room for critical cases and we allocated staff to take care of them. Triage is now done and critical cases are placed in that room for special care." –Midwife, Kibungo Hospital

Another provider echoed the sentiment of improved facility readiness to successfully navigate multifaceted approaches to providing life saving care.

'For example, we had had a case of preeclampsia; the woman was in critical state, we took vital signs and tested for albiminuria, administered magnesium sulfate loading dose, called ambulance, cesarean section was performed and the mother delivered a healthy baby. I am telling you, before, this woman would have died since we did not know how to manage the case let alone know that we were allowed to keep MGS04 in the maternity ward'. –Midwife, Gituza Health Center

Data use for action

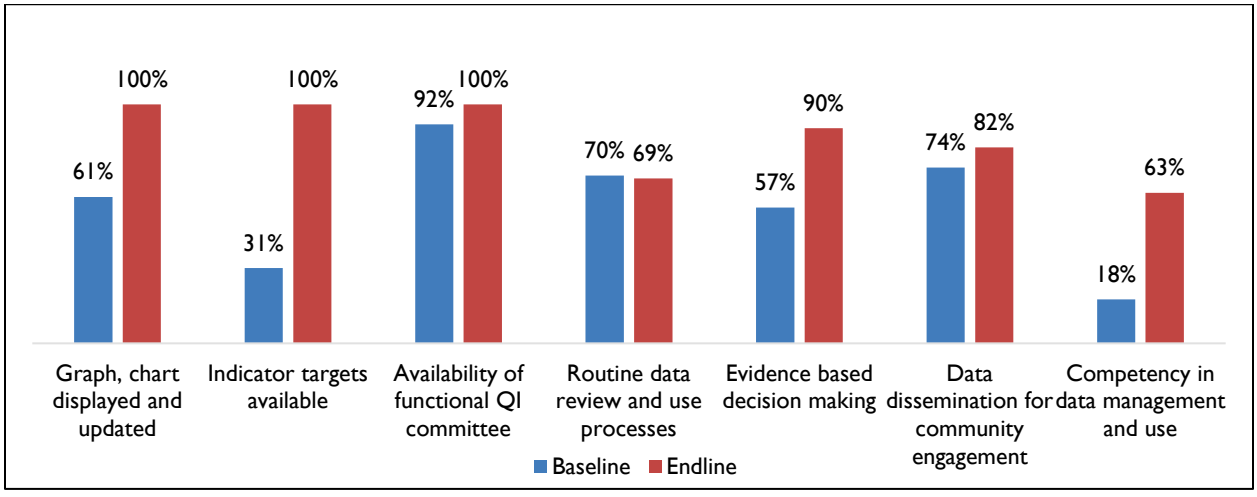
Staff at assessed health facilities reported using data dashboards in DHIS2 more than before, as well as the ability to understand service delivery data, address any gaps or mistakes, and make data-informed decisions. Key informants at the central level reported the use of data at the national level has improved, and the capacity of lab technicians and data managers to generate quality, usable routine data has been strengthened. One national level respondent highlighted this as a crowning achievement of the Government of Rwanda's collaboration with MCSP.

"Before it was very hard to get actual data, staff didn't know why they needed to collect all these data, you would ask for the number of deliveries done and receive data which was not related to reality, simply because they didn't know the importance of reporting good data. After receiving capacity building and data management supported by MCSP, changes are remarkable, everyone knows how to collect good data and its importance in decision making'. –Maternity Matron, Hospital

Data from the quantitative health facility readiness assessment also included questions around data. Visualization and use of data for action showed considerable improvements both at health center and at hospital level as shown in Figures 3 and 4. The most marked improvements were seen in respondent reported availability of indicator targets at both health centers and hospitals, and in the display of updated charts, evidence based decision-making and competency in data management at the hospital level. Evidence-based decision making at health centers and use processes at hospitals remained about the same between baseline and endline, while evidence-based decision making increased at hospitals. Respondents also gave important examples of evidence based decision making during the qualitative data collection. One providers gave an example of an important experience with improving data quality and use.

"Before submitting a certain report, I check and ensure the quality of my data. One time we found that the number of patograms was not equal to the number of normal deliveries, there were missing patograms, we discovered that the missing patograms were attached to transfer notes. We made copies of the missing patograms and showed the issue to the staff".
–Midwife, Gituza health center

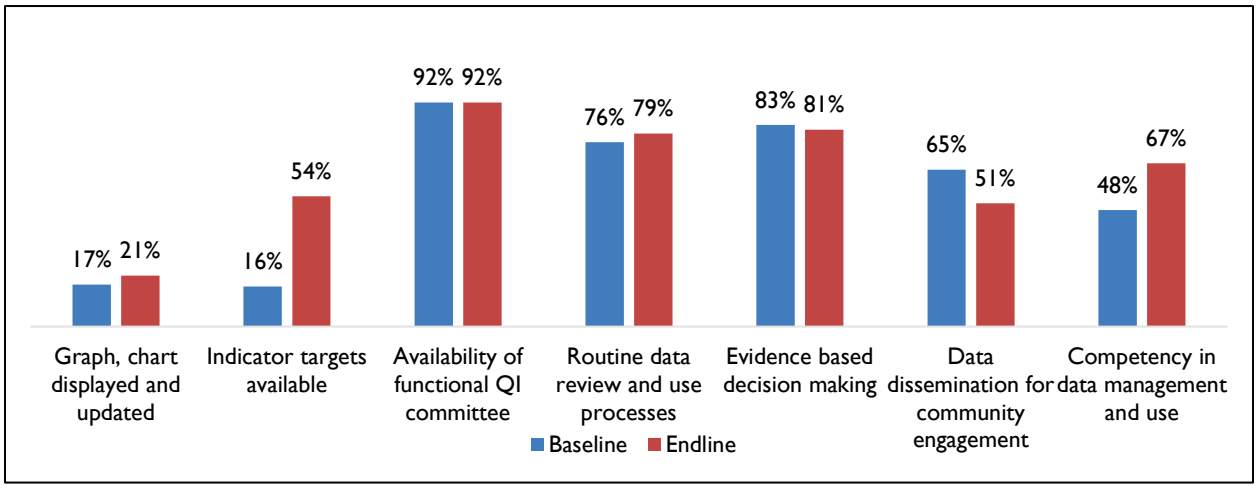
Figure 3: Improved environment, tools and processes for data use for decision making at all MCSP-supported hospitals (n=12)



Source: Project data

While the structures, tools and processes for data use and decision making generally improved at the hospital level, health centers saw less gains in the same areas. This may be due to some areas having high values at baseline, such as 92% of MCSP supported health centers already having functional QI committees. Health centers do need continued support in data use for decision making, making sure that other key staff [in addition to data managers] are involved in the collection, analysis and use of data.

Figure 4: Findings regarding data and data use at baseline and endline at all MCSP-supported health centers (n=52 facilities)



Source: Project data

Provider Capacity Development

Figures 5-8 present routine program data on the number of clinical mentees whose specific competencies were "validated" within each technical area over the life of the project. A mentee is considered validated in a specific technical area when they achieve a score of 85% on the mentorship checklist, conducted by a mentor during a routine visit. In the initial four MCSP districts, providers first received training in RMNCH via several modules, after which they received mentorship. In the six scale up districts, providers started training and mentorship in parallel. Once mentorship activities began, mentors conducted two mentorship visits per health center per month. A mentor had two to three health centers on which to follow up and two to three mentees at each of their assigned health centers. At several specific visits throughout the project, numbers one through five in the figures below, mentees were validated by their mentor. With each subsequent visit, more mentees were validated by their mentors, adding to the pool of providers enabled to provide quality services to clients. Some mentees were not validated on the first visit, which could be explained by: some providers may have missed the first round(s) of LDHF training and thus needed training before they could become validated; some were new to the facility; and some needed additional trainings and clinical supervision/mentorship to bring their competency levels up to the benchmark. As seen in the figures below, by the end of the project, a cumulative 199 mentees were validated on FP Counselling, 90 were validated on IUD insertion, 74 were validated on uterine atony, and 184 were validated on implant insertion.

Figure 5: Validated mentees on FP services (n=160 health centers, 12 hospitals)

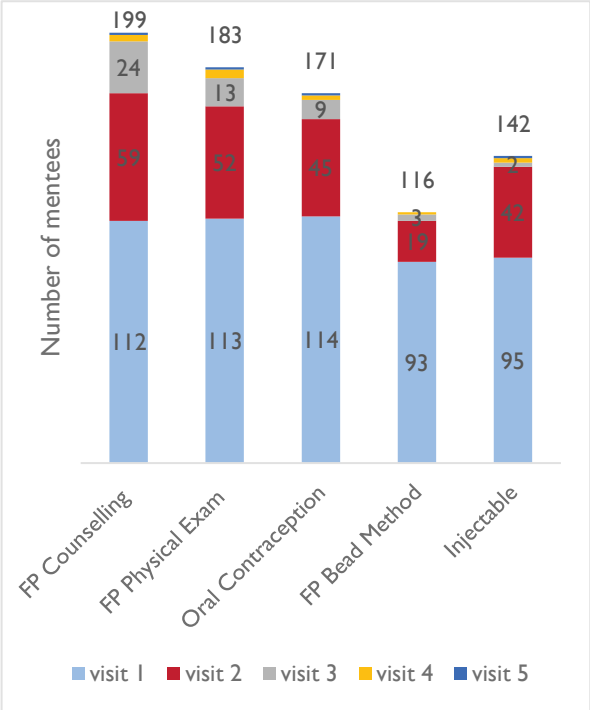


Figure 6: Validated mentees on IUD services (n=160 health centers, 12 hospitals)

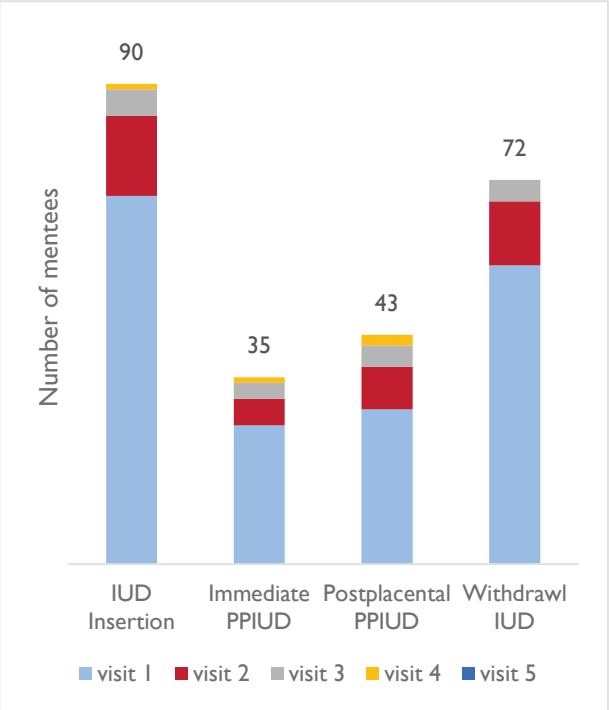


Figure 7: Validated mentees on specific uterine competencies (n=160 health centers, 12 hospitals)

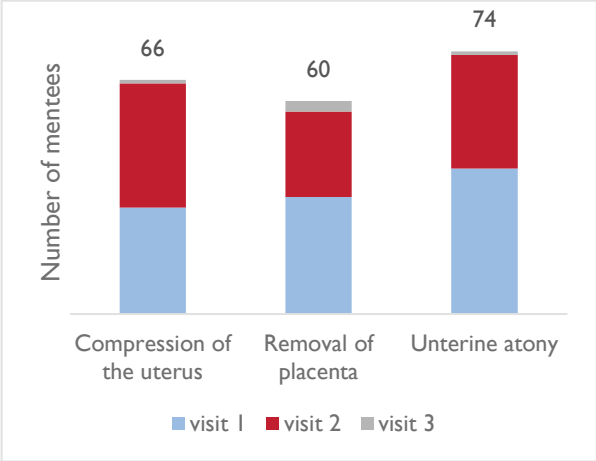
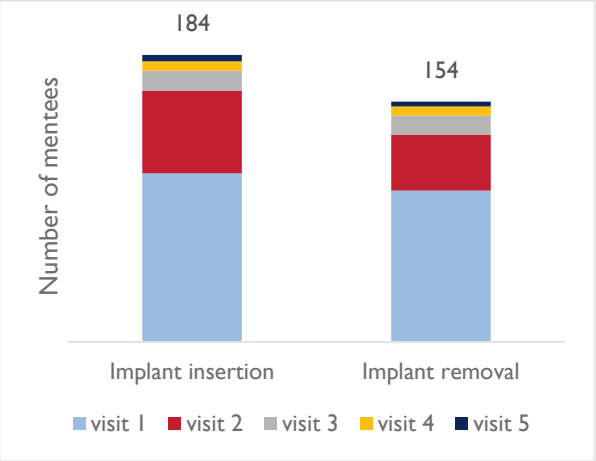


Figure 8: Validated mentees on implant services (n=160 health centers, 12 hospitals)



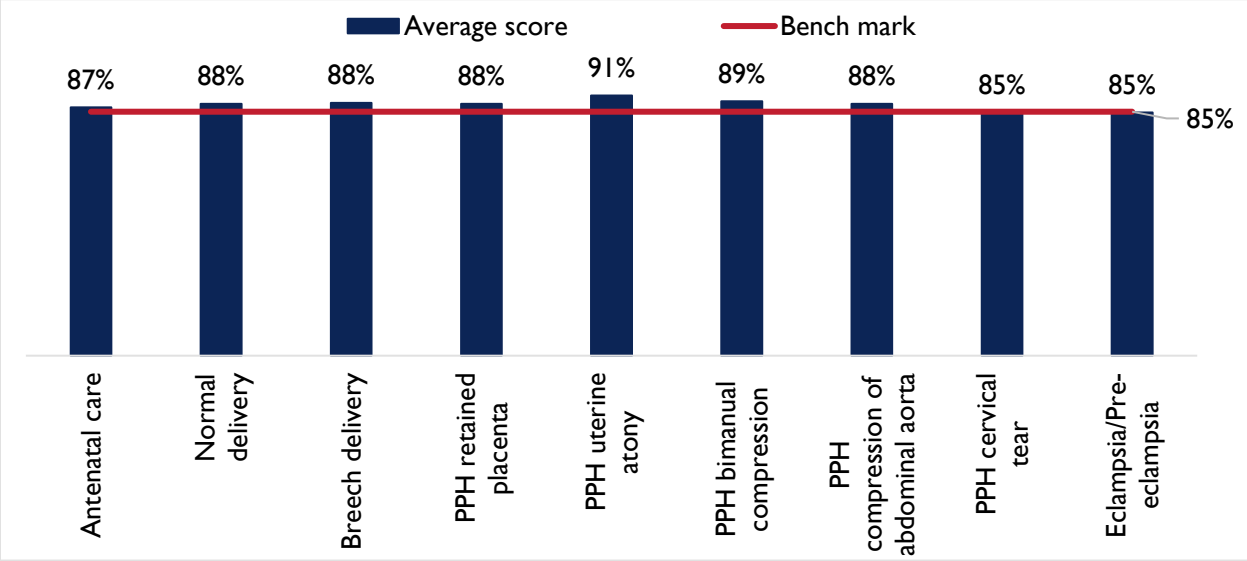
Provider Competency at Endline

Average mentorship checklist scores at endline among providers who were previously validated are presented in Figures 9-12. A benchmark of 85% was used because it was the benchmark employed during LDHF training, a score above which a participant must reach in order to be 'validated'. Providers performed at or above the benchmark on nearly all components of the mentorship checklist in B-EmONC, Newborn, IMCI, and FP. During KIIs, healthcare providers and stakeholders at all levels of the system reported that LDHF trainings and mentorship were preferable and more effective methods to build and maintain capacity compared to traditional approaches.

"LDHF training used by MCSP was a very good approach in term of improving health care competence because it is facility based with team focus, repeated practice after learning on anatomical model, case discussion and dealing with real cases management in the hospital and getting direct feedback. LDHF gives the opportunity to train more people at the same time, it is an ongoing practice supported by peers. LDHF training approach is good in term of staff management because no one need to leave the work for training, trained staff play a big role in training of new staff and the practice continue on anatomical model". –Clinical Director, Rwamagana Hospital

Maternal Health

Figure 9: Previously-validated mentees scored at or above benchmark for all B-EmONC competencies at endline assessment (n=64 providers)



*For routine care, mentees were observed with clients. For rare events, mentees were scored through observation with an anatomical model.

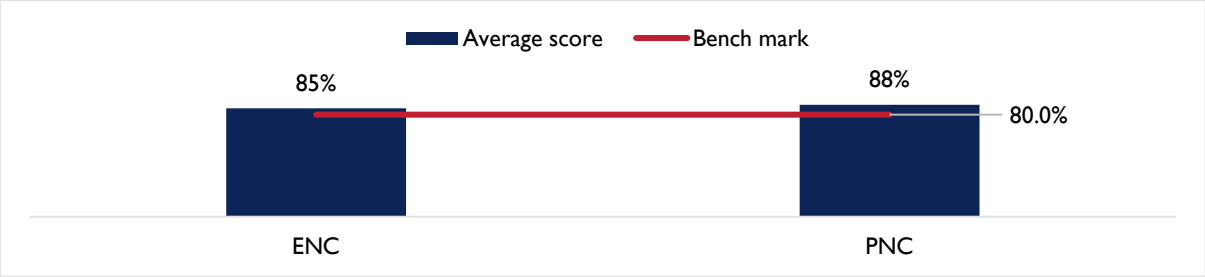
Key informants at selected MCSP supported facilities reported feeling more confident in their skills and making facility level changes in order to improve maternal health services as a result of the LDHF and mentorship approaches.

"Before we had no place reserved for maternal emergencies, we did not give much considerations to those emergencies, they shared the same wards with other cases. After training and mentorship, we created a room for critical cases and we allocated staff to take care of them. The triage is done and the critical cases are placed in that room for special care" – Midwife, Hospital

"For example, we had had a case of preeclampsia; the woman was in critical state, we took vital signs and tested for albiminuria, administered magnesium sulfate loading dose, called ambulance, cesarean section was performed and the mother delivered a healthy baby. I am telling you, before, this woman would have died since we did not know how to manage the case let alone know that we were allowed to keep MGS04 in the maternity ward." – Midwife, Health Center

Newborn health

Figure 10: Previously-validated mentees scored at or above benchmark for all Newborn competencies at endline assessment (n=64 providers)



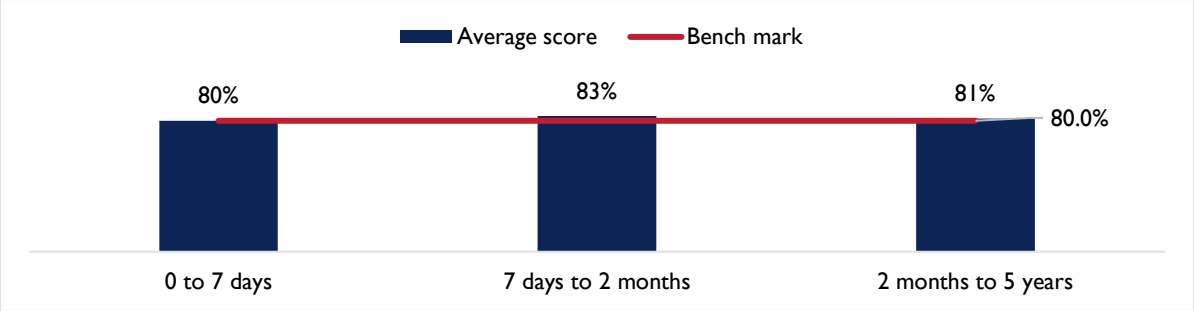
*For routine care, mentees were observed with clients. For rare events, mentees were scored through observation with an anatomical model.

Prior to receiving trainings and mentorship, providers did not always know how to properly apply methods to save a newborn in distress and were unable to prevent neonatal death. After MCSP's LDHF and mentorship approach, data show that providers maintained high scores in the areas of essential newborn care (ENC), and post-natal care (PNC).

"Before, a baby with fetal distress died easily because we lacked knowledge about how to help baby to breathe or how to do resuscitation. We were all ignorant in the matter of Apgar, resuscitation was done without following resuscitation steps. But today, no child dies due to fetal distress. We try our best, we resuscitate, we call for help and we save the baby's life."
– Midwife, Gituza Health Center

Child health

Figure 11: Previously-validated mentees scored at or above benchmark for all IMCI competencies at endline assessment (n=52 providers)



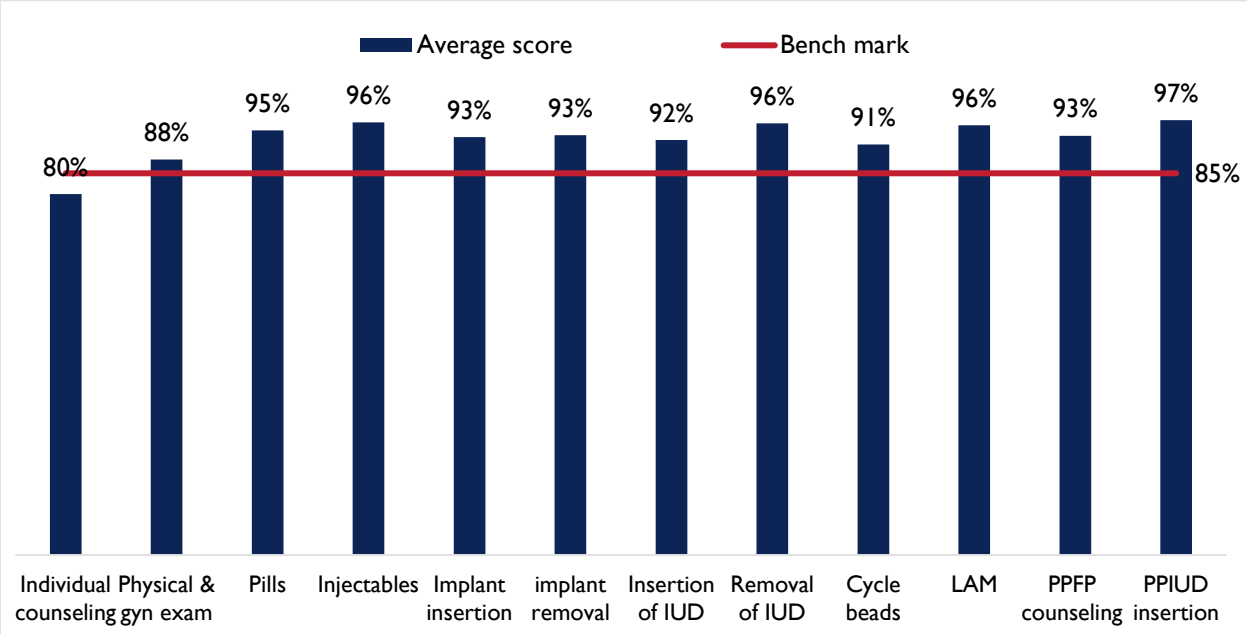
Health providers who work in IMCI consultation rooms felt that LDHF trainings helped improve case management and confidence in providing quality service in health centers through the use of protocols.

"Our knowledge level increased, there has been changes in the treatment of children. Before we treated children without taking into considerations other signs like malnutrition. After trainings, if the child is coughing, we pay attention on height, weight, MUAC. This helped us a lot in saving children and to appropriately care for children. Before we did not give importance to such things, we considered them as not necessary or important, but today things have changed." –IMCI nurse in-charge at a Health Center

"After MCSP training, transfer has been reduced. Before when children came here, we did a transfer immediately. Today we try to treat without transfer. We gave a transfer for example if a child has pneumonia with complications or dangerous signs. We just give him first aid, and then, we transfer them." –IMCI nurse in-charge, Health Center

Family Planning

Figure 12: Previously-validated mentees scored at or above benchmark for majority of FP competencies at endline assessment in 64 facilities (n=64 providers)



Respondents agreed that significant improvements have been achieved in provision of family planning services, most notably due to increases in postpartum family planning. After receiving the training and mentorship, providers at all facilities strive to counsel all women who come for delivery on postpartum family planning methods. Health facilities now have at least two trained providers who can provide modern methods to women who elect a method after birth.

"The most important thing we benefitted from training and mentorship is how to provide family planning methods. The number of family planning users has increased; we have more staff to provide family planning method including me. Postpartum family planning is 100% while before MCSP it was not done at all." –Head of Health Center

"I should salute the MSCP for capacity building, we wish they would continue, now people doing family planning can do insertion of implant, they are very confident, we have done that several times without having any complication and now can work independently because they have been trained, this was really the impact of training offered by MCSP". –Director General, Hospital

Improvements to overall quality of care

Following training and mentorship, the number of transferred cases from health centers to hospitals reduced significantly because most of the complicated cases that would usually be referred to the district level hospitals, such as newborn asphyxia, can now be managed at the health center level. Respondents noted that they still get very few or no counter-referrals from the hospitals to which they transferred their patients.

Stakeholder Perspectives

Central level key informants acknowledged the impressive gains in quality of RMNCH care and data collection and use at the facility level after mentorship and trainings were instituted. One representative from the Maternal, Child, and Community Health (MCCH) Division at RBC noted the need to integrate and budget for the provider capacity building and facility quality improvement approaches into national policy, including for transportation and accommodation costs for mentors. In addition, it was suggested to formally evaluate the mentorship approach to produce evidence that can inform national policy development.

Providers and other facility level staff also endorsed the approach, their sentiments captured in the quotes below.

'I have been a titulaire in different HCs for more than 16 years, we've had several trainings in various domains, topics but once you left the training facility it was finished, no one asked you what you studied so that you share. And most times you already even forgot about it, but with LDHF approach, there is a difference; the training happens on site, more staff benefit in terms of theory and practice as it was done on site. Cases are even managed during the training'. –Titulaire, Ruhunda Health Center

"The way MCSP was implemented is totally different from other INGOs. When someone gives you knowledge and skills, these ones do not disappear because they (someone) stopped teaching you. For example, I was coordinating mentorship activities not because I would be paid but because it would improve health facility indicators and the wellbeing of the community. I will make sure myself that skills gained are maintained and transferred to new staff". –Titulaire, Ruhunda Health Center

"I should salute MSCP for capacity building, we wish they would continue, now our staff in family planning can do insertion of implants, they are very confident. we have inserted implants several times without having any complication and now can work independently because they have been trained, this is the impact of the training offered by MCSP'.
–Director General, Ruhengeri Hospital

Recommendations

With data from pre and post assessments combined with routine service data at supported facilities suggest that MCSP supported interventions contributed to improved quality of RMNCH care. MCSP's capacity building approach using LDHF training combined withclinical mentorship targeting high impact RMNCH interventions, and quality improvement approaches resulted in increases in health provider skills and knowledge, data use for decision making, and health facility readiness. As a result of the documented effectiveness of these approaches, the Rwanda National Health Sector Plan prioritizes these approaches. Therefore, it is recommended that MoH provide leadership to ensure resources are allocated to scale up these approaches country wide.

At the central level, LDHF trainings and clinical mentorship are perceived to be more cost effective than traditional training but needs to budgeted appropriately. A coordination mechanism at the central level would help to ensure smooth implementation of mentorship as the approach is expanded to more districts. All mentorship activities and outcomes should be systematically documented to track progress and analyzed over time.

In addition to central level and professional association staff, districts and health providers must be engaged in planning capacity building activities to increase ownership. At the district level, LDHF trainings and mentorship should be integrated into routine activities. In particular, experience exchange visits between high and low performing facilities is a useful way to promote learning between facilities and districts. To ensure a high quality and consistent mentorship approach is used for all providers country wide and can be measured effectively, RBC/MoH should issue clear guidance and develop national guidelines for all stakeholders including implementing partners supporting service delivery and health systems strengthening.

At the district and facility level, key indicators should be tracked to measure progress and evaluate effectiveness of strategies and approaches. Facility staff need tools and guidance to track key indicators, and data systems including dashboards must be in place in order to continuously track clinical outcomes. Facility leaders can foster and promote a culture of data being a part of everyone's responsibility including providers. Under MCSP, as part of facility QI plans, data review meetings with facility staff were required which provided an opportunity to review data and make adjustments.

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.