HEALTH DEVELOPMENT INITIATIVE - RWANDA

NARRATIVE REPORT 2009 - 2010

January 2011

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FOREWORD

We are pleased to present to you the 2009-2010 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 2008.

We take this opportunity to thank all the partners who made this possible. These include but not limited to Ministry of Health, Ministry of local Government, UNAID, PSA, 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.

Kigali, January 2011

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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 assigned 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 continue to 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 this 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

School youth at Kagarama secondary school writing their anonymous questions

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.
- School debates to allow the students to freely express their views and sharpen their critical thinking

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. Since 2010 the anonymous questions collected from youth are presented in a Newsletter and distributed to a larger youth and parental community. This innovative strategy builds a sense of communal ownership among the youth and facilitates peer education since some of the questions are responded to by youth themselves.

Sexual health education for secondary school students.

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 one of the trainings in Bugesera

In March 2009, over 30 nurses in the health centers of Bugesera 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. Nurses from Muhima hospital in Kigali also benefited from the training.

3.2.2 Provision of basic diagnostic equipment and supplies

In 2009 HDI donated digital fetoscopes, ambu bags, Stethoscopes, Blood pressure machines and small surgical sets for around 7 health centers of Bugesera district. This was all possible by the generous support of UJAMA Medical connections and Health Leadership International

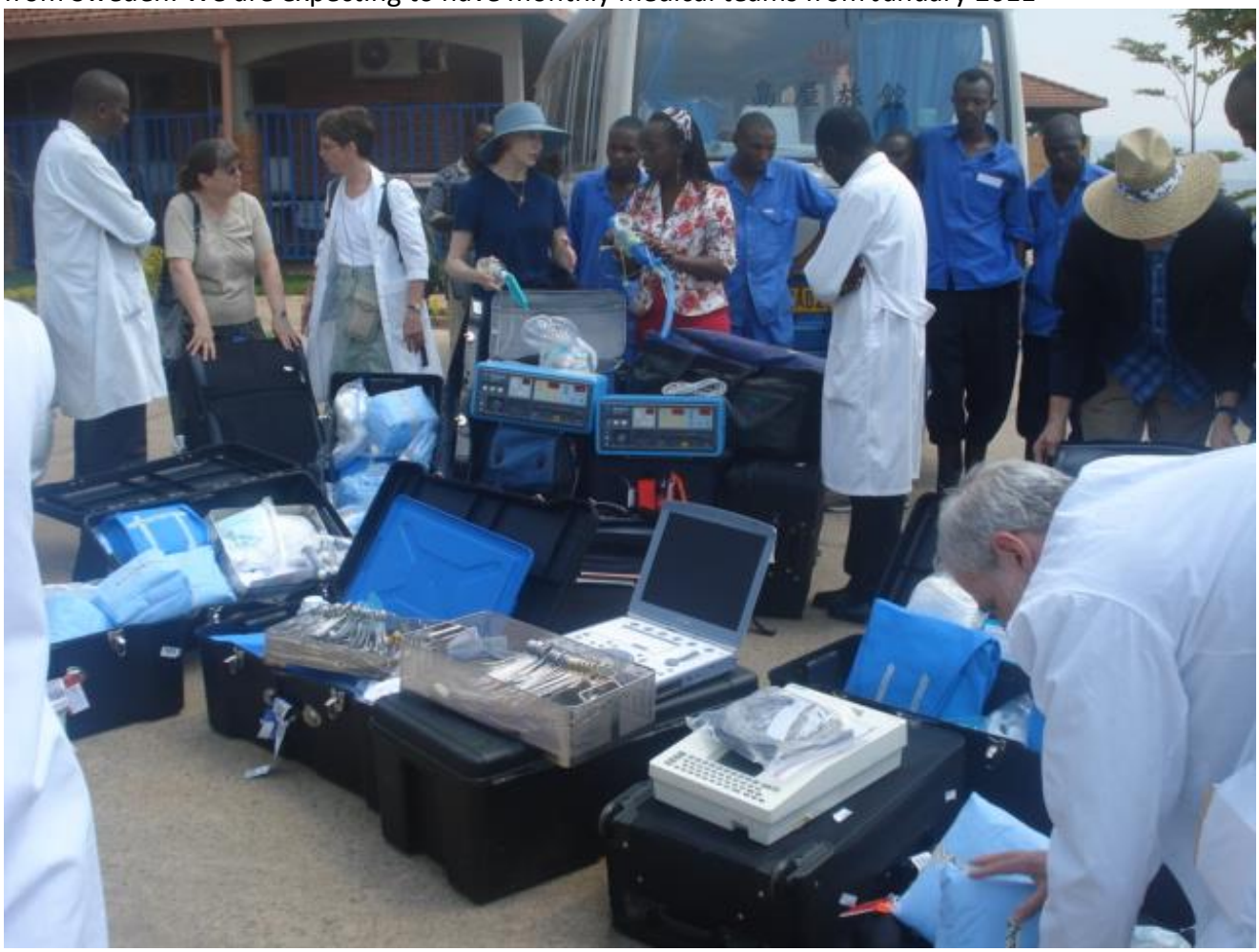
"We are very thankful for these important equipments. We can now easily examine and give good care to our patients."
Willy, head nurse, Nzangwa health center

"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."
Jeremie, Head nurse, Gihinga health center

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 several medical teams from the UJAMA Medical Connections (USA), Health Leadership International (USA), Healing hearts North West, Healing the children USA, and one team from Sweden. We are expecting to have monthly medical teams from January 2011



UJAMA Medical team at Kibagabaga Hospital, June 2008. *©Photo by Eddy 2008*

3.2.4 Neonatal life support and advanced life support in obstetrics

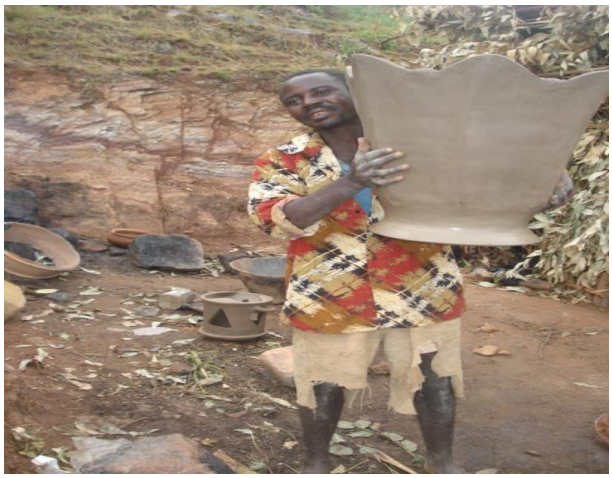
In June 2008 health centers of Nzangwa, Gihinga and Juru in Bugesera district benefited a one-day job training from the UJAMA Medical Connections from the United States of America.
The training came as part of the continual medical education which HDI has thought to be a better way of improving quality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

3.3 COMMUNITY HEALTH EDUCATION

3.3.1 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. Community involvement and participation

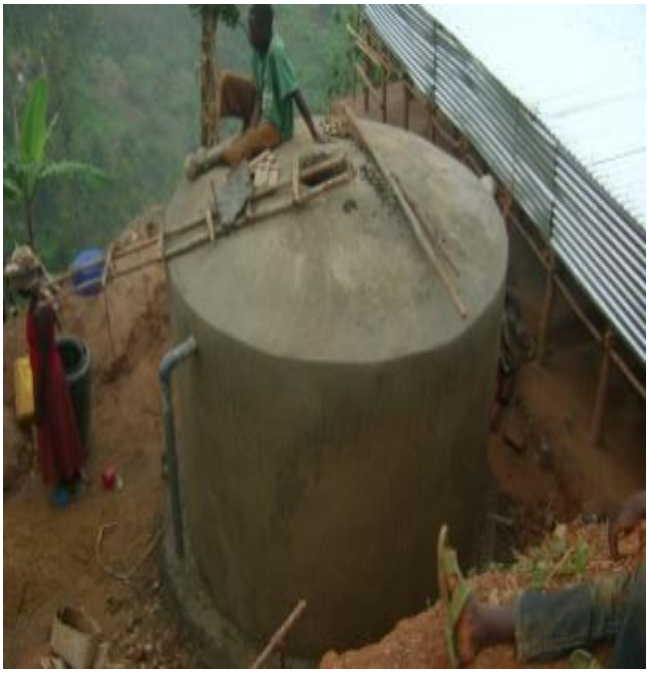
The village councils were elected from the village members under the facilitation of HDI. The aim of having a village council was two folds. The first one was to help on the process of mobilizing the community by empowering them and create awareness, self organization and action. The second one was to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

3.3.3. Improving environmental health conditions by enhancing hygiene and sanitation

The community members were sensitized to have hygiene for instance by washing their hands before and after eating, when they come back from toilets, to wash themselves and their clothes regularly. They were explained the importance of being clean and how best they can do to prevent diarrhea by drinking a clean water. They were also sensitized on how to maintain their environment free of malaria by removing bushes around their compounds. One water tank is under construction to gather water from their houses and it will help the community to fetch water at their nearest vicinity.



3.3.4 Facilitating increased accessibility to health care services

The majority of the targeted community members have been facilitated to have access health care services through health insurance. They are able to go their nearest health centre at least cost, only 21 persons are not covered by health insurance because of difference causes as they listed: There are some mothers who were pregnant in time of health insurance provision and now they have babies so their babies were not included in that provision, some village members were not there they were out for casual labor, and there are new persons who joined the village after identification of the inhabitants of the targeted village. To improve health status kids of 1year to 10 years were given vitamins and tablets to cure intestinal worms. The community health worker "NGOMIRAKIZA" was given some medicines and soaps to help enhance good health and hygiene for some particular cases.

Figure. 2: The handing over medicines to community health worker.

3.3.5. Improving nutrition in Bwiza Village

The introduction of cultivation on terraces has remarkably improved the agriculture production and productivity in general.

Sorghum displayed

Cassava displayed

This time people in BWIZA village are happier and their health looks at least improved food wise. They testified then that there is remarkable difference as they compare the previous yield and actual yield due to the use of terraces. They are aiming to double their terraces so that they would get much harvest in next seasons. They highlighted that they need a variety of seeds as well as fertilizers to sustainably improve their harvest.

We visited one of the village members who has practiced animal husbandry of Guinea pigs. We founded it to be very impressing. The action permits to get manure to serve as organic fertilizer for depleted gardens subsequently increasing productivity thereby protect kids against kwashiorkor. Karl Deringer encouraged this community by donating some cash so as to buy more Guinea pigs which will be served to 5 families.

Karl Deringer encouraging a member of the community.

The goats distributed to these vulnerable families of Bwiza village were from different environment and no sufficient information on goat adaptability had been explored, consequently they died. To address that challenge, HEIFER International particularly Dr. KAYUMBA Charles was invited to give a technical and professional advice. He recommended that to empower the village members skillfully by allowing them to visit a farm of goats in NGOMA District would be constructive.

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 Feb. 2009 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.

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 model hospital.
- Building new partnerships.

8 CONCLUSION

The organization realized many activities during the period 2009 and 2010. 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 2011 and strategies have been developed to improve the interventions and visibility of the organization in the upcoming years.

Kigali, January 2011