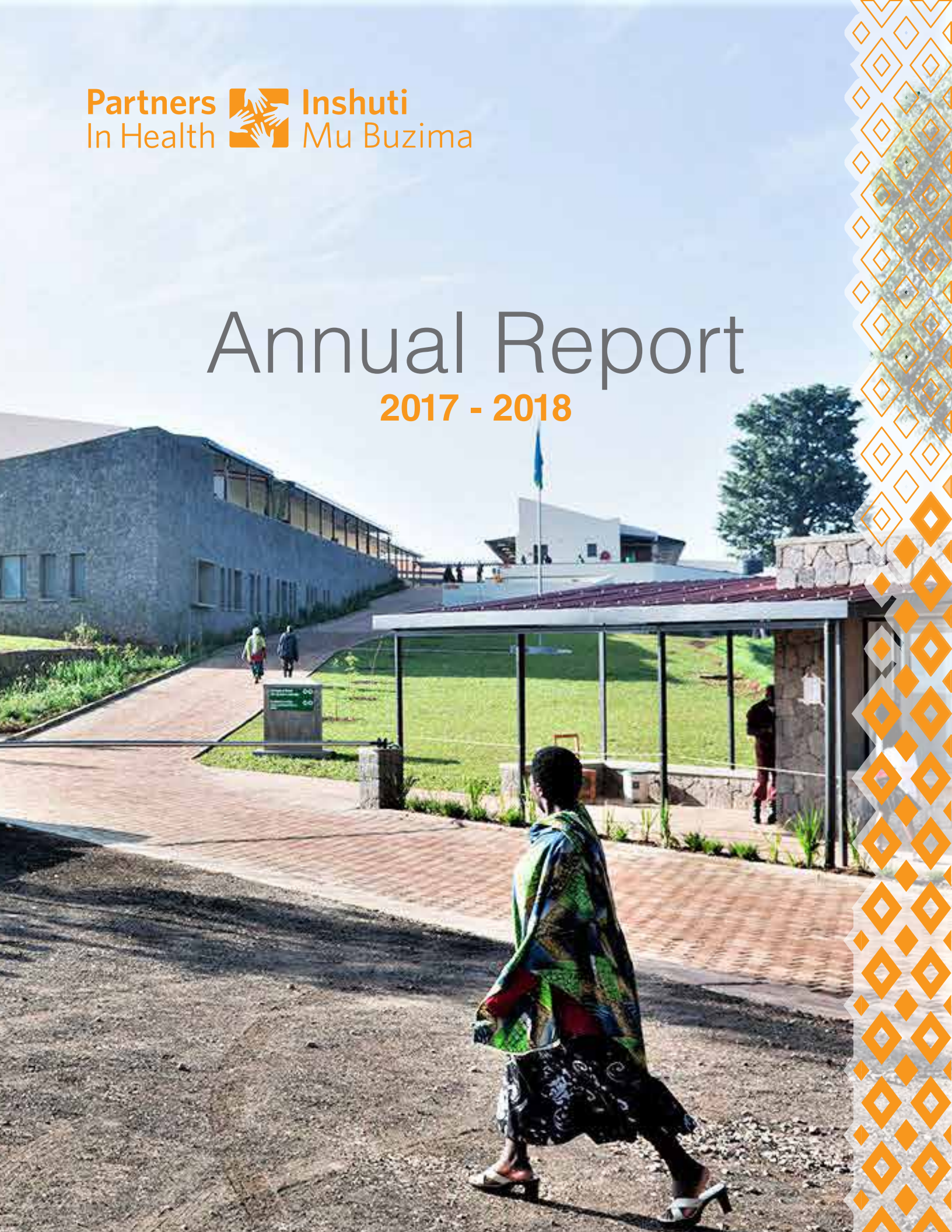
Partners In Health

Inshuti Mu Buzima

Annual Report

2017 - 2018



Partners In Health Inshuti Mu Buzima

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In the Neonatology Unit at Rwinkwavu District Hospital, Mukamana is holding her grandchild Gloria Ineza applying Kangoroo Care as shown by the Expert Mother Nadine Kamikazi (right) to her daughter Gisele Mutimucyeye (in pink).

Dear friends,

For those of us who have been in Rwanda for a long time, if not our entire life, it is easy to see the impact that the Ministry of Health has made over the past decade- improved access to health services has resulted in longer life expectancy and significantly reduced morbidity and mortality in our communities. For close to two decades, PIH partnered with the MOH in this journey insuring that every pregnant women reach a health facility so she could deliver her child alongside a skilled birth attendant, no matter her financial or social status. Today, we are dedicated to ensuring the services she receives are the best they can be- from her first antenatal visit, to the delivery of her child, to her last postnatal care visit. We want to ensure that as mother and baby enjoy a higher quality of care we continue to expand access to services- we are now ensuring that patients can receive, oncology care, mental health care and treatment for non-communicable diseases at their nearest health facility. The breadth and depth of what we are doing here in Rwanda has expanded, but our commitment to bringing the best within reach and serving the most vulnerable through holistic clinical care has remained steadfast.

When I reflect over the past two years, my heart swells with gratitude for our dedicated staff and pride in the victories we have shared with our partners at the Ministry of Health and the Government of Rwanda. In this report, we share with you how a model for saving thousands of newborn lives was expanded to eight new hospitals nationwide; how acknowledging and empowering our patients as experts has improved breastfeeding rates in our hospitals; how collaborating with partners outside of the health sector has helped us reach school-aged children sick with malaria; how a patient-centered approach is helping us reach adolescents at risk for pregnancy and STIs; how cancer is no longer a death sentence in rural Rwanda, how our most socioeconomically vulnerable patients are now providing food in their communities; how our clinical research in Hepatitis has influenced national policies regarding accessibility of treatment; and, of course, how excited we are to continue to support the Ministry of Health and Government of Rwanda towards realizing Universal Health Coverage.

From the community health worker trekking through the rain to follow up on a sick child, to the mentor patiently showing another nurse how to use a piece of medical equipment, to the obstetrician gynecologist reassuring their patient during labor- we are as dedicated as ever to ensuring every patient receives the care they deserve.

There are so many of you who have walked with us on this journey over the past two years. Your solidarity and commitment has made our work here shine as a beacon and example to the rest of the world of what we can accomplished when we, build systems, pay attention to results and hold ourselves accountable to a greater purpose. We are grateful for your continued dedication to ensuring happy, healthy and productive lives are within reach for all Rwandans.

With humility and gratitude,

Dr. Joel M. Mubiligi
Executive Director

All Babies Count

Staff, Stuff, and Data-driven Quality Improvement

From 2007 to 2010, Under-five mortality was 107/1000 in 2007 and 76/1000 in 2010 (DHS 2007 and DHS 2010). **In 2013, PIH launched All Babies Count (ABC)** model in 2 hospital catchment areas in Eastern Province. When ABC launched in 2013, neonatal mortality was at 28 deaths per 1,000 live births. In 2015, PIH concluded ABC's 18-month change acceleration process in 2 hospital catchment areas. After intervening in Eastern Province, we saw a 40% decline in neonatal mortality in 2 districts to 17 deaths per 1,000 live births. **In 2016, PIH and the MOH secured funding from Saving Lives @ Birth to transition the ABC model to scale in Rwanda.**

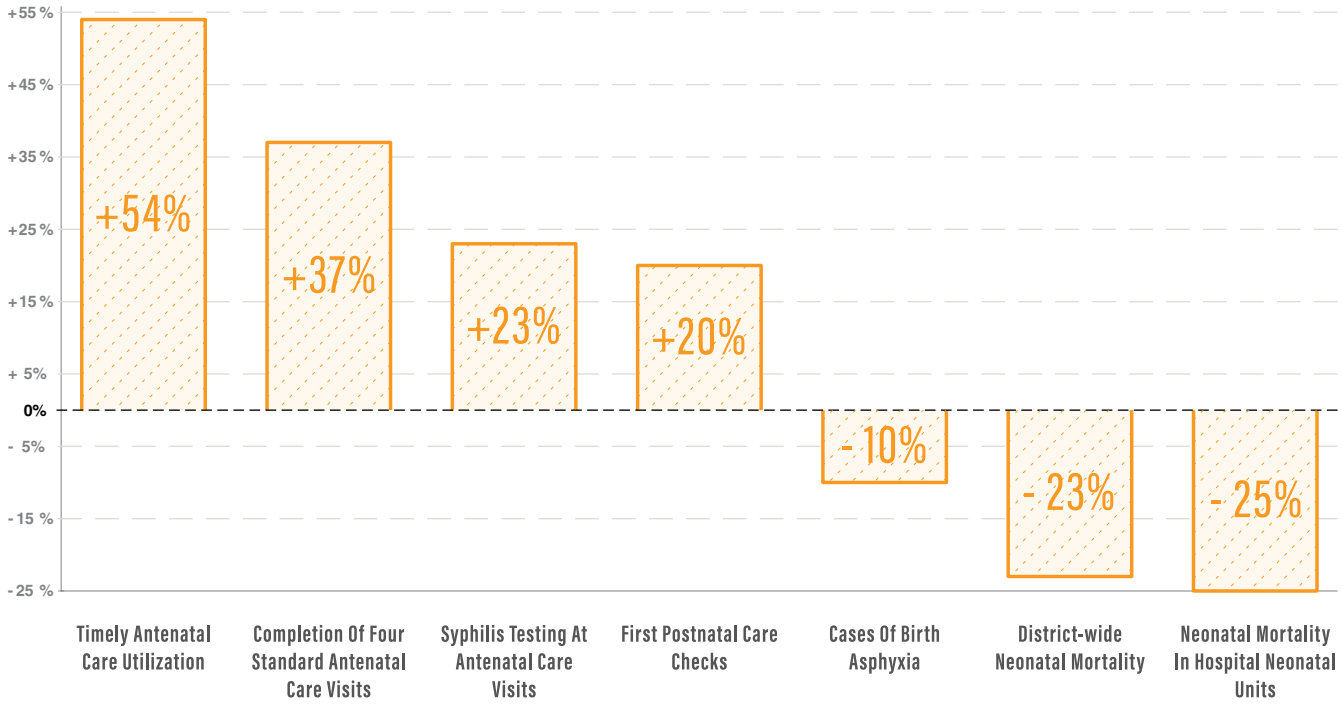
2017

PIH introduces ABC model to 7 additional hospital catchment areas around the country

Midline evaluation of ABC in 7 additional hospital catchment areas shows remarkable progress after 12 months

2018

PIH hires its first Biomedical Engineer to support equipment functionality at 3 PIH-supported districts and hospitals implementing ABC



Nurse Ndayisenga is holding Manzi from his incubator, in the PIH supported Neonatalogy unit at Kirehe Hospital.

Baby Gasaro is laying under an infant warmer, while Nurse Nyirisafari is looking for an IV line, in the PIH supported Neonatology Unit at Kirehe Hospital

Global Relevance

- The Lancet Commission on High Quality Health Systems showed that nearly two-thirds (61%) of neonatal deaths and half of maternal deaths in low and middle income are a result of poor quality of care rather than a result of lack of access to care.

- In Rwanda, the MOH has made tremendous strides on the path to universal access to health care with nearly every woman accessing antenatal care (99%) during pregnancy and near universal health facility delivery (91%) and the establishment of special newborn care units for sick and small newborns at the hospital level. Despite these investments, over half of neonatal deaths in 2018 occurred within the first 48 hours of life when these newborns are in the care of health facilities immediately after delivery and 71% of neonatal deaths are determined in facility death audits to be avoidable.

Advocacy & Policy

- ABC was co-designed by MOH and PIH with end-user input and the core components of the approach are embedded into national policies and strategies.

- To achieve the SDG of 12 neonatal deaths per 1,000 live births, Rwanda aims to cut neonatal deaths nearly in half in the next decade

What's Next

ABC will complete the final impact evaluation in 2019, after which IMB will seek opportunities to share lessons learned and recommendations on scaling this approach in other contexts.

Promoting Exclusive Breastfeeding

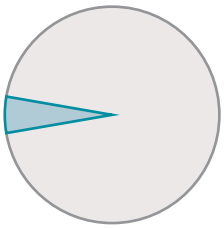
Dignifying Spaces and Leveraging Patients as Experts

In 2014, PIH started Pediatric Development Clinics, an innovative model for following up sick and small newborns from Neonatal Units through a partnership with the Ministry of Health and UNICEF. Infants from Neonatal Units are likely to have difficulties with breastfeeding due to poor muscle development. For most infants in neonatal units, clinicians initiate feeding through naso-gastric tubes then transition to cup feeding, rather than breastfeeding. Mothers continue cup feeding which is challenging to maintain when they return home. Use of infant formula in the home also carries risk when access to clean water and sustainable hygiene methods are difficult to maintain.

JANUARY 2017 PIH prioritizes promotion of early and exclusive breastfeeding especially for infants who have feeding difficulties

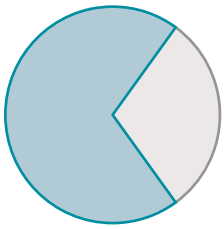
PIH conducts needs assessment and collects baseline data for operational research **OCTOBER 2017**

JANUARY 2018 PIH collaborates with hospital leaders to determine program implementation



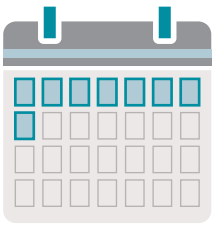
Exclusive Breastfeeding On First Day Of Life In Neonatal Unit

5.4%



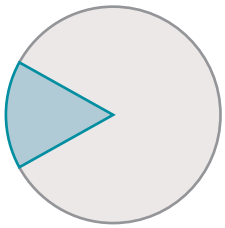
Exclusive Breastfeeding Rate At Discharge From Neonatal Unit

70%



Length Of Hospital Stay

8 day



Infant Mortality

16.1%

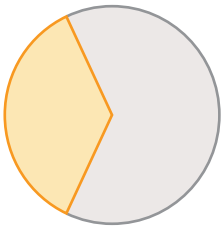
PIH conducts staff trainings and mentorship of nurses, midwives, nutritionists & social workers with expert Speech and Language Therapists. **OCTOBER 2017**

PIH procures inputs for a stress-free, baby-friendly hospital environment: Porridge, drinking water, refrigerators for storing breastmilk, and “breastfeeding corners” with chairs and privacy screens.

JANUARY 2017 PIH hires “Expert Mothers,” or breastfeeding peer counselors to provide breastfeeding counseling and support to moms in Rwinkwavu Neonatal Units

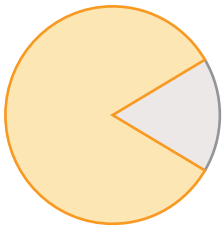
JANUARY **2017**

In Eastern Province, Expert Mothers counsel 2.5 new patients per day on average and 15 follow-up patients per day on average



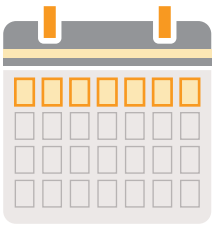
Exclusive Breastfeeding On First Day Of Life In Neonatal Unit

36%



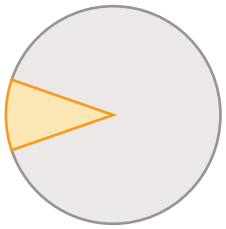
Exclusive Breastfeeding Rate At Discharge From Neonatal Unit

87%



Length Of Hospital Stay

7 Days



Infant Mortality

10.5%

Expert Mother Nadine Nirere conducting a breastfeeding workshop at Kirehe Hospital.

Global Relevance

In low-income settings, half of the babies born 2 months early die due to a lack of feasible, cost-effective care, including breastfeeding support whereas in high-income countries, most survive. Despite this inequity, the WHO guidelines lack information on specific feeding guidelines for infants in low-resource settings with feeding difficulties

**all statistics presented in infographics is from RNEC-approved research studies conducted by IMB/MOH*

School Health Program

A Multi-sectoral Approach

Rwanda has made tremendous progress to reduce malaria related mortality and morbidity. However, the burden of this infectious disease is still high particularly in Eastern and Southern parts if Rwanda. In 2010, Malaria incidence had declined from 120 cases/1000 people at risk in 2001, to less than 60 cases per/1000 people at risk in 2010 (MPR 2011). Between 2012-2017, malaria incidence increased by a factor of 7. In Kayonza it increased by a factor of 15 within the same period (HMIS).

2017

PIH creates a School Health Program to reach the group most vulnerable to the resurgence of malaria: Children 5-14 years old living in Kayonza.

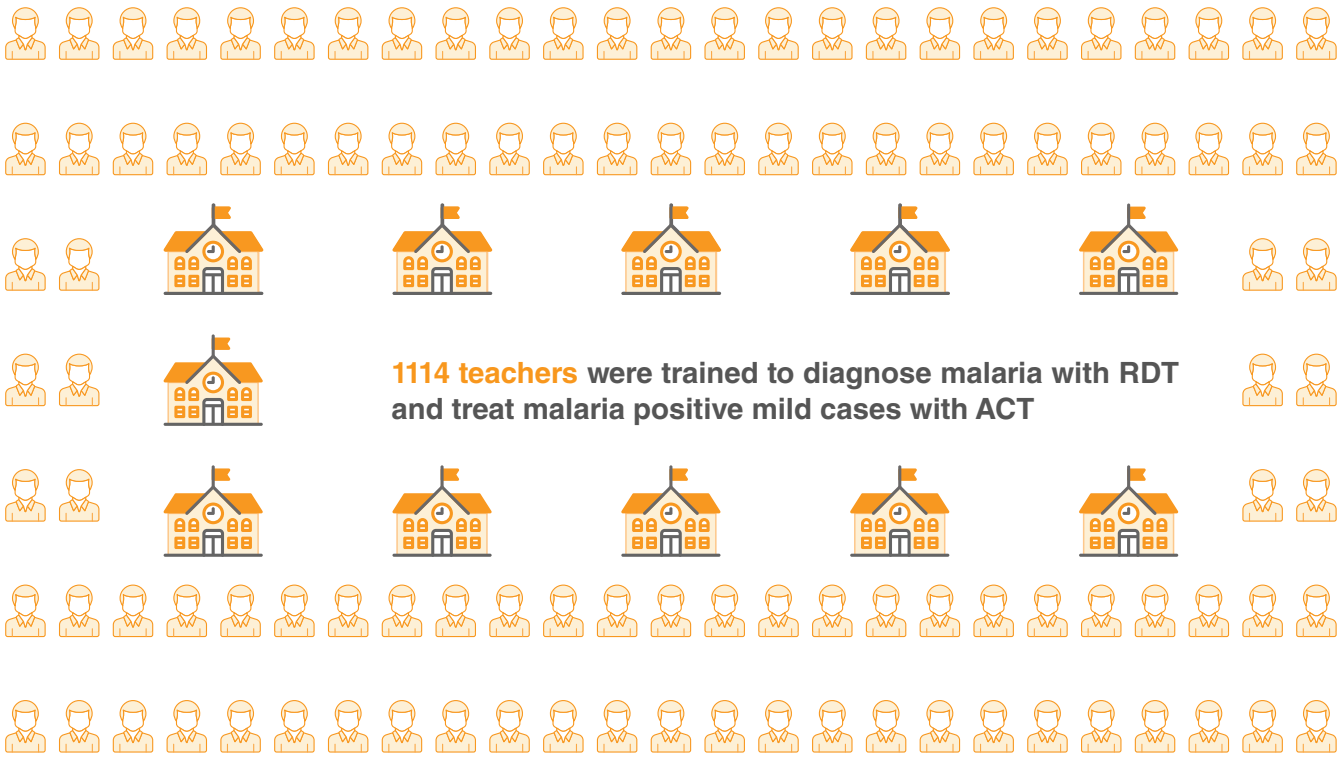
Malaria prevalence is 3 times higher in Kayonza than the rest of Rwanda, with children 5-14 most affected.

Kayonza District had malaria incidence rates approaching 1,000 cases/1,000 persons (HMIS 2018)

2018

PIH initiates School Health Program which trains teachers to diagnose malaria using Rapid Diagnostic Tests, refer severe cases and treat mild cases at 9 schools in Kayonza District

PIH forms Teachers Health Clubs to incentivize and motivate teachers to get involved in school health.



1114 teachers were trained to diagnose malaria with RDT and treat malaria positive mild cases with ACT

2017

School Health Program reaches 15 schools in Kayonza: each has a health club motivated to promote better health conditions at school including screening and treating malaria, mentorship on sexual and reproductive health and nutritional follow up to eligible students

31 624
CASES OF FEVER WERE ASSESSED AT THE 15 PILOT SCHOOLS

54%
OF FEVER CASES TESTED POSITIVE FOR **MALARIA**

99.9%
BEGAN THEIR TREATMENT AT SCHOOL AND WERE SENT HOME WITH INSTRUCTIONS FOR TREATMENT COMPLETION

26.5%
DECREASE IN PROPORTION OF KIDS WHO MISSED SCHOOL

School Health Program teenagers celebarating the end of a month-long campaign led by community health workers in Ndego Sector in Kayonza District. The theme of the campaign was to promote awareness on preventing teen pregnancy, malaria and HIV/AIDS.

Advocacy & Policy

The School Health Program was successful because PIH collaborated with both the Ministry of Health and the Ministry of Education. Through government partnership, the School Health Program was able to access both Rapid Diagnostic Tests (RDTs) for diagnosis and ACT medication for treatment at no cost. The supply chain was so strong that schools faced stock-outs of supplies less than 2% of days over the course of a year. After learning the results of this project, the Malaria Technical Working Group at Rwanda Biomedical Center has included school engagement as a part of their next strategic plan.

Peer Educators at the Youth Corner

Nothing for Us, Without Us

In 2015, 7.1% of Rwandan girls aged 15-19 had begun childbearing in rural areas and 19% of female youth had already engaged in sex by the age of 18. One third of Rwanda's population is young (aged 10-24), and 19% of young people aged 16-24 are unemployed. Early childbearing occurs more frequently among young Rwandan girls with a primary education (9%) who are poor (11%) than among Rwandan girls with a secondary education or higher (4%) who are rich (6%).

2017

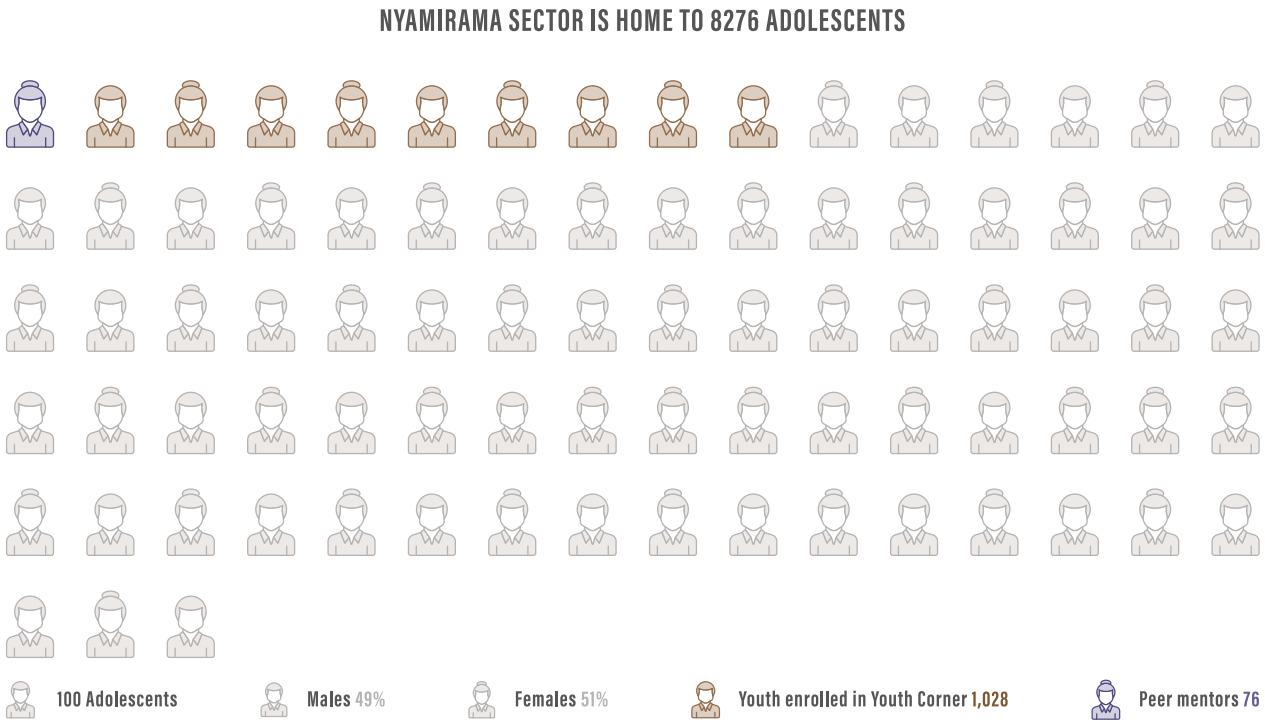
Nyamirama sector is home to **7887 adolescents**, **60% of whom are girls**.

2018

PIH, together with Kayonza District through Nyamirama Health Center, identifies pregnant teens and teen moms in the community and begins **Teen Mom Education Sessions** to support them not only in learning about reproductive health, but also in accompanying them towards economic self-reliance and in rediscovering a path to a better life through counselling...

NOVEMBER 2018

Youth Corner highlighted at the International Conference on Family Planning.



Youth Peer Educators having a training on Adolescent Sexual Reproductive Health facilitated by PIH Community Health Coordinator Elias Ngizwenayo, behind Nyamirama sector Youth Corner House in Kayonza District.

In 2019, PIH built an Information Computer Technology (ICT) lab in Kayonza to improve the computer literacy of health providers and adolescents involved in Youth Corner so 76 peer educators will be able to use online platforms to convey sexual and reproductive health information and 4,300 youth will be able to access the ICT lab and improve their computer literacy and knowledge about sexual and reproductive health.

Global Relevance

- Approximately 16 million girls aged 15 to 19 years and 2.5 million girls under 16 years give birth each year in developing regions (WHO)
- Conditions and complications related to pregnancy and motherhood have been the leading causes of deaths in women and girls aged 10-24 years globally (WHO)
- Aside from early childbearing, adolescent girls face multiple health problems including sexually transmitted infections (STIs) including HIV&AIDS, stigma related to teenage pregnancy, unsafe abortion, school dropout, drug and substance abuse. They are also vulnerable to harmful practices like early marriage and sexual violence.

Advocacy & Policy

Older men or “sugar daddies” are preying on girls and young women who are ignorant about reproductive health, illiterate and unemployed, which results in early child bearing, rejection by their family, teenage parenthood and further entrenchment in poverty. PIH-IMB is working to advocate for and support young women and adolescent girls economically and psychosocially so that they can make informed decisions about their health and bodies and secure their bright futures.

POSER

From relief to sustainable livelihoods

Between 2011-2014 PIH's Program on Social and Economic rights provided immediate relief by way of food packages, housing and covering fees for community-based health insurance. Historically, livestock has meant a secure financial future for Rwandans. With livestock, Rwandan families can access loans, but without it, poor people have nothing to offer as collateral.. In 2016, In collaboration with local leaders, social workers, and nurses across different clinical programs, PIH selected 800 vulnerable households and organized those households into self-help groups composed of 15 to 25 households.

2017

Agriculture: PIH-IMB successfully advocates to acquire cultivable land owned by the district

PIH-IMB provides agricultural trainings and inputs and beneficiaries provide labor

- PIH-IMB provides livestock to every household, mainly to avail a small quantity of fertilizer to kitchen gardens at a household level.
- Self-help groups (SHG) meet weekly and every member saves at least 100 Rwandan Francs, kept at the SHG account or given in rotation as credit with a lower interest rate to the SHG members.

2018

Self-help groups have combined their efforts and formed two legally recognized cooperatives **Imyumvire Myiza (300 members)** in Bungwe Sector and **Turwanye Inzara (500 members)** in Butaro Sector. They have easy access to psychosocial sessions and share experiences within their cooperatives.

2 cooperatives save 4,000,000 Rwf ($4,300 USD) annually through their saving scheme

2 cooperatives earn up to 3,000,000Rwf ($3,200) per agriculture season from the land provided by the Burera District

PIH-supported cooperative members grow produce about 20 minutes from the Kirehe District Hospital.

In 2019, POSER households still struggle with lifelong illnesses and disability. 23% have members with chronic diseases; 16% have members with physical disability; 14% have members with mental disabilities. However, they are in a better financial position to pay for medical expenses now. 57% of beneficiaries reported that support they received from PIH helped them to increase their household income: 12.6% of households increased income by 30%. 9.3% of households increased incomes by over 30%. While PIH used to pay for community health insurance, 90% of POSER-supported households can now pay for their health insurance themselves.

Global Relevance

The fulfillment of social and economic rights are necessary preconditions for the full realization of the right to health. Conversely, access to health care is necessary for full enjoyment of other social and economic rights. From 2016, in addition to its programs to ensure access to high quality health care for the poor, PIH-IMB decided to implement a Program on Social and Economic Rights (POSER)- the cornerstone of a broader strategy to break the cycle of poverty and poor health.

Globally, though stunting among children under five years of age has fallen from 32.6% in 2000 to 22.2% in 2017, it is still a challenge in parts of the world that struggle with food insecurity. Burera District, where the intervention took place, is among the five poorest rural districts with the highest proportion of food insecure households (30%) and highest prevalence of stunted children (40%) in all of Rwanda. (Comprehensive Food Security and Vulnerability Analysis (CFSVA):2018).

Advocacy & Policy

In 2018, 59% of our beneficiaries supported by the POSER program stored enough crops or saved enough crop-generated-income to sustain food security for at least 7 months. We will continue to advocate for holistic care and support to vulnerable patients to ensure they are able to live healthy, happy and productive lives.

Hepatitis

Evidence-based Interventions and Government Accompaniment

In 2013, the first guidelines for treating viral hepatitis were disseminated nationally. In 2015, one course of Hepatitis C treatment was unaffordable for most Rwandans. Treatment cost $780 per patient and only 253 patients received treatment nationwide.

2017

In the first large-scale prospective study of its kind, PIH conducts follow-up for 300 Hepatitis C patients who had 12 weeks of treatment at Rwanda Military Hospital

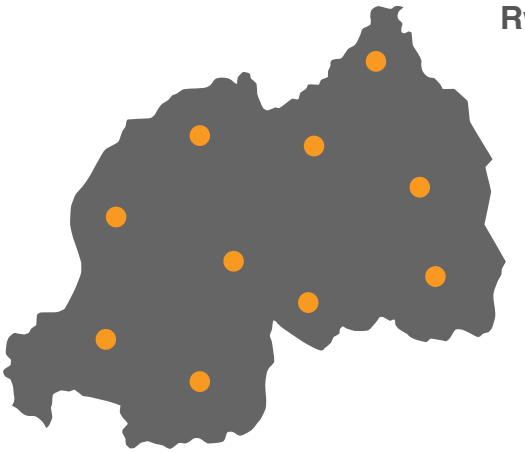
PIH treats and follows up 300 Hepatitis C patients at Rwanda Military Hospital

Each Icon represents 30 people

2018

PIH-led study published in Lancet Gastroenterology & Hepatology Journal **shows high cure rate,** except for patients with a specific genotype who do not respond to Hepatitis C treatment

87% of the 300 PIH-treated Hepatitis C patients are cured



Rwanda launches a 5-year Hepatitis C Elimination Plan

10,000 Hepatitis C patients treated nationwide

Hepatitis C treatment costs **$60 per patient**

In Mahama Refugee Camp, Lab Technician Marie Mahoro is conducting a Rapid Diagnostic Test during a PIH-supported screening campaign for Hepatitis B and C organized by the Ministry of Emergency Management. Mahama Refugee Camp, located in Eastern Province, is hosting over 60,000 Burundian refugees.

In August 2019, PIH started a Hepatitis C program to explore and research treatments across genotypes. In 2024, Rwanda aims for 112,000 Hepatitis C patients to be treated nationwide.

Global Relevance

- Globally, 71 million people live with chronic Hepatitis C, one of the world's most common infectious diseases. There are often no symptoms so patients do not seek diagnosis or treatment. The blood-borne virus commonly is transmitted through contaminated injections or transfusions. The virus currently has no effective vaccine and can cause serious scarring of the liver, known as cirrhosis, or liver cancer. There are 1.7 million new cases and 400,000 people die of Hepatitis C each year, and most of its burden falls mainly on low or middle-income countries.

- The prevalence of Hepatitis C in Rwanda is not well documented but recent campaigns showed a prevalence of 8% among people aged 15 and above, and 15% among people aged 45 and above.

Advocacy & Policy

The initial research allowed us to provide evidence that Hepatitis C treatment is effective and safe, and we can use it to cure patients in Rwanda. Following this research in December 2018, Rwanda launched its plan to eliminate Hepatitis C in the country by 2024—significantly sooner than the World Health Organization's target of 2030. However, PIH's research also showed that a small portion of Rwandans with a certain genotype are not responding to treatment as expected, which is why PIH is now doing follow-up studies to determine how we can cure ALL patients. We must find a way to treat everyone if we want to eliminate Hepatitis C nationally and worldwide.

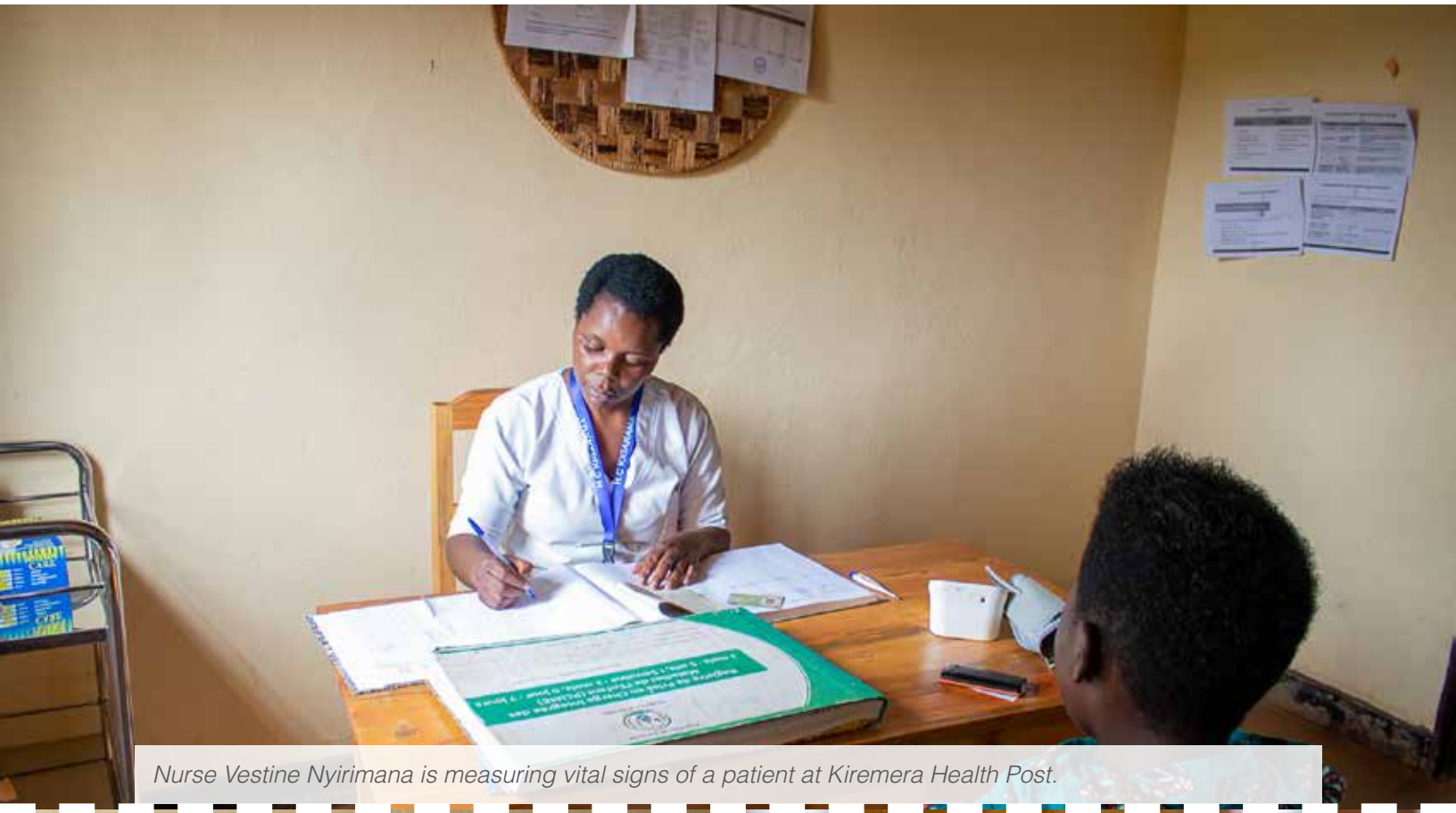
Health Posts

What are health posts?

Although much progress has been made in increasing geographic coverage of health service access for all Rwandans, some still walk up to an hour to reach a health facility. In order to further reduce the distance between patient and facility, the Ministry of Health is introducing at the cell level to bridge the accessibility gap. Health posts are managed by private nurses licensed to deliver a selection of primary health care services, dispense medications, and perform a host of laboratory services such as rapid tests for malaria, HIV, and pregnancy.
Health posts are a key part of the national strategy to achieve reduction of Maternal and Newborn Mortality and Universal Health Coverage.

Between January 2017 - December 2017, PIH built 11 health posts
Between January 2018 - December 2018, PIH built 5 health posts

Karemera Health Post built by PIH in Kirehe District



Nurse Vestine Nyirimana is measuring vital signs of a patient at Kiremera Health Post.

Lab Technician Eugenie Ingabire is conducting a blood glycemia test on Uwase, a patient from Kiremera cell.

Drug distribution room at Kiremera Healh Post.

Oncology
Whatever It Takes

The Butaro Cancer Center of Excellence provides high quality free cancer care to every Rwandan and people from neighboring countries. Before the center opened in 2012, cancer care was completely inaccessible for the vast majority of Rwandans. Only the wealthiest individuals could afford to seek treatment outside of the country. We are working to create a model of cancer care that is both effective in low-resource settings and accessible for poor and rural populations.

Pathology Lab

When the cancer center first opened, one of the challenges we faced was that there were very few pathologists in the country and the pathology labs that existed had limited capabilities. Diagnosis of cancer, and therefore effective treatment, is impossible without highly skilled pathologists and a fully stocked lab. In 2012, we physically sent every biopsy tissue to the United States for examination, which meant that patients would wait up to eight weeks to receive diagnosis. Today, due to state-of-the-art pathology lab at Butaro, the turn-around time from biopsy to results in hand is 5 days.

Pediatric Oncology Ward at Butaro District Hospital.

A Center for Oncology Training

We provide oncology education for the next generation of Rwandan health care leaders. Expert oncologists and oncology nurses from around the world regularly visit the hospital to provide clinical mentorship. As the nation's center for oncology training, physicians, residents and nurses from across Rwanda visit Butaro Hospital to gain the knowledge and experience needed to treat cancer. We offer a three-month longitudinal training program for nurses from referral hospitals in Rwanda. The program provides both lectures and practical training regarding chemotherapy mixing and administration,management of chemotherapy side effects,and palliative care skills. Nurses that complete this training are able to return to their hospitals and will function as the lead oncology nurses while passing on acquired knowledge to their colleagues. The University of Rwanda now offers a Nursing Master's Degree in Oncology which includes hands-on learning at Butaro Hospital. Additionally, internal medicine, pediatric, surgery and pathology residents from the University of Rwanda complete a rotation with the oncology department at Butaro Hospital.

Promoting Early Detection

One of the most critical determinants of a cancer patient's outcome is how early they begin treatment. Unfortunately, many patients arrive at the hospital with late stage cancers. We are working to improve awareness of cancer in Rwanda in order to detect,diagnose, and treat cancer earlier. Community health workers are being trained to recognize potential signs of breast cancer in women in their communities and connect them to their local health center.

Nurses at the health centers are trained to perform clinical breast exams and when needed refer patients to the hospital. With programs like this, we hope to catch cancer earlier and improve patient outcomes.

Front view of the yellow color coded Pedriatic Oncology Ward of Butaro Hospital.

Providing Economic and Social Support

In order to make the care affordable to our patients,most of whom are subsistence farmers from the surrounding region, we cover the full costs of chemotherapy drugs and necessary medical tests that are not covered by the patient's insurance. For vulnerable patients traveling from far away we compensate the cost of transportation. We provide financial assistance to ensure they never miss an appointment due to travel costs. Because of the long distances and difficult terrain it is unrealistic to expect patients to be able to return home on the same day they arrive for chemotherapy.

Thus, we provide dorms with meals for patients staying overnight to accommodate this need. Certain types of cancer such as cervical cancer require radiotherapy, however there are no radiotherapy machines in Rwanda. We accompany over 100 patients every year to Nairobi, Kenya to receive the treatment they need. Cancer patients are particularly susceptible to become underweight or malnourished so we provide food for vulnerable patients both while they are in the hospital wards and when they are back home, which is why we provide food packages to these patients. We believe in doing whatever it takes to help a patient become healthy.

Battling cancer can take a toll not only on physical health, but on mental health as well. Patients with cancer experience higher rates of depression and anxiety. To improve the quality of life of our patients we have formed support groups for women with breast cancer. The support group, which meets every other week, provides an opportunity for these women to share their experiences, provide peer support surrounding economic and psycho-social challenges, and receive guidance on health system navigation.

Scaling-Up Cancer Care

The Butaro Cancer Center of Excellence is just the beginning. We are supporting the Ministry of Health to develop cancer centers in other referral hospitals. We have partnered to develop clinical protocols and standard operating procedures for cancer care that are applicable to the low-income setting in Rwanda. We have designed a digital platform to record oncology data in the electronic medical record system- OpenMRS. This system improves clinical workflow, quality of care, and our ability to conduct research. Additionally, this system allows us to support the development of a national cancer registry which will provide critical information for national monitoring and evaluation, research, and health system strengthening. Through our strong partnership with the Government of Rwanda, the lessons learned from the Butaro Cancer Center of Excellence will be applied nationally to serve thousands more battling cancer.

Cancer Patient Story

Left to Die, Chosen to Live, Elisa's Legacy

Cancer survivor Elisa Niyoniringiye and his father Valens.

Elisa Niyoniringiye, 15, loves to play football. He loves it when the ball flies high, and he has to leap forward into the air to catch it, kicking it and gathering up a storm of dust. One fateful day in June 2016, Elisa did not notice that his friend had leapt with him, and as he bounced the ball on his head then his stomach, that his friend tried to kick the ball. In the throes of soccer induced excitement, Elisa was kicked quite hard in the stomach. He felt a dull pain, but shrugged it off and continued to play.

The next morning, as Elisa tried to get up to go to school, he felt a sharp piercing pain in his abdomen. It came and went quickly and he paid no mind. But this was the beginning of his illness. Within two weeks, the pain in his stomach spread and grew and he suddenly began to urinate and pass bloody stool.

"He told me that his stomach hurt and I scolded him, thinking he had played too hard or eaten something unsanitary. But when we saw that his urine and his stool was bloody, we became alarmed. I am ashamed to admit that I didn't even have the Community Health Insurance (Mutuelle de Sante) and so I could not take him to the health center. I resolved to go to a pharmacy and get antibiotics and painkillers and then hope for the best." Valens, Elisa's dad, says.

After getting the medicine, things seemed to cool down for Elisa. The family who lives in Batera village, Gihundwe Cell, in Kamembe sector of Rusizi district was relieved because Valens could not afford to pay for the Community Health Insurance (Mutuelle de Sante). “I am unemployed. My wife is a is a street hawker. We are in category 1 of Ubudehe. We can barely afford to get a daily meal for our eight children so I was pleased when I didn’t have to take Elisa to the Health Center.” Valens says.

However, Valens suspects that the over-the-counter medicine that he got for Elisa quickly exacerbated the problem. Two months in, Elisa started vomiting blood, he had rectal bleeding, and his stomach had swollen painfully. Valens recalls Elisa being unable to stand up straight and crawling everywhere because he was in so much pain.

Valens’ family and friends congregated, and they asked him to let his son die, since it was clear that he had been bewitched and they could not afford to even pay mutuelle, let alone whatever was ailing Elisa.

“They told me that I had 7 other children to take care of. They asked me not to do anything and let the illness take its course.” Valens recounts, distraught at the memory.

Valens refused this course of action, and decided to take his son to the hospital in Rusizi. And so began a long journey of referrals and transfers that saw Valens take Elisa to 8 hospitals in three districts for almost all of 2017, before getting to CHUK, a Kigali teaching hospital, where Oncology experts connected them to Butaro Hospital.

“I regret that I did not immediately take Elisa to the hospital when he had first exhibited signs of sickness.” Valens laments.

Once at Butaro Hospital, Inshuti Mu Buzima (Partners In Health) agreed to pay Elisa’s medical costs, and several tests were conducted which included among others a colonoscopy, stool tests, an MRI, and a CT scan. It was concluded that Elisa had Nephroblastoma.

With PIH support, Elisa underwent a nephrectomy surgery and spent three months recuperating at Butaro Hospital before he was selected to go to Kenya for radiation treatment in August 2017.

A year later, Valens watches as his healed son leaps into the air to receive a wide shot from his best friend Dieudonne. He is animatedly shouting to his friend, and running energetically as he is thoroughly engrossed in the game.

You can see the worry competing with happiness on his father’s face, but he is grateful.

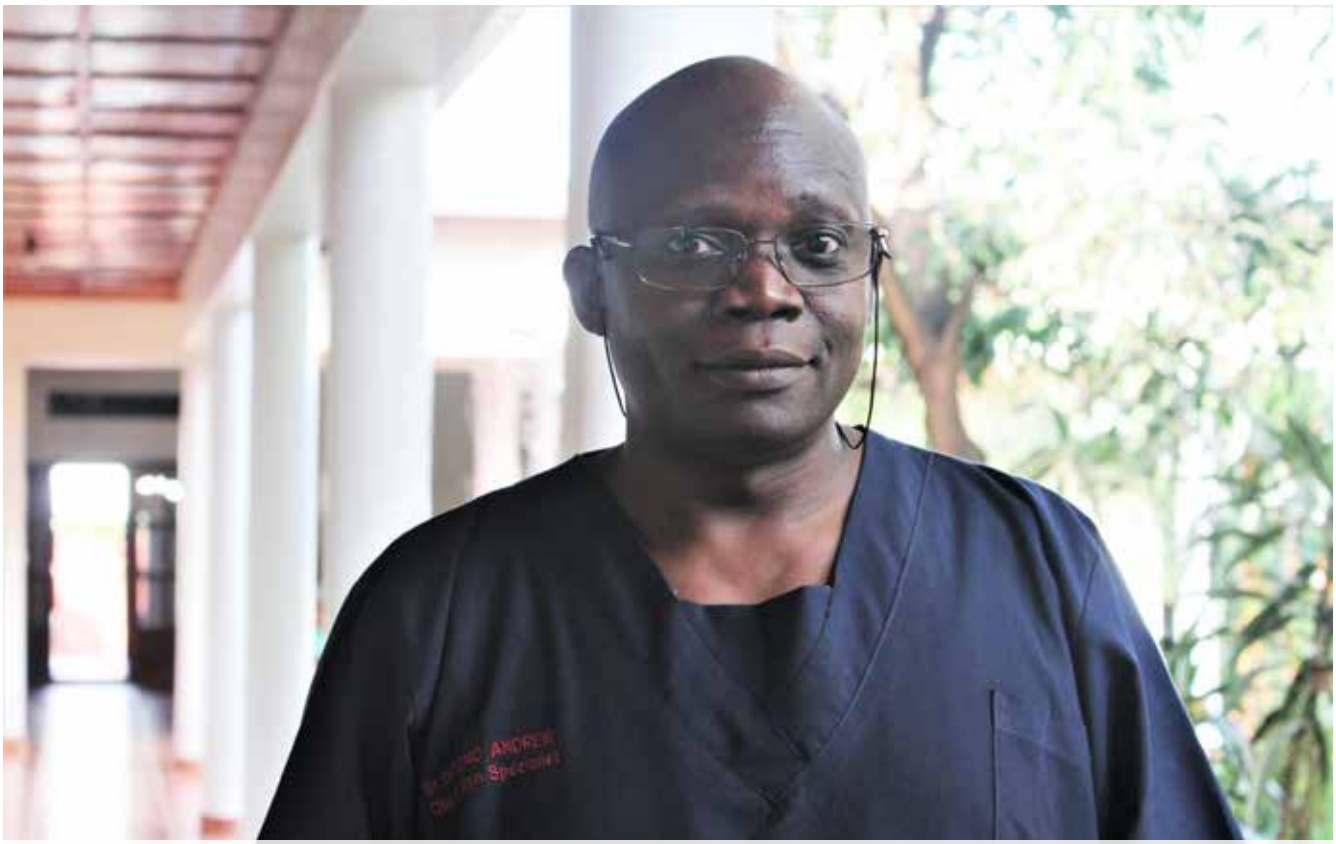
> ***“It is still hard to admit that he is well, and his cancer is totally healed. I will forever be grateful to Inshuti Mu Buzima for supporting us and giving us world-class care. When we were in Kenya, we had a PIH staff member with us, they guided us and demystified the entire process for us.”***

Elisa was given good food, and he had space to play, and even when we came back, Butaro Hospital doctors kept calling and checking on us to find out how Elisa was doing. This has been a harrowing past few years for the family, but also amazing because we acquired a new family. Inshuti Mu Buzima,” Valens asserts.

Elisa has resumed school and hopes to become a famous footballer when he grows up.

Accountability & Attention to Results

Dr. Andrew Oryono, Obstetrician Gynecologist at Rwinkwavu District Hospital



Dr. Andrew Oryono is the Rwinkwavu Hospital's Obstetrician Gynecologist specialist.

He will tell you himself, music is a part of his heritage. Born to two teachers from Abim district in Northern Uganda, Dr. Andrew Oryono and his 6 siblings had a very happy and musical childhood, and can recall frequent instances when he used to sing, dance and play instruments with his family. Even though his father was a teacher, Andrew recalls him most fondly as the man who was always bent over, gently dressing the wounds of patients at no cost, with his copy of "The Home Doctor" to which he always referred. Andrew's father never asked for money for the care he provided, accommodated those who came long distances, and fed them when they were hungry.

During his formative years, Andrew was convinced he wanted to be a priest. In fact, he joined a seminary with the sole purpose of becoming a priest. All that came to change when his mother who was pregnant with her 7th child, who had attended five antenatal care visits lost her life during childbirth in Abim Hospital due to neglect by the midwife in attendance. Andrew's mother had called for the midwife multiple times, but her three calls for help had been dismissed. Soon she grew weak and passed away. Andrew was distraught and had a hard time reconciling the Bible's teachings with his reality at the time. He was convinced that his mother's death had been completely preventable.

That is when he made the decision to pursue medicine because what had happened to his mother could not happen again to anyone else. Despite his father's wishes for Andrew to follow in his footsteps and become a teacher because of his mother's death, Andrew left the seminary and pursued a medical program at Gulu University as part of its first cohort of medical students.
In Uganda, each summer medical students would go to their home districts and practice. In Abim Hospital, where his mother had died, the head of the hospital was also the sole doctor. So in 2009, as Andrew waited for his internship placement, he practiced medicine at Abim Hospital, where he had more medical training than any of the full-time staff, aside from the Director. To say that Abim Hospital was ill equipped for care is an understatement, in fact, Andrew recalls when he got involved in a road traffic accident and dislocated his right ankle joint and sustained a fracture before the start of his internship, he was the only doctor since their Director had travelled. He recalls being put in a cast that was set incorrectly. Once he awakened from the anesthesia, he instructed the team on how to cast him correctly. Without an orthopedic officer in the hospital, Andrew had to train them on-the-job, using his own injury.

After graduating, Andrew worked in different places before coming to Rwanda to support Kacyiru Police and Muhima hospitals as an Obstetrician Gynecologist (OBGYN) specialist. While at Muhima hospital, he received the Employee of the Year award for the reduction in maternal mortality and birth asphyxia. However, Andrew knew that he needed a change and luckily, he saw a job posting for an OBGYN in Rwinkwavu. He told his Director he was going to apply.

Despite Dr. Joel Mubiligi's worries that he may not acclimate to working in a rural area, Andrew knew when he arrived in Rwinkwavu that he had found the right place. He said that practicing medicine in a rural hospital is his calling.

"Being pregnant is not an illness,' he says, "So when a pregnant woman comes to a hospital alive, she should leave the hospital alive, with her baby."

In Uganda, the "blanket sign" is an unofficial term clinician's use that demonstrates the status of a mother in labor. If a mother has a clean, expensive looking blanket, she will often receive better treatment because doctors think that this person has money or could be the mother or sister or wife of someone important. Andrew explains that this idea is pervasive, even in Rwanda, and more should be done to improve the quality of care for mothers regardless of their socio-economic status, because each and every mother is important and deserves a safe delivery.
Andrew visits Rwinkwavu hospital twice daily, whether he is on call or not. His round starts from neonatology; after which he checks in on the mothers who've had C-sections to see if there are any infants or mothers needing assistance. Then he goes to the operating theatre to check and see if he can help with anything. Very few doctors go to the labor wards to check on mothers, as they feel it is the domain of the nurses. To this, Dr. Andrew says:

"Pride is what kills most people. If God has given you the gift of saving lives, there is no job that is too small or too unimportant for you. Not when God is your supervisor."

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Thank you for your continued, faithful support of our work.

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