HEALTH DEVELOPMENT INITIATIVE - RWANDA

2007 - 2008

REPORT OF ACTIVITIES

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FOREWORD

We are pleased to present to you the 2007-2008 report of activities. This report documents the contribution by Health Development Initiative and its partners in improving healthcare for Rwandan communities in the last two years. We are grateful that the organization doubled its activities and increased its visibility compared to 2006.

We take this opportunity to thank all the partners who made this possible. These include but not limited to Ministry of Health, Geneva Global, Health Leadership International, Medical Connections UJAMA, Mr. Robb Angel and Other individual donors. To all of you we say thank you.

We are happy that Rwanda is making substantial progress towards improvement of health and is working towards achievement of the Millennium Development Goals. However this remains a challenge with limited resources, the current population growth rate and a high burden of preventable diseases. In this regard we recognise that we still have a long journey to achieve our mission and call upon development partners to support the ongoing process to address these challenges.

Last but not least we are very grateful to the devotion of the leadership, staff, partners, volunteers and members of the organization in the realisation of the activities mentioned in this report. To all of you we say thank you and look forward to a continued fruitful partnership.

Dr. Aflodis KAGABA,

Executive Director.

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1 HEALTH BACKGROUND IN RWANDA

Much of Rwanda's health sector was destroyed in the genocide of 1994. With a real Gross Domestic Product (GDP) per capita of $230; the country remains one of the poorest in the world[1]. However, during recent years Rwanda has made significant progress in health. Specifically, in the area of maternal and child survival, the 2000 and 2005 Demographic and Health Surveys (DHS) report a decrease in infant mortality from 108/1,000 to 86/1,000. Decreases in under-5 mortality (from 196/1,000 to 152/1,000) and maternal mortality rate (from 1,071/100,000 to 750/100,000) are also reported.[2] Early results from an interim DHS conducted in 2007/2008 show continued significant improvements, with infant mortality down to 62/1,000; and under 5 mortality down to 103/1,000.

Health care system in Rwanda has been decentralized to better coordinate services among hospitals, local health centers and communities. The system faces many resources challenges, including chronic shortages of qualified physicians, nurses, midwives, and poor clinical and laboratory infrastructure, especially in rural areas. High rates of maternal and child illnesses, as well as the disease burden of HIV, malaria, and tuberculosis, limit life expectancy to 52 years of age (UNDP, 2007).

The ministry of health in Rwanda is an institution appointed to coordinate health services in the country. It is dedicated to provide and continually improve the health services of the Rwandan population through the provision of preventive, curative and rehabilitative health care faces challenges.

Rwanda is making substantial progress towards improvement of health and is working towards achievement of the Millennium Development Goals. However this remains a challenging task because of being in a state of post conflict, with few natural resources, being landlocked, and with high population growth. Like many impoverished sub-Saharan countries, Rwanda's health system faces a high disease burden of preventable diseases.

The health sector continues to face severe problems illustrated in the basic health indicators. HIV/AIDS, malaria, and tuberculosis, combined with the lack of child and reproductive health services and adequate nutrition are all issues. The need to scale up major programs to combat HIV/AIDS, tuberculosis, and malaria and, at the same time, integrate them with the basic package for primary health care is a particular challenge. These challenges dictate that other actors come in and assist the government in addressing these issues. In this report we are pleased to present to you our contribution in these last two years.

1 Health Sector Strategic Plan (HSSP) 2005-2009, Government of Rwanda.

2 Working Toward the Goal of Reducing Maternal and Child Mortality, USAID Maternal and Child Health, 2008 Report to Congress, Maternal and Child Health Program Descriptions, Africa.

2 HEALTH DEVELOPMENT INITIATIVE - RWANDA

Health Development Initiative (HDI) is an independent, non-governmental, non-profit organization based in Kigali, founded by Rwandan physicians dedicated to promoting health and development in disadvantaged communities. HDI strives to improve health care for all Rwandans with emphasis on underserved populations through community-based interventions such as disease prevention, health training, and capacity building at both the individual and institutional level.
The HDI founders were born and grew up in remote areas of eastern and central Africa where simple, preventable diseases claimed many lives, especially women and children. This inspired them to become health care workers to improve people's lives. It is this same spirit that led to the creation of Health Development Initiative – Rwanda, to empower individuals and communities with knowledge and skills in public health and primary care such that all Rwandan citizens can lead healthy lives, free from preventable disease and premature mortality.

2.1 OUR MISSION

Our mission is to organize and promote community-based health care development in Rwanda. We work to build sustainable alliances between the community and professional health care providers, as well as to empower providers to better educate and serve their communities. Through education and improved health care capacity at different levels, we seek to bridge the inequalities in health care in our country.

2.2 OUR VISION

A healthy society in which medical care is accessible to all communities regardless of socioeconomic level, in which women and their families are educated and informed about reproductive health, family planning, and newborn care, and in which preventable disease no longer threatens lives.

2.3 OBJECTIVES

To build the capacity of Rwandan communities and institutions to provide better health services to all segments of Rwandan society.

To contribute to the fight against HIV/AIDS, malaria, TB and other preventable diseases by education and empowerment of local health care workers and patients, and by advocating for affordable health care services for all.

To support those who wish to serve disadvantaged communities through a sustainable volunteer program.

To educate young people, especially primary and secondary school youth, about reproductive health, family planning, HIV/AIDS, STIs, and drug and alcohol awareness.

3 AREAS OF FOCUS

HDI's interventions are mainly in 4 areas of focus namely reproductive health and HIV/AIDS, medical and technical support, maternal and child health and community health education. In all our activities, gender is cross cutting.

3.1 REPRODUCTIVE HEALTH AND HIV/AIDS

3.1.1 SHARE project

Talking about sex is a major issue in African culture and it is a sensitive topic among parents and their children yet it is a natural phenomenon whereby we should not hide from it. The youth have always been hardest hit of these problem. Discussion about sex was not allowed during ancient time and continues even now. Behaviour change is inhibited by African culture whereby sexual matters have been considered as a taboo and signifies immorality. Youth explore and in their attempts to understand sex, they consult their peer groups. This often leads to misinformation.

Statistics from 2006 show that scarcely 50% of Rwandan youth have any understanding of HIV. Only 26% of females and 40% of males, aged 15 to 24, used a condom during their last high-risk sexual encounter. Because sex and STIs are taboo subjects, many Rwandan youth are never correctly educated about the preventability of sexually transmitted disease. Often, young people live in fear of diseases like AIDS, and thus perpetuate prejudice against infected individuals. Popular media and common slang target women as HIV's root cause, contributing to the high level of domestic violence against women and fear of women's sexuality. Politics in Rwanda have been marked by totalitarian regimes that rejected political diversity, leading the country with fear and frowning upon freedom of expression. Undereducated youth played a big part in carrying out the 1994 Genocide, manipulated by those in power to destroy Rwanda. Today, the lack of safe spaces for youth to discuss sexual health and reproductive education is of major concern, as youth compose the largest percentage (over 45%) of the Rwandan demographic. The way forward is to provide clear information in a youth-friendly tone, and to empower young people to make informed and responsible decisions.

After assessing the curriculum in schools by Health Development Initiative teams, it was found that basic health education is not well covered in the school curriculum for students in Rwanda. As a result, students do not learn basic health behaviors that can improve their health and the welfare of their families. For example, misinformation and misunderstanding about human sexuality are very common. By providing information about human reproduction and contraception, one might be able to help students avoid unwanted pregnancy. By tracking the number of unplanned and unwanted pregnancies year to year at a secondary school, one can evaluate the outcome of an educational program teaching basic reproductive health and human sexuality.

SHARE project was thought to create a receptive environment for creating awareness on HIV/AIDS and other sexually transmitted diseases. SHARE project strengthens moral values, cultivates self esteem. Real life lessons are taught using the curriculum which was well designed for youth education on HIV/AIDS and other sexually transmitted diseases. In designing the curriculum many models were adopted and adapted to the Rwandan context, and therefore easy to administer to Rwandan youth.

Sexual Health and Reproductive Education, a project supporting Rwandan youth, before they become sexually active, to develop positive attitudes about sexuality through deepening awareness about reproductive health as part of a comprehensive strategy for combating the AIDS epidemic and the contraction of other STI's.
SHARE introduces a sexual education curriculum in secondary schools, using innovative education strategies, such as role-playing, creative writing, and sharing personal experiences.
HDI also targets non-schooling youth, including girls who are involved in or predisposed to prostitution. These adolescents will have a multiplier effect in their communities as they pass on their education through word of mouth and education strategies, proposed and developed by the youth themselves. Thus, the program SHARE will affect the lives of thousands of Rwandan families

An HDI facilitator demonstrating how to use a condom to youth in Kacyiru sector.

Our program mainly covers sex and sexuality, HIV/AIDS and STI's, family planning, physiological and anatomical changes in the body, drug and alcohol abuse. Thus far, the beneficiaries are very interested.

3.1.1.1 The methodologies applied in this program

- Creating plenary sessions with different youth groups and then meet experienced facilitators to have an in-depth discussion on matters regarding reproductive health in youth.
- Pre and post testing is used to test youth knowledge on HIV/AIDS and reproductive health in general.
- Story/experience sharing from a group of people living with HIV/AIDS.
- Secret questions are sent in as small notes and answered by a facilitator from Health Development Initiative.

Since 2006 HDI has been actively involved in education on reproductive health in Rwandan youth who are in secondary and primary schools. To date, this program has reached about 5000 young people in schools. In future anonymous questions collected from youth will be presented in a monthly open talk magazine and distributed to a larger youth and parental community. This innovative strategy builds a sense of communal ownership among the youth that gather to discuss HIV, reproductive health, family planning and STI prevention.

Sexual health education for secondary school students.

3.1.2 Supporting Benihirwe association

Since 2007 HDI has been supporting Benihirwe association, an association of about 300 people living with HIV/AIDS. HDI regularly sends physicians and other health professionals to train the members of Benihirwe to foster their positive living.

The trainings have been concentrating on:

- HIV/AIDS prevention,
- Hygiene and sanitation,
- Nutrition and HIV,
- Pregnancy and HIV,
- Family planning,
- Side effects of Anti Retro viral regimens,
- Group counselling,
- Tuberclosis and HIV/AIDS and
- Community organization.

3.2 MEDICAL AND TECHNICAL SUPPORT

3.2.1 Training of health professionals

HDI believes that quality health care provision depends on knowledge of providers, it is in the same development. HDI has trained nurses from Shyara, Rweru and Nyamata to improve on their effectiveness and efficiency in service delivery in their respective health units. Nurses were trained in primary health care, recognition and response to health emergencies, and promoting family planning and patient education. The rationale of these trainings was to make them at a forefront to manage most of the illnesses which their clients present.

A plenary session with Nurses during their training in 18th May, 2007

In 2008 nurses in the health centers of GIHINGA, NZANGWA and JURU were trained in neonatal support and management of emergency obstetric cases. This training came as part of continuing medical education and was funded and facilitated by UJAMA Medical Connections- a US non profit organization we partner with. We have planned another training of ten health centers staffs of Bugesera in March 2009.

3.2.2 Provision of basic diagnostic equipment and supplies

In 2008 HDI donated digital fetoscopes, stethoscopes, digital blood pressure machines and small surgical sets. This was all possible by the support of Health Leadership International (HLI), a U.S.A based non- profit.

> ***"Was it not for this digital feotoscope we wouldn't have realised that Nyirahabimana had twins, which prompted our urgent transfer to the Nyamata hospital."***
> - head nurse from Nzangwa -
>
> ***"I really can't remember the number of difficult cases this fethoscope has helped us."***
> ***"Sometimes I wonder how we used to work without it."***
> - nurse from Gihinga -

In the same development, through Medical Connections UJAMA we donated medical materials and supplies worth over thiry million Rwandan francs to Kibagabaga Hospital in Kigali in June 2008.

3.2.3 Medical missions

In a bid to contribute to improvement to quality health care, HDI invites and coordinates medical missions from the developed world. HDI has made linkages with specialist physicians, experienced nurses and midwives from the United States of America and Europe who we invite and come to provide mentorship and work alongside with their Rwandan counterparts. We have invited over fifteen physicians experienced in surgery, obstetrics and gynecology, neonatology, cardiology, family medicine and public health. This kind of working relationship has created an on-the-job training to junior doctors and nurses working in Rwandan health facilities and improves on the quality of service provided.
Thus far, HDI has hosted medical teams from the UJAMA Medical Connections (USA), Health Leadership International (USA) and one team from Sweden. We are expecting to have an orthopedic surgery team from Healing the children Oregon chapter (USA) in January 2009; In future we hope these teams will be coming at least every three months.

UJAMA Medical team at Kibagabaga Hospital, June 2008.

3.3 COMMUNITY HEALTH EDUCATION

3.3.1 Bugesera health project

3.3.1.1 Training community theater groups

HDI engaged youth volunteers in the sectors of Rweru, Shyara and Nyamata, to join the cause of helping their fellow community members with health education through theater performances. HDI hired an experienced mentor who trained these youth. The training included basic knowledge on the main health challenges, information gathering to know what health related problem could be in audience villages and therefore design a targeted message also youth were trained in familiarization and having a post performance discussion with HDI staff for correction and checking the relevancy of the content.

A training of youth theater groups *©Photo by Amina Ntumurize 2007*

"Be the change that you want to see in the world." - Gandhi -

Theater is an important part of many people's lives, bringing the gifts of entertainment and story sharing to people around. No matter the style of theater, performances have the potential to create magical and unforgettable moments for their audiences.

Trained theater performing group in Rweru sector posing for a photo after their performance

A crowd of spectators of Shyara Theater Group

Since introducing of theater groups, community health insurance subscription has increased from 57% in April 2007 to 86% in March 2008. This shows that the communities are understanding the importance of seeking the health care services.

3.3.1.2 Training of community health workers

Community health is a perspective on public health that assumes communities to be an essential determinant of health and the indispensable ingredient for effective public health practice. With this knowledge, therefore, community health workers have the advantage of knowing the community holistically in terms of culture, norms, tradition, formal and informal networks, support system and belief system. Most likely, they will also know the health problem in their communities.

It is in this light therefore this intervention was proposed. A training of the community health workers empowered them with the capacity to carry out preventive education and sensitization in their community.

A Training of community health workers first group

Along with the training to community health workers, Health Development Initiative developed a comprehensive manual for reference to the community health workers.
Training of the community health workers aimed at empowering them with the capacity to carry out preventive health education and sensitization in the community, but also to monitor the success of the program in the community.

Mukaka Dative (in a white T-shirt from the right) is a trained community health worker by this project

According to the republic of Rwanda's national community health policy, the community health workers are to guide and strengthen the provision of community health services and also provide a

framework of working towards meeting international commitments such as Millennium Development Goals (MDG).

In our areas of interventions community health workers trained by this project are involved in interventions like child survival strategies which entails weight taking for children under five years of age and Vitamin A supplementation every after three month. On top of that they do monthly reporting to the nearest health unit. The concept behind this is to closely cooperate with the existing institutions of health so that we can share experiences, encourage common grounds of operations and avoid duplication of activities with the limited resources available.

A group of trained community health workers posing for a photo with the executive secretary of Bugesera district after officially closing the training

In our operation zones community health workers have caused some achievements in mothers' enrollment into the family planning programme which has increased from 7.25% in April 2007 to 9.6% in March 2008. Further also we have noted a reduction in malaria cases from 329 cases in April 2007 to 38 cases in March 2008.

3.3.2 COPHAD project

With support from her partner Health leadership International, Health Development Initiative started a community based health development intervention in the community of pottters of Bwiza in Gasabo district.
The Community of Potters Health and Development Project (COPHAD) was designed to develop, test and refine an integrated community intervention process. Poor, isolated rural Rwandan marginalized community that will lead to improvements in self-governance, health, sanitation, water resources, education and jobs, and thus set the stage for continued community progress from poverty towards self-sufficiency.

People of Bwiza village belong to the community of potters who live outside the mainstream culture and society. They comprise the poorest communities in Rwanda. Geographic, social and economic barriers segregate them from the services and opportunities of the rest of the country. Jobs, education and healthcare are distributed away from them, and thus these individuals suffer severely from the effects of poverty, illiteracy and illness.


Pottery is the main source of income.

We are applying a people -centred development approach. The approach will encourage better use of their own resources, establish capacity and create willingness to participate among the beneficiaries.

3.3.2.1 Community involvement and participation

The village councils were elected from the village members under the facilitation of HDI. The aim of having a village council was two folds. The first one was to help on the process of mobilizing the community by empowering them and create awareness, self organization and action. The second one was to involve the communities into decision making from the beginning of the project.

The council has been empowered with knowledge from weekly trainings and encounters to enhance their fellow communities into activities leading to their development. Among these activities are sensitizing the community on health, especially on hygiene and sanitation, use of modern medicine by encouraging the community to go the health clinics whenever they fall sick, creating a sense of togetherness in the community and social cohesion for common good.
The communities and the village council members are realising the importance of having leaders among themselves so that they can have an organised way of development. The village council has

been a platform for the communities to give their ideas and suggestions on different matters which face them as a group and the following has been achieved:

→ Improving housing conditions

People of Bwiza lived in small huts which were made of small sticks with grass. These kinds of shelter were not very protective during the harsh conditions of heavy rainfall and cold during the night. The project has assisted all village members with water plastics or tarps to cover their existing structure. The tarps provided were big enough (12 feet by 15 feet) to cover their houses. The village council members have been teaching their fellow communities and they decided to rebuild their houses. The exercise was carried out under their supervision and benefited from the advisors' expertise provided by the project administration.

"There is no a single drop of water in my house when it rains, I am very happy for this. We can also sleep well in the night when it is raining. Our children will also be sleeping now instead of crying when it rains." *- Nibose Jean d'amour, Male, 32 years -*

Village members supporting each other in renovating their houses.

→ Agriculture

People of Bwiza do not have enough land for cultivation. They live by working for others, apart from the tiny gardens they can have near their houses. The village council has expressed the need to have a big piece of land where they can be able to dig and have enough food. We have provided 2.5 tonnes of manure to the village. People will apply it to their land to improve crop yields this growing season. By increasing the fields of cassava, maize and sweet potatoes, this project will reduce food insecurity in the village.

In addition we have obtained seeds for vegetable crops such as tomato, eggplant, cucumber, squash and carrots that we will introduce to the villagers.

3.2.2.2 Increasing health care accessibility through adherence to mutuelle scheme

Since 1999 the government of Rwanda introduced a community based health insurance as a way of risk pooling and to address the issue of improving financial accessibility to health care and equity in the national health system.
Today the national wide adherence to this kind of health insurance stands at 85 %. People in Bwiza did not have this kind of insurance. COPHAD paid for the health insurance of all community village members in Bwiza with the agreement that in the next year, each household will contribute 1000 Rwf (The value of one U.S. dollar fluctuates between 500 and 600 Rwf.). The process will go on until they are able to pay all of their Mutuelle costs per household.

In order to be able to pay their health inssurance; the COPHAD project encouraged the village council to find a way to excavate stones from the land in the village instead of at the existing quarry. In this way the village would be able to create their own quarry business. COPHAD contacted local authorities to survey village land and confirm that it was unsuitable for agriculture. The local authority gave permission to the villagers to start their own quarry. The village council then started their own quarry association named "Terimbere nawe mubumbyi" which means "potters rise up and help yourselves". Village household contributed money to the association to provide initial capital of 16000 Rwf. Then COPHAD introduced contractors to the quarry association. The contractors were satisfied with the stone and offered to buy two dump trucks per day, for 16000 Rwf per truck. Now the association enjoys steady income. COPHAD is helping to facilitate obtaining better quarry tools for the association.

"I was caught up with coughing. I went to the health centre and was given pills and now I do not have any problem. I only paid 200 Rwf, in contrast to what I could have paid if I did not have health card." - Mukankubana Donatira -

"I was very sick and in pains with my breast which had swollen, one of the village council members advised me to go to the health centre. I went there and got treatment."
- Uwamahoro Nyirakaranena -

Uwamahoro Nyirakaranena with a mastitis.

Uwamahoro Nyirakaranena after treatment was able to resume breastfeeding

"I went to the health centre with my two children. I went there for my prenatal services and treatment of my children. We only paid 600 Rwf. When I compare the services we were given, I assume we could have paid 7 times more than we did because we had mutuelle cards." - Uwamahoro Claudine, village council member -

3.2.2.3 Hygiene and sanitation promotion

People in Bwiza are one of the indigenous renowned ethnic groups. They live in Bwiza village in Gasabo district of Kigali town. Hygiene and sanitation systems of this society are different from the majority of Rwandan population like other components of culture. This difference is evidenced by their views, places of defecation and cleansing practises, hand washing, sources of water, means of collecting and preserving water, using of water among others.
This project has been training them on hygiene and sanitation. These trainings have made the communities to know the importance of being clean and also how best to prevent diarrheal diseases by use of latrines. The village council has been sensitizing the community to dig up their own latrines and start using them. The process is going on slowly as the soils are very hard and the tools to use in the exercise are limited. Most people are buying time waiting for the rainy season so that the soil can get a little soft to dig up. Two families have so far finished digging up their latrines and already using them. HDI has provided the basic tools for this exercise as requested by the village council; the tools will continue circulating among the communities who are ready to start digging up their latrine. On top of this HDI has managed to mobilize some clothing and shoes locally; these are being given as incentives to village members with outstanding initiatives in enhancing the exercise.



Three stages of digging and construction of a latrine in Bwiza.

→ <u>Improving access to safe water</u>
Based on preliminary findings, people in this village need to be supported such that they can collect water easily and quickly. We have conducted a preliminary study to map and survey the village. Water resources have been identified . Preliminary plans for a surface well enhancement of the village's primary water source have been completed. Plans are in place to complete this improvement by March 2010.

→ Oral health

Health Development Initiative introduced oral health in Bwiza as part of combating over 95% dental carries in this village. With help from a dental surgeon from Romania, we trained on the importance of dental hygiene and demonstrated how to use a tooth brush. All villagers received tooth brushes; the villagers were adviced to use salty water because tooth pastes are expensive.

Dr Roland Hermann teaching how to use a tootbrush.

A village council member overseeing the tooth brushing demonstration.

→ Shoes and clothing

We distributed approximately 150 pairs of plastic shoes. The villagers have used the shoes to go to the market, church and make social visits to friends outside the village. Also, because children need shoes to go to school, they are now able to attend. Some had dropped out of school because of the lack of shoes, but now they have resumed attendance because of this initiative.

The project has donated clothing from the Spokane team and other well wishers, the donation worth 1635 USD. These aids were however not enough for everyone in the village. The first time of distribution, each household received at least one item and the rest were kept and distributed as incentives to outstanding community members in promoting hygiene and sanitation.

HDI distributed shoes and uniforms to all school aged youth in the village. There are 10 pupils going to a nearby primary school. Their performance is not very good, though improvements have been measured. There is an outstanding student in the village, who consistently receives good marks and is in the top 25% of her class. The student was rewarded with pens, books, shoes and clothing as a way of encouraging others to perform better next year.

There are also young people in the village who have passed primary school age but they wish to be supported to enrol in vocational schools. We have created a partnership with " Ligue pour la promotion et intergration des poitiers de Rwanda" (LIPIPORWA) to allow students from Bwiza to enroll in their vocational training programs at a subsidised rate.

3.3.2.3 Ongoing challenges and planned response

Challenge	Response
Lack of arable land	Provided manure
Lack of seeds	Provided seeds
Quarry association is inexperienced	Support ongoing quarry association
Need for vocational training	Negotiate cooperative educational agreement with LIPIPORWA.
Inadequate water supply	Planned intervention to improve water supply in March 2009.
Lack of social cohesion	Support village council to create income generating projects that will allow people to cooperate and reconcile their differences.
Mutuelle cards needs renewal in 2009	Each family will contribute 1000 Rfr for the mutuelle card per one family member. COPHAD will subsidize payment for mutuelle cards for remaining family members.
Many people spend their income on local brew instead of saving it.	Discuss this issue with the village council to identify possible solutions.

3.4 MATERNAL AND CHILD HEALTH

3.4.1. Training of advocates of safe motherhood

These groups were formally known as Traditional Birth Attendants (TBA'S) and they were performing deliveries in the village. With the current scourge of infectious diseases like HIV/AIDS, Hepatitis (A and B) the practice of home delivery was discouraged by the Ministry of Health. Further, current World Health Organization (WHO) and the Millenium Development Goals (MDG) emphasize safe births through access to skilled birth attendants. In this wasy maternal and child mortality rates can be reduced during birth and even afterwards.

Training of advocates of safe motherhood *©Photo by Dan 2007*

Health Development Initiative started operating in the district while these people were still in existence and also working. With HDI as a stakeholder for health development, an approach was designed to train "former TBA's" as advocates of safe motherhood in the villages where they come from. Due to their understanding of the complex community psychology, culture, and other social factors, these people could be used to connect health care consumers with providers. In this regard, HDI trained them in order to ably disseminate information on antenatal care, understanding the risks of home deliveries and the importance of giving birth under a skilled health worker to all clients who could seek assistance from them.

Following this approach, deliveries under skilled health personnel increased from 37.8% to 45.9% in HDI's operational areas. These figures are still low HDI will work closely with these groups and community health workers to increase the attendances.

3.4.2 Neonatal life support and advanced life support in obstetrics

In june 2008 health centers of Nzangwa, Gihinga and Juru in Bugesera district benefited a one-day job training from the UJAMA Medical Connections from the United states of America.
The training came as part of the continual medical education which HDI has thought to be a better way of improving quality care by training staff in their facilities and working with them. We are expecting to have another team of specialists in June who will come to continue training in health centers of Bugesera district.

3.4.3 Deworming and vitamin A supplementation

The COPHAD project conducted two village wide campaigns in Bwiza village for deworming all villagers and providing them with supplemental vitamin A. The first campaign occurred in July 2008; the second, in January 2009. More than 120 persons participated in the first campaign and 80 - 100 in

the second. All children and infants participated in both. Albendazole 200 mg tablets and vitamin A 200,000 IU capsule were used in the campaign. In addition, height, weight and Mid Upper Arm Circumference (MUAC) measurements were obtained from all participants to document nutritional status and growth. To explore how to provide nutritional supplements to severely malnourished infants, we created a peanut butter and infant cereal based supplement. We are providing it to the most nutritionally deprived infants and track the clinical outcome in terms of growth parameters of height and weight.

4 ADVOCACY

Communities and political leaders at the district level, especially in HDI's catchment areas have been informed on the epidemics. They are motivated to get involved and provide leadership in prevention, care mitigation activities, initiated by Health Development Initiative, provide capacity to key actors so that they can be agents of lifestyle change. This has been facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices. Thus, community members adhere to the health mutual insurance.

5 LESSONS LEARNT

We learnt that community theater performances were very popular with community members and with the performers themselves. Testimonies gathered after the performances demonstrated that many people expressed strong feelings about the importance of the health messages presented, such as family planning. The fact that the second performance in a village attracted many more people than the first one demonstrates the widespread appeal of this activity. The ability of performers to customize their performance based on improvisation around local names and personalities seemed to heighten the audience's appreciation for the presentations.

We realized the importance of creating measurable out comes that can be tied to the intervention itself, and the difficulty in connecting specific behavior changes to an isolated intervention, such as a theater performance. Also, that behavior itself may be difficult to measure directly. We gained a greater appreciation for the value of baseline data collection, such as by surveys of knowledge, beliefs and attitudes towards specific health knowledge content areas. We came to realize that it is important to design the study carefully so that the outcomes are both defined and measurable, the intervention is practical and tested, and the evaluation is considered before the work begins.

In addition we gained a much greater understanding of the needs and shortcomings of the care delivery systems available at the health centers. Our perception is that if health centers receive an increased number of patients as a result of more people seeking health care, the health centers may have difficulty in meeting the demand for additional services. We are concerned that the health centers will need capacity enhancement, such as the provision of running water, expansion of maternity services and continuing medical training for the staff.

We learned that poverty itself is a huge barrier to the access to health care in Rwanda. Even the required 200 Rwf co-pay for services represents an unacceptable financial burden to many people. And we learned that in many areas, people have come to accept poor health as a way of life, without the realization that services to reduce suffering and prolong life are available.

6 CHALLENGES

- Some communities are living far from the health facilities.
- Poor hygiene and sanitation.
- High levels of poverty.
- Limited funding which affects the organizations capacity to fully undertake the planned activities.
- Low knowledge on health issues among the rural communities.
- Poor knowledge among health care providers especially those serving in remote areas.

7 OUR PROSPECTIVES

- Rolling out SHARE project into more schools and youth groups at risk.
- Addressing maternal and child health with special emphasis.
- Extending COPHAD interventions into other districts.
- Contributing to the fight against Gender Based Violence.
- Continuing medical and technical support to the health care system.
- Reinforcing community health education.
- Setting up a mobile clinic.
- Establishing a modal hospital.
- Building new partnerships.

8 CONCLUSION

The organization realized many activities during the period 2007 and 2008. However there is a long way to go. It is important for the organization to improve on the quantity and quality of her interventions basing on the lessons learnt. Despite the numerous challenges highlighted in this report, we look forward to a busy year 2009 and strategies have been developed to improve the interventions and visibility of the organization in the upcoming years.