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INKUNGA Y'ABANYAMERIKA

RWANDA FAMILY HEALTH PROJECT

ANNUAL REPORT

SEPTEMBER 1, 2012– SEPTEMBER 30, 2013

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ACRONYMS

ARV	Antiretroviral
CBEHPP	Community-Based Environmental Health and Promotion Program
CBP	Community-Based planning
CHW	Community Health Worker
DHMT	District Health Management Team
EMTCT	Elimination of mother to child transmission
ETAT	Emergency triage assessment and treatment
FCA	Facility Capacity Assessment
FH	Family Health
FHP	Family Health Project
FP	Family Planning
FP/RH	Family planning and reproductive health
GBV	Gender based violence
HMIS	Health management information system
IMCI	Integrated Management of Childhood Illness
IR	Intermediate result
LAPM	Long acting and permanent methods
MCH	Maternal and child health
MEMS	Monitoring and Evaluation Management Services
MNCH	Maternal, neonatal and child health
MoH	Ministry of Health
MTCT	Mother to child transmission
OpenMRS	Open medical records system
OSC	One stop centers
PAC	Post Abortion Care
PDSA	Plan-Do-Study-Act
PMP	Performance management plan
PMTCT	Prevention of mother to child transmission
RBC	Rwanda Biomedical Center
SDPs	Service Delivery Points
TOT	Training of trainers
TWGs	Technical working groups
USAID	United States Agency for International Development

I. Background and Overview of Report

Project Background. The objective of the Rwanda Family Health Project (FHP) is to increase the use of district-level facility and community-based family health (FH) services. For the purpose of this activity, “family health” includes an integrated package of services related to family planning and reproductive health (FP/RH), HIV/AIDS, maternal, neonatal, and child health (MNCH), malaria prevention and treatment, nutrition, and safe water and hygiene. “Integration” means the organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to costs, outputs, impacts and use.

The Family Health Project works at district-level with facilities and communities to achieve the following four intermediate results (IRs):

- Project Intermediate Result One - Improve the quality of facility and community-based family health services
- Project Intermediate Result Two - Expand access to FH services, primarily by increasing the number of skilled health care providers
- Project Intermediate Result Three - Increase demand for facility and community-based FH services
- Project Intermediate Result Four - Strengthen management of facility and community-based FH services

Overview of Annual Report Purpose and Format. This annual report provides a high level retrospective of FHP’s first year with a focus on reporting against the approved performance management plan (PMP) and analysis of outcomes and outputs. For a description of project activities, please refer to previous quarterly reports as well as to the annexes of this report, which provide detailed updates against every activity included in the year one work plan, as reported to the Ministry of Health.

This report is organized according to the project’s four intermediate results, described above. The first section of this report details the cross-cutting and high level outputs, outcomes and impacts achieved during project year one. The second, third, fourth and fifth sections are reports against the project's four IRs. Each of these five sections include tables that show the project’s performance against the indicators and year one targets included in the project’s PMP as well as provide some analysis and explanation of FHP performance against indicators. At the end of each of these sections we have highlighted, through a success story in the USAID-approved format, one or a few particular activities (per IR) that were successful and contributed to the project’s overall impact. The final section of the report discusses lessons learned by the project during its first year of implementation. As mentioned above, the annexes of the report and previous quarterly reports provide a detailed account of project activities, organized by IR.

Additionally, and as instructed in the project contract, we have reported into USAID's Monitoring and Evaluation Management Services (MEMS) system according to the requirements of that system. This report should be considered supplemental to the MEMS reports and every effort has been made not to duplicate information between the two reports. As mentioned above, this report focuses on reporting against the PMP while the MEMS reports report against supplemental indicators agreed upon with USAID after contract award.

II. Report on FHP Project Objective – Increase the use of district-level facility and community-based family health services

Discussion of FHP's grants program. As mentioned above, FHP is organized by result areas which have been developed to support the overall project objective of increasing the use of facility and community based family health services. In addition to the activities planned under those result areas (which are described in subsequent sections and the annexes of this report), the project has one major cross-cutting activity that will support achievement of the four project intermediate results as well as the overall project objective; the issuing and oversight of grants to all supported health facilities and district level administrative structures. FHP has a large grants program with 177 active grants during the first year of implementation. FHP uses grants to provide financial, operational and clinical support to health entities. Financially, the project supports costs critical to high quality service provision, such as salaries of physicians, nurses, and laboratory technicians and meetings and travel expenses for these staff. The provision of financial support creates opportunities for the project to provide technical assistance, both in management and operational systems as well as in clinical service delivery. On the operational and management side, the project's grants team works to build capacity in critical areas such as accounting, reporting and resource management. And on the clinical side, grantees are supported through site visits and targeted technical assistance from project staff that supplements the training and capacity building offered under IR 2. An understanding of the project's grants program is essential when reviewing the project's progress against PMP indicators, as grants have contributed significantly to the project's ability to achieve its year one targets.

Indicator Table. In the table below we present our progress against PMP indicators that measure the project's success in achieving the overall project objective, which is to increase the use of district level facility and community based family health services. The first four columns of the table (indicator number, indicator, rationale and targets) have been taken verbatim from the project's approved PMP. The final two columns have been added to show the project's achievements against the targets set at the beginning of the year and to provide some analysis and explanation – either of how we achieved or exceeded our targets or of why we were not able to meet them. Refer to the actual PMP for information on how and why targets were calculated.

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
Project Objective: Increase the use of district-level facility- and community-based family health services.					
1	<p>Number of new family planning users (in target districts).</p> <p><i>Definition:</i> Number of new users of modern family planning methods.</p> <p><i>Disaggregation:</i> None</p>	Measures use, encompassing contributions of quality, demand, access, and management.	NA	149,886	In line with discussions with USAID the project did not set a target for this indicator for the last year. However, the project tracked the number of new family planning users in supported districts. FHP implemented three activities which contributed to the addition of new users. The project trained community health workers in Rwamagana and Ngoma Districts in community-based family planning (activities 47& 48 in Annex II), which includes counseling (for community members on the impact of population growth) and referral to health centers. In addition, as part of the package of support for long acting and permanent methods (LAPM), the project conducted outreach and sensitization activities to inform local leaders and about LAPM benefits and options (activities 13 to 19 in Annex II). And finally, through the grants program, the project supported counseling and referral in family planning for HIV positive patients.
2	<p>Number of additional USG-assisted CHWs providing FP information and/or services during the year</p> <p><i>Definition:</i> USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance.</p> <p>Community Health Workers (CHW): Any type of CHW as defined by country programs.</p> <p>FP Information: FP information and/or FP counseling provided by a CHW</p> <p>FP Services: FP referrals and/or methods provided by a CHW.</p> <p>Disaggregation: None</p>	Increased FP use is related to its physical availability through numerous sites, including door-to-door offering of FP information and/or services, especially if the information and/or services are offered in a quality, client-friendly, convenient and affordable manner. Increased family planning use reduces the unmet need for FP, number of unintended pregnancies, number of abortions, and neonatal, infant, child and maternal mortality and morbidity.	948	1,886	<p>FHP's achievement against this indicator is double its target because the project planned to support the community based family planning program (CBP) in one district (Rwamagana) (activities 47 and 48 in Annex II). However, during implementation, the MoH submitted a request for the project to support CBP in Ngoma district as well. After analyzing the project budget and discussing with USAID, the project agreed to take on the additional district.</p> <p>In addition to supporting training of community health workers in the CBP package (which includes counseling, administration of condoms, oral contraceptives, injectables and the standard day method, and referrals) the project also supported validation of CHWs trained in CBP. Validation is the process through which CHWs skills are tested and verified and CHWs are not authorized to independently provide a service until they have been validated in that service. FHP not only supported validation in Rwamagana and Ngoma but also supported validation of CHWs in Nyagatare and Gasabo.</p>

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
3	<p>Number of service delivery points (SDPs) providing FP counseling or service</p> <p>Definition: Number of USG-assisted service delivery sites providing FP information and/or services.</p> <p>Service Delivery Points: Clinics, hospitals, facilities (government, private or NGO/FBO) pharmacies, and/or social marketing sales points. Does not include community health workers (CHWs).</p> <p>FP Services: Provision of FP methods and or FP referrals.</p> <p>USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance.</p> <p>Disaggregation: By methods (pills, injectables, IUD, condoms, standard days, TL, VAS, implant)</p>	<p>Increased FP use is related to its physical availability through numerous sites offering FP counseling and/or services, especially if the counseling and/or services are offered in a quality, client-friendly, convenient and affordable manner. An increased contraceptive prevalence rate (CPR) will reduce the unmet need for FP, number of unintended pregnancies, number of abortions, and neonatal, infant, child and maternal mortality and morbidity. Initially, the percent of USG-assisted FP SDPs should approach and reach 100%.</p>	180	239	<p>All FHP-supported sites provide counseling in family planning and non-faith based sites also provide patients with family planning methods. While faith-based sites do not provide methods, they do refer patients to "secondary posts" where they are able to receive methods. FHP supports service delivery points in the provision of family planning counseling and services through training and validation of service providers, provision of equipment (activities 13 to 19, Annex II), provision of salaries through grants and quality improvement – analysis of indicators and implementation of methods for improving performance against them (activities 28 & 29, Annex I).</p> <p>It should be noted that the project achievements against this indicator exceed that targets because the number of districts to be supported by the project increased after targets were set and the PMP was finalized.</p>
4	<p>Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission</p> <p>Definition: Number of women who received PMTCT ARV to prevent MTCT at PMTCT service outlets. This counts all types of regimen options in the total number of women who receive any PMTCT ARV.</p> <p>Disaggregation: Age, sex, location.</p>	<p>Measures contributions across four IRs, with the aim of increasing use at the facility level. Measures delivery and uptake of ARV prophylaxis for PMTCT.</p>	2,734	2,737	<p>The project met this target through implementation of three major activities. First, the project supported five districts in the development of Strategic Plans to eliminate mother to child transmission of HIV (EMTCT) (activity 25, Annex II). During the development of these plans, officials reviewed PMTCT data specific to their districts and set targets and timelines for elimination. In addition, and linked to the first activity, the project supported PMTCT implementation through its quality improvement initiatives. Districts and facilities implementing the PDSA approach (activities 28 & 29, Annex I) used the EMTCT plans to identify areas of focus and indicators for quality improvement and are currently implementing approaches to improve against those indicators. And finally, through its grants program, the project provides salaries to the nurses and doctors to provide PMTCT services including counselling and testing of ARVs. In addition, at some facilities the project is supporting (through grants) psychosocial counseling for women in PMTCT.</p>

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
5	<p>Number of HIV-positive adults and children receiving a minimum of one clinical service.</p> <p><i>Definition:</i> Measures how many HIV-positive individuals received care and support services, defined by receipt of at least one clinical service.</p> <p><i>Disaggregation:</i> Standard PEPFAR disaggregation, sex, age, location, facility type.</p>	<p>Measures contributions across four IRs, with the aim of increasing use at the PO level. Informs country programs and PEPFAR about scale-up of clinical services for HIV-positive individuals. PLWHA should receive a comprehensive package of services to improve quality of life, extend life, and delay the need for antiretroviral therapy (ART).</p>	52,880	51,416	<p>At the end of year one the project had achieved 97% of this target, due both to the support provided through grants as well as the technical assistance provided by project staff. The grants program supports implementation of the following HIV clinical services by paying salaries of providers and providing operational funding for expenses such as meetings and transportation: voluntary counseling and testing (VCT), provider initiated testing (PIT), PMTCT, Antiretroviral Therapy (ART), clinical care, post exposure prophylaxis (PEP), prevention with positives (PWP), and community outreach. In terms of technical assistance, the project supported quality improvement of HIV services (activities 21 to 23, Annex I), provided training in HIV service delivery (activities 25 to 29, Annex II) and worked through DHMTs to improve the management of HIV services (activities 15 & 16, Annex IV).</p>
6	<p>Number of adults and children with advanced HIV infection receiving ART.</p> <p><i>Definition:</i> Data for this indicator can be generated by counting the number of adults and children currently receiving ART in accordance with the nationally approved treatment protocol, or World Health Organization (WHO)/Joint United Nations Program on HIV/AIDS-(UNAIDS) standards at the end of the reporting period.</p> <p><i>Disaggregation:</i> Standard PEPFAR disaggregation, sex, age, location, facility type.</p>	<p>Measures contributions across four IRs, with the aim of increasing use at the PO level. Permits monitoring of trends in ART coverage and use.</p>	38,246	38,692	<p>FHP supports the provision of ART through its grants program and was able to achieve 100.4% of this indicator target because of the financial support the project provided to health facilities for salaries (of doctors and nurses prescribing and administering ART) and transportation costs for drug requisitions. In addition, through supervision visits, data quality audits and grantee reporting, the project was able to monitor progress against this indicator and provide targeted technical assistance/capacity building to facilities as needed to meet it.</p>

Highlighted cross-cutting success. As mentioned above, the project has an extremely large grants program that contributes to the technical success of project activities. Through grants the project is able to support operations at supported facilities and also to provide assistance and support in management and operations as well as in service provision. The success story on the follow page highlights FHP’s responsiveness when the need for the project’s grants program was identified by USAID. As illustrated in the story, the project was able to issue 178 grants agreements in five weeks – quite a feat! It should be noted that this success story was not put into a standard format because it was intended for an internal audience of USAID staff and contains more information than the standard format allows.

The Beginning of a Beautiful Relationship



FHP Chief of Party Doris Youngs signs a grant agreement with the Nyagatare District Hospital on behalf of the American people.

The Rwanda Family Health Project (FHP), a five-year, USAID health program, has issued 178 grants to support the provision of health services in Rwanda. The grants — which were issued to administrative districts, hospitals and health centers during five full-day workshops — will be used to fund salaries and operational activities such as supervision visits. The decision by USAID to continue grants support to 18 districts came as a relief to many of the grantees, who were not clear when future financing would materialize since the projects currently providing funding are ending. “Over the last couple weeks and days, our District Health Management Team has been pondering our future and feeling stuck. With this support we can revitalize our work,” said the district health director of Nyagatare, at FHP’s Nyagatare-based grantee orientation workshop. This proclamation was received with enthusiastic nods of agreement from other grantees in the room. FHP staff also heard similar expressions of gratitude towards USAID and the American people from workshop attendees in other districts (see box above).

In addition to the expressions of appreciation for the financial support, grantees recognized USAID, the Rwandan Ministry of Health (MOH), and FHP for the efficiency and effectiveness of the grant-issuing process (see box). Grantees appreciated efforts made to provide personal communication and follow-up, and recognized the rapidness and clarity of the process.

A Thank You to the American People

I wanted to express my particular appreciation for the support provided for staff salaries. With the closure of the previous support we were starting to feel deserted but we now we know that the American People are with us.

*-director,
Munini District Hospital*

Kudos for RFHP

Note that these quotes are not exact because they have been translated from Kinyarwanda.

“I invite all participants to join me in applauding RFHP. They have come in rapidly and helped to provide answers to many questions we have been asking ourselves.”

—district health director, Nyagatare District

“The level of organization and detail is excellent. RFHP used signature flags to indicate to us every single point in our grant agreement where we have to sign and had an efficient process in place for signing our agreements.”

— Comment by many grantees

To ensure that there was no gap between funding and that health services could continue, FHP was required to issue all grants within the span of three weeks through a truly collaborative process. USAID worked tirelessly to obtain approvals and to provide the project with guidance and information regarding the grants strategy. FHP staff members worked long hours to gather critical budget information, prepare grant agreements, initiate relationships with grantees, organize workshops, and process financial transactions (see box for a detailed account of events). And throughout, key MOH staff provided guidance and support to the efforts. The time and effort invested by all parties culminated in five successful workshops, 178 signed agreements, uninterrupted health services, and

Grants Support by the Numbers

178 institutions in **18** districts and all **five** provinces (including Kigali) receive grants support from RFHP.

15 administrative districts, **16** hospitals, **144** health facilities, and **three** prisons have signed grant agreements with RFHP.

\$3,812,890 is the total value of the grant agreements signed.

30 RFHP staff provided support to the effort.

Three weeks is the amount of time between identification and payment of grantees.

the gratitude of a large number of health providers who know their income is safe.

But the work is not over for FHP. Now that grant agreements have been finalized and initial payments have been issued, staff can begin conducting site visits to solidify positive relationships. Site visits will be used to build the capacity of grantees, provide technical assistance, and to gather information for longer-term follow-on grants. It is anticipated that these follow-on grants will continue to enable service providers to conduct necessary activities such as participating in in-service training courses and obtaining state-of-the-art medical equipment. Project staff are looking to the future positively and excitedly and believe that this is only the beginning of a long and fruitful relationship between the project, the MOH, and health service providers.

Timeline for Grants Disbursements

USAID and RFHP staff members were involved in ensuring that the health facilities received their grants in a timely way. Below are some key dates and events that led up to the actual disbursement of funds to grantees.

9/13 – USAID provides RFHP with the final list of 178 sites to be supported.

9/14 – USAID approves RFHP’s grants manual.

9/13 to 9/26 – RFHP staff work to gather and compile critical data (mostly financial and performance related) into a comprehensive database for planning and preparations.

9/24 to 9/28 – RFHP conducts an intensive communications and outreach campaign during which each of the 178 grantees is contacted by telephone and e-mail and is hand delivered an introductory document and invitation.

9/26 and 9/27– USAID formally approves RFHP’s request to disburse grants to 53 faith-based organizations and 125 governmental entities.

9/28 to 10/2 – RFHP staff prepared 178 grant agreements, budgets, and annexes.

10/3 to 10/9 – RFHP hosts five grantee orientation meetings where the project is introduced, grants protocol is explained, and grant agreements are finalized.

10/5 to 10/19 – RFHP makes grant disbursements so that salaries can be paid by the end of the month and health services can continue uninterrupted.

III. Report on Intermediate Result 1 – Improved quality of family health services

Discussion of FHP’s approach to achieving IR 1. Under IR 1, FHP is working to improve the quality of care by focusing on activities aimed at achieving three sub-results, each with a different focus on quality:

- Sub-result 1.1: National policies, protocols, guidelines and performance standards strengthened
- Sub-result 1.2: Functional linkages between services strengthened to support “smart integration”
- Sub-result 1.3: Rwanda quality management strengthened

Indicator Table. In the table below we present our progress against PMP indicators which measure the project’s success in achieving the project’s first intermediate result – improved quality of family health services. As mentioned in Section II, the first four columns of the table (indicator number, indicator, rationale and targets) have been taken verbatim from the project’s approved PMP. The final two columns have been added to show the project’s achievements against the targets set at the beginning of the year and to provide some analysis and explanation – either of how we achieved or exceeded our targets or of why we were not able to meet them. Refer to the actual PMP for information on how and why targets were calculated.

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
Project Intermediate Result 1: Quality of facility- and community-based family health services improved.					
7	<p>Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results</p> <p><i>Definition:</i> This indicator requires a minimum of counseling, testing, and the provision of test results.</p> <p><i>Disaggregation:</i> Sex, age, pregnant/non-pregnant</p>	<p>Reflects quality of testing and receiving of results and counseling in terms of comprehensiveness of service. Requires a minimum of counseling, testing, and the provision of test results. Through disaggregation, encompasses the required RFP indicator for “number of pregnant women who are counseled and tested for HIV and receive their test results.”</p>	850,167	850,988	<p>The project was able to achieve 104.6% of this target. Through grants FHP supports VCT and PIT by paying salaries of counselors and laboratory technicians as well as by paying travel and per diem costs for outreach activities that focus on counselling and testing. In addition, through supervision visits, data quality audits and grantee reporting, the project was able to monitor progress against this indicator and provide targeted technical assistance/capacity building to facilities as needed to meet it.</p>

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
8	<p>Percentage of health facilities correctly using the PDSA cycle methodology to support quality improvement</p> <p><i>Definition:</i> Numerator: Number of all supported facilities correctly implementing the PDSA methodology.</p> <p>Denominator: The total number of all supported facilities that have been trained on PDSA methodology to improve quality of services</p> <p><i>Disaggregation:</i> None</p>	Reflects the input and output of the project in order to improve quality of care at the community and at health facility level.	90%	91%	Quality improvement is a cornerstone of FHP implementation. It is the cross-cutting approach that the project uses to support all health services under its purview. PDSA is the MoH's QI methodology of choice and, as such, the project worked aggressively to roll it out to as many facilities as possible during the first year. During year one the project rolled out the approach in at least 5 facilities in each of the 17 out of 20 supported districts and, at the time that this report was being drafted, was able to verify that 91% of facilities were using it correctly (verified through site visits).
Sub-Intermediate Result 1.1: National policies, protocols, guidelines, and performance standards strengthened.					
9	<p>Number of technical and strategic documents developed or updated (including strategies, training manuals, policies, norms, standards, and protocols/guidelines).</p> <p><i>Definition:</i> Policies, norms, standards, and protocols updated with project assistance, approved by MOH, and disseminated. Includes those revised to meet WHO standards and/or the local context.</p> <p><i>Disaggregation:</i> Document type</p>	Revision of policies, norms, standards, and protocols is a priority activity and will improve quality by establishing clear expectations for service delivery.	10	10	<p>In the year one work plan, the project committed to supporting the development of ten technical and strategic documents and was successful in meeting that target. Key documents that the project contributed to during the first year include</p> <ul style="list-style-type: none"> • The 2013- 2017 maternal and neonatal strategic plan • The National Health Promotion Strategy • Gender Based Violence Policy • Review and validation of CHW GBV training module • Child Survival Strategic Plan • 2013-2017 Nutritional Policy • Family Planning Policy • Adolescent Sexual and Reproductive Health and Rights Policy
Sub-Intermediate Result 1.3: Rwandan quality management strengthened.					
10	<p>Number of individuals trained in quality improvement techniques.</p> <p><i>Definition:</i> Number of people (health professionals, primary health care workers, CHWs, volunteers, non-health personnel) trained in methods aimed at meeting performance standards using project funds.</p> <p><i>Disaggregation:</i> Health providers, non-health providers</p>	Training in quality improvement techniques will lead to knowledge transfer at the facility, community, and GOR levels and facilitate innovation and ownership of techniques, ensuring sustainability.	90	342	<p>The project originally anticipated training 2 people each from 45 health facilities in quality improvement techniques. However, once quality improvement was identified as the project's mechanism for technical assistance, the project trained a larger number of providers than originally planned – 4 to 5 individuals from 5 facilities in each of the project's 17 districts.</p> <p>Additional information on PDSA, which was the quality improvement technique used can be found in the success story following this section.</p>

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
11	<p>Number of individuals (from health facilities and administrative units) trained in at least one core FH service using project funds.</p> <p>Note: Core FH services include the following: FP/RH, malaria treatment and prevention, MNCH, child health and nutrition, safe water and hygiene, HIV/AIDS.</p> <p><i>Definition:</i> Number of people (health professionals, primary health care workers, volunteers, non-health personnel) trained using project funds. Training refers to new training or retraining and assumes that training is conducted according to national or international standards when these exist. Training must have specific learning objectives; a course outline or curriculum; and expected knowledge, skills and/or competencies to be gained by participants.</p> <p><i>Disaggregation:</i> Sex, cadre (doctor, nurse, CHW, etc.), location, FH service (FP/RH, malaria treatment and prevention, MNCH, child health and nutrition, safe water and hygiene, HIV/AIDS).</p>	<p>Supports access of skilled health providers in each component of package of FH services. Through disaggregation, encompasses four required training indicators from the RFP.</p>	2,662	1,602	<p>During Y1 FHP supported the MOH to provide numerous trainings in various service areas. Some of the trainings provided during the project's first year include:</p> <p>HIV</p> <ul style="list-style-type: none"> • Task Shifting <p>Maternal and Child Health</p> <ul style="list-style-type: none"> • Post –Abortion Care • C-Section • Family Planning/HIV/MCH integration • Emergency Triage Assessment and Treatment • Adolescent Sexual and Reproductive Health and Sexual Rights • Integrated Management of Childhood Illnesses <p>Family Planning</p> <ul style="list-style-type: none"> • Tubal Ligation, Vasectomy and Semen Analysis <p>Cross Cutting</p> <ul style="list-style-type: none"> • Quality Improvement/PDSA • M&E Systems and data use for decision making <p>It should be noted that the target, when set, included community health workers. However, after reviewing the definition associated with the indicator it was determined that community health workers should not be counted. For this reason that the project did not meet its year one target.</p>

Highlighted success under IR 1. Many of the indicator explanations above reference PDSA, or Plan-Do-Study-Act, which is the MOH's quality improvement methodology of choice. PDSA begins with the identification of key indicators for improvement. FHP has trained sites to analyze data and identify gaps and then discuss probable causes in order to propose solutions which are adapted to the problems (Plan phase) and applied in practice (Do phase). In the study phase, indicators are reevaluated for change. If change is noted, then the sites can "act" by scaling up the solutions, within their own facilities and by sharing knowledge and best practices with other facilities

PDSA is the first quality improvement (QI) approach being rolled out in practice in Rwanda. This approach enables and empowers practitioners at the bottom level to create change, without having to wait for a top-down mandate. The story below provides a more detailed overview of how PDSA works and how it can be used to improve quality of health services.



SUCCESS STORY

RFHP Uses Quality Improvement for Better Health

Outcomes

PDSA Helps Pregnant Mothers



Photo by Lauren Crigler

Above: RFHP staff supporting a quality committee through the "plan" phase of the PDSA cycle

Although the PDSA model was initiated relatively recently, there is already evidence of its success in improving health outcomes. Most notably, Jarama Health Center (HC) in Ngoma and Murambi HC in Rulindo have increased the percentage of pregnant women seeking antenatal care in the first 14 weeks of gestation. Early antenatal care attendance during pregnancy is important to identify and mitigate risk factors and encourage women to plan to give birth with a skilled attendant. Baseline data (from late 2012) indicated that 24.5% of pregnant women served by Jarama HC and 32.7% served by Murambi HC were seeking antenatal care before 14 weeks of gestation. As part of the PDSA process, and with support from RFHP, the HCs identified the following strategies to increase early ANC attendance:

- Link pregnant women who are identified during outpatient care by the outpatient department (OPD) to the ANC clinic for a same day visit
- Conduct outreach and communications regarding the importance & benefit of early ANC visits at waiting areas of OPD and ANC clinics
- Conduct communications and outreach on the importance & benefit of early ANC visit at community level through community health workers
- Informing the community on the benefits of early ANC during "Umuganda" (Monthly community services)

By the end of September, 2013, Jarama Health Center had increased the percentage of women seeking early antenatal care to 45.3% & Murambi Health Center had increased its percentage to 55.2%.

U.S. Agency for International Development
www.usaid.gov

The Rwanda Family Health Project (RFHP), in collaboration with the Rwandan Ministry of Health, is working to improve the quality of family health services using the Plan-Do-Study-Act (PDSA) model for quality improvement (QI) which consists of the following four phases:

PLAN. During this phase facilities work to prioritize and choose areas for improvement, understand the underlying processes related to those areas, identify interventions, and develop action plans for improvement.

DO. During this phase, facilities implement action plans, all the while documenting lessons learned and measuring improvements.

STUDY. This is the phase at which results are analyzed to determine which interventions were actually successful in creating improvements and impacts.

ACT. Successful interventions are shared, institutionalized and scaled up during this phase.

As a first step, RFHP supported the establishment and strengthening of facility-based Quality Committees (QC) at five health centers in each of the seventeen project supported districts. Quality Committees act as the focus of the improvement process and are composed of a cross-functional set of decision-makers. These committees were trained by RFHP in PDSA methodology.

The health center QI committee members collected at least six months baseline data on eight key indicators that were selected by district level officials as representing national and regional health priorities. With RFHP support, each quality committee organized the baseline data into a prioritization matrix and used it to select two indicators for initial focus.

Next, Quality Committees developed detailed action plans with key activities, measurements, delegations of responsibility, and specific time periods, to follow the implementation of each intervention. Currently Quality Committees are holding monthly meetings to review implementation against action plans and to determine corrective actions as necessary. RFHP technical staff have been supporting the continual quality improvement process through coaching visits, which are conducted in collaboration with district level management officials.

Supporting QI processes to improve clinical care allows RFHP to provide a more targeted and needs based style of capacity building that addresses gaps identified by facilities themselves through their QI processes. And most importantly, quality improvement is a sustainable approach which really empowers facilities to develop their own strategies for improvement that are based on data and are applicable and relevant to the context. Joyce Ruvurajabo, a member of Murambi Health Center's Quality Committee recognizes the value of PDSA and the ways in which it has enabled her health center to make positive changes. She stated "The PDSA model helped our quality committee to meet regularly around real issues and practical discussions. We now focus on key and few indicators and are happy to contribute to the solutions for the gaps our health facility, instead of waiting for others to bring solutions to us."

IV. Report on Intermediate Result 2 – Improved access to family health services

General Overview of FHP’s approach to achieving IR 2. Under IR 2, FHP implements activities aimed at expanding access to health services. This IR has been divided into two sub-results, each focusing on a different level of service provision:

- Sub-result 2.1: Availability of facility-based services expanded
- Sub-result 2.2: Availability of community-based services expanded

FHP’s approach to improving access is by increasing the capacity of health providers to provide quality care through of focused trainings in multiple technical areas. During its first year FHP conducted multiple trainings in conjunction with the MoH, both at the facility level and at the community level.

Indicator Table. In the table below we present our progress against PMP indicators meant to measure the project’s success in achieving the project’s second intermediate result – improved access to family health services. As mentioned in Section II, the first four columns of the table (indicator number, indicator, rationale and targets) have been taken verbatim from the project’s approved PMP. The final two columns have been added to show the project’s achievements against the targets set at the beginning of the year and to provide some analysis and explanation – either of how we achieved or exceeded our targets or of why we were not able to meet them. Refer to the actual PMP for information on how and why targets were calculated.

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
Project Intermediate Result 2: Access to facility- and community-based family health services improved.					
Sub-Intermediate Result 2.1: Availability of facility-based services expanded.					
12	<p>Number of service outlets providing the minimum package of PMTCT services as defined by national standards.</p> <p><i>Definition:</i> The minimum package of services for preventing MTCT includes at least all four of the following services: (1) Counseling and testing for pregnant women. (2) ARV prophylaxis to prevent MTCT. (3) Counseling and support for safe infant feeding practices. (4) Family planning counseling or referral.</p> <p><i>Disaggregation:</i> Type of facility, location.</p>	Provides a quantitative measure of the stage of PMTCT service expansion and current availability of PMTCT services supported by the USG.	146	141	RFHP received guidance from USAID on the number of sites projected to receive support in PMTCT at the beginning of the year. The projections for this target is based on the number of supported sites that already provided PMTCT services and the number of new sites expected to begin to administer PMTCT with USAID support. Due to many factors USAID opted to limit the number of new PMTCT sites and, as such, the achievements document the number of sites already providing the minimum package of PMTCT services at the beginning of project year one. RFHP supported these sites in the provision of PMTCT through grants (financial support for salaries and psychosocial care for PMTCT) as well as through technical assistance for EMTCT.

#	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
13	<p>Percentage of health facilities offering integrated HIV and MCH services.</p> <p>Definition: Integrated services to be defined as adhering to nationally defined standards.</p> <p>Disaggregation: Facility type, ART, location.</p>	Proxy indicator measuring the degree to which the full range of services is available at clinics.	16%	6%	As part of its scope of work, FHP supports integration of services to promote efficiency and effectiveness. During project year one FHP worked to support the roll-out and implementation of an integrated model for HIV, family planning and MCH (activities 10-13, Annex I). While the project made progress by defining the elements of the model, there is still work to be done to get the MoH and the RBC to agree on a final model. It is for this reason that the project was not able to meet its target for this indicator.
Sub-Intermediate Result 2.2: Availability of community-based services expanded.					
14	<p>Number of CHWs successfully completing training in at least one FH service with project assistance.</p> <p>Definition: FH services defined as FP/RH, malaria treatment and prevention, MNCH, child health and nutrition, safe water and hygiene, HIV/AIDS, and TB. Successful completion will be determined based on pre- and post-knowledge tests.</p> <p>Disaggregation: None</p>	Community Health Workers that are trained in service provision will be able to provide additional services at the community level, thereby increasing the availability of community based services.	14,151	14,518	<p>FHP exceeded this target and was able to train a significant number of community health workers in the following areas:</p> <ul style="list-style-type: none"> • Community Based Nutrition (activity 51, Annex II) • Community Based Family Planning (activity 48, Annex II) • Identification and referral of Gender Based Violence (activity 54, Annex II) • Integrated Community Case Management (activities 17 to 20, Annex I) • Community Based Environmental Health Promotion Program (activity 20, Annex III)

Highlighted success under IR 2. Family Planning is a priority of the Ministry of Health as it promotes improves living standards at the household level and allows for greater impact of Government sponsored social programs (in education, nutrition, etc.). During its first year FHP provided capacity building in family planning service delivery at several levels of the health system. The success story on the following page details the project's support of the national community based family planning program and long acting and permanent methods program.



SUCCESS STORY

RFHP Supports Family Planning at all Levels of the Health System



A Community Health Worker providing FP counseling on during a validation session

Photo by Suzanne
Mukashanya

Below is a testimony from Saide Munyaneza, vasectomy patient:

"We have four children and decided that we didn't want to have more. I asked my wife to use a FP method and she tried an implant. But after some time we realized she was having side effects so I asked her to go to the health center to remove it. Because I am a CHW I knew that there was a permanent FP method for men that did not use hormones. I told my wife that I would use it so that she could rest her body. Also, I thought that if I used this method then I would be better able to sensitize others about it."

After we decided together that I would get a vasectomy, we went to the health center where a counselor taught us and took our phone number. When a team of doctors came to the health center, the nurse called me and I went to the health center with my wife. The medical team explained the method to us and we agreed that it would work for our needs.

They asked me to come back three months after the procedure so that they could confirm that it was effective. They gave my wife pills to use during those months. I returned to the health center and they did a test. Now my wife does not need to use pills.

Since I have had the vasectomy I have not had any health problems or any problems regarding sex. There have been no changes at all. When my wife had an implant she was always ill but now she is healthy and is working for our family."

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As stated in Rwanda's Family Planning (FP) Policy 2012-2016 "the Ministry [of Health] continues to consider FP a top priority and one of the strategies contributing significantly to the nation's socioeconomic development." At a household level, FP enables families to devote more resources to each child, thus improving nutrition and educational statuses and living standards. FP also empowers women – improving health and allowing them more opportunities to enter the workforce. FP is also beneficial at a national level as it makes investing in social services and creating social change more affordable/ possible for governments. The Rwanda Family Health Project (RFHP) is supporting the Ministry of Health's FP program by training doctors and community health workers to provide FP services.

Vasectomy is a surgical FP method that is conducted by doctors at hospitals and health centers. During its first year, RFHP supported the training of: 8 counselors to conduct pre-procedure couples counseling, 8 doctors to conduct the actual procedure, and 80 nurses and technicians to conduct post vasectomy semen analysis (to verify efficacy). RFHP also supported sensitization events where district leaders informed opinion leaders on the importance and value of FP.

To expand FP services beyond health centers, Rwanda implemented a community-based FP Program (CBP). Through this program, community health workers (CHWs) provide information on FP and referral to health centers to communities. In addition, CHWs are trained to provide some methods of family planning, such as condoms, pills, and injectables. For the past year RFHP supported the training of 1887 CHWs and the validation of 1,717 CHWs, bringing CBP services to four districts (Nyagatare, Ngoma, Rwamagana and Gasabo). During the ten day CBP sessions, CHWs receive theoretical trainings on the value of and administration of FP services and then learn practical skills (such as administering injectable contraceptives). After the training CHWs are able to practice the skills they have learned at health centers, under the supervision of the site trainer (who is usually a nurse at the health center). Then, after about six months, RFHP supports the validation process, through which CHWs are observed to see if they have retained the skills and information learned during training and practice. Validated CHWs are certified to independently provide the CBP package in their communities. Ephrem Simuteze, a CHW from Rwamagana District feels that being able to offer FP services has strengthened his role in his community. He stated "CBP has strengthened my collaboration with the neighbors that come to seek services and advice. They come because they know that now injectables are available but then they stay to discuss other health problems. I feel that now that I offer CBP my community believes in me and recognizes my competence."

V. Report on Intermediate Result 3 – Improved demand for family health services

General Overview of FHP’s approach to achieving IR 3. Under IR 3, FHP aims to strengthen the linkages between communities and providers and implements activities aimed at achieving two sub-results, each using a different methodology to increase the demand for FH services. The sub-results under IR 3 are as follows:

- Sub-result 3.1: Awareness and motivation to seek provider services in a timely manner improved
- Sub-result 3.2: Family implementation and follow-up healthy behaviors strengthened

Indicator Table. In the table below we present our progress against PMP indicators meant to measure success in achieving the project’s third intermediate result – improved demand for family health services. As mentioned in Section II, the first four columns of the table (indicator number, indicator, rationale and targets) have been taken verbatim from the project’s approved PMP. The final two columns have been added to show the project’s achievements against the targets set at the beginning of the year and to provide some analysis and explanation – either of how we achieved or exceeded our targets or of why we were not able to meet them. Refer to the actual PMP for information on how and why targets were calculated.

No.	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
Project Intermediate Result 3: Demand for facility- and community-based services increased.					
Sub-Intermediate Result 3.1: Awareness and motivation to seek provider services in a timely manner improved.					
15	<p>Percentage of pregnant women with four ANC visits in target areas</p> <p><i>Definition:</i> Numerator is number of pregnant women with a minimum of four ANC visits during pregnancy, including provision of PMTCT services in 14 districts. Denominator is total number of pregnant women in 14 districts. .</p> <p><i>Disaggregation:</i> location.</p>	Measures awareness of FH services, which fosters care-seeking behavior.	29%	29.4%	ANC attendance is an issue that FHP has tackled in an integrated way. Health facilities are looking at ANC indicators as part of their quality improvement efforts and are implementing strategies to increase number and frequency of visits (activities 21 to 23, Annex I and success story in Section III). In addition, the project is providing training to CHWs and health care workers to conduct outreach and share information with community members on the importance of ANC attendance (activity 58, Annex II). The project will also conduct its own outreach, through community level campaigns and started developing those campaigns during year one (activities 6 through 14, Annex III). And finally, DHMTs are aware of the importance of ANC attendance and are analyzing the issue from a management perspective (see DHMT success story in Section VI).

Highlighted success under IR 3. A major accomplishment under IR 3 is the implementation of the Ministry’s Community Based Environmental Health and Promotion Program (CBEHPP) in Kicukiro and Rulindo districts. The program empowers and enables community members to improve their hygiene and sanitation status. This community mobilization model is a new and innovative approach that

uses community hygiene clubs to build capacity, promote health behaviors and increase the use of health services. More information regarding FHP's work with the CBEHPP model can be found in the story on the following page.



SUCCESS STORY

RFHP Supports Communities in Supporting Themselves

Hygiene Club in Action



Photo by Malick Kayumba

The "Isoko y'isuku" CHC cleaning the compound of the home of a vulnerable member of their community.

Cerapie Uwimbabazi is a single mother of three children who, because of sickness, has a difficult time providing for her family. She and her children were identified by the "Isoko y'isuku" CHC, located in Biryogo village (in Kicukiro District) as one of their village's most vulnerable families, and her household was targeted for support, for which she describes her gratitude:

"This morning, I had a phone call from one of my neighbors who was saying that she wanted to visit us with some friends and I said, you are all welcome, I will be home in few hours. Then when I arrived at home, I was very surprised to find many people, most of them my neighbors, some of them constructing a toilet, others cleaning my compound and another group seated in my house with baskets (uduseke) full of all kinds of food for my family. I am blessed!"

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In Rwanda, infectious diseases, such as diarrhea and intestinal worms, are a major cause of morbidity and mortality. Statistics reveal that most of the diseases treated at health facilities can be prevented through improved hygiene and sanitation practices in the household.

In this context, the USAID-funded Rwanda Family Health Project (RFHP) is working with the Rwanda Ministry of Health to implement a community based environmental health promotion program (CBEHPP). CBEHPP is an approach that empowers and enables communities to improve their behaviors and reduce disease burdens.

CBEHPP works through community hygiene clubs (CHC), which act as engines to achieve practical behavior change in every homestead. Executive club members are trained by RFHP to conduct community mapping exercises and measure hygiene behavior, recognize vulnerability, create realistic plans and targets and provide relevant health information to fellow community members. During Fiscal Year 13, and with the support of USAID and the MOH, RFHP trained 4,865 executive club members in two districts. In Kicukiro District alone, 324 CHCs have been created and membership totals 25,845. And the CHCs have already begun impacting their communities. To date, the Kicukiro CHCs have constructed 13 toilets and 46 hand-washing systems, developed 55 kitchen gardens, paid health insurance or "mutuelle" fees for 152 of their poorest community members and supplied them with necessary equipment and materials, such as mattress, clean water drains and rubbish bins.

RFHP and the MoH rely on district authorities to ensure effective implementation of CBEHPP. The project has trained 1,004 district officials to provide supervision and oversight of the clubs. These officials now meet monthly to evaluate the implementation of their respective clubs, share best practices, challenges and solutions and coordinate and plan activities.

CBEHPP has the potential to be a successful model for community mobilization because it works through existing structures and empowers communities to help themselves. Francine Kabagwira, a CHC member from Kicukiro district is encouraged by the potential her club has to make a difference in her community. She commented "I am sure that, with the knowledge and the education material we received from the [CBEHPP] training, and our determination, I am confident that we can solve all our hygiene and sanitation issues and change the behavior of our neighbors for our good health and better future."

VI. Report on Intermediate Result 4 – Strengthened management of family health services

General Overview of FHP’s approach to achieving IR 4. Under IR 4, FHP will implement activities aimed at achieving three sub-results, each focusing on different aspects of health systems management:

- Sub-result 4.1: Facility functionality and equipment, supply, and logistics systems improved
- Sub-result 4.2: Facility management improved
- Sub-result 4.3: Management of CHW cooperatives strengthened

Indicator Table. In the table below we present our progress against PMP indicators meant to measure the project’s success in achieving the project’s fourth intermediate result – strengthened management of family health services. As mentioned in Section II, the first four columns of the table (indicator number, indicator, rationale and targets) have been taken verbatim from the project’s approved PMP. The final two columns have been added to show the project’s achievements against the targets set at the beginning of the year and to provide some analysis and explanation – either of how we achieved or exceeded our targets or of why we were not able to meet them. Refer to the actual PMP for information on how and why targets were calculated.

No.	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
Project Intermediate Result 4: Management of facility and community-based health services strengthened.					
16	<p>Number of DHMT quarterly meetings that were conducted in FHP supported districts to discuss and/or analyze their data for informed decision making.</p> <p>Definition: This is the number of DHMT quarterly meetings that were conducted during the reporting period in FHP supported districts to discuss and/or analyze their data for informed decision making.</p>	Measures the capacity of health facilities to make evidence based clinical as well as management decisions	28	27	DHMT meetings were financed through project grants to administrative districts. The project’s technical staff, including the M&E and IR 4 Teams and the District Coordinators provided technical support to the DHMTs. The M&E team provided trainings on using existing M&E systems to aggregate and extract data and then use it for decision making (activities 12 & 13, Annex IV). The IR 4 Team supported the DHMTs in setting meeting agendas and following up on priorities identified during the meetings.
Sub-Intermediate Result 4.1: Facility functionality and equipment, supply, and logistics systems improved.					
17	<p>Number of health facilities implementing OpenMRS (EMR)</p> <p>Definition: This is the number of health facilities in the supported districts that use electronic medical record keeping for HIV infected individuals using the OpenMRS database during the reporting period</p>	Implementation of OpenMRS will enable providers to carry out client-centered follow up of HIV+ patients thus enabling a better tracking of the quality of services offered	30	30	The MoH is working towards having all facilities utilize their endorsed medical records system (OpenMRS). FHP supported implementation of OpenMRS in 30 facilities by providing equipment and cabling and building capacity at each site to use the system effectively (activities 4-10, Annex IV).
Sub-Intermediate Result 4.2: Facility management improved.					

No.	Indicator (Name, Definition, Disaggregation)	Rationale	Y1 Targets	Y1 Achievements	Analysis and Explanation of Y1 Performance
18	<p>Percentage of health facilities reporting on a timely basis into the HMIS.</p> <p><i>Definition:</i> Reporting should be in line with HMIS procedures and protocols.</p> <p><i>Disaggregation:</i> Facility type, location.</p>	Measure of the capacity for planning at central and decentralized levels.	100%	99.25%	The project's M&E team provided extensive capacity building support to all supported entities in monitoring and evaluation, including data collection, reporting, analysis, and use. (activities 9&10, Annex IV). The team provided hands on mentoring to each facility to ensure that M&E staff understood reporting requirements and were able to fulfill them. The team also conducted routine data quality audits and used those results to build capacity at the facility level to ensure higher quality future reporting.

Highlighted success under IR 4. One of the project's recognized activities during its first year was the operationalization of District Health Management Teams, or DHMTs. Since DHMTs are the district level managers of health services, their functionality is critical to the success of the project's forth IR. The success story on the following page provides more details regarding the roles of the DHMTs and gives examples of what they have been able to accomplish thus far.



SUCCESS STORY

Improving Management of HIV and Other Services through DHMTs

Nyagatare DHMT – Making Decisions



Photo by Malick Kayumba

The DHMT from Nyagatare District is committed to meeting the needs of its population and has already initiated multiple activities, such as the below, to do so.

Increasing HIV testing. After reviewing data, the DHMT recognized that there was a segment of their population who had a likelihood of being HIV positive but was not being tested. These were men who were married to pregnant women who were identified as positive during their antenatal care (ANC) visits. The DHMT agreed it is important to encourage men to accompany their wives for ANC visits so that they can be tested. As such, the DHMT issued a recommendation to supported health centers to engage community members in informational meetings at which the importance of men's participation in ANC would be emphasized. The DHMT will revisit the data at the next meeting to determine if their recommendation is making a difference in the number of men being tested and treated.

Radio Shows to Engage with the Community. In an effort to include the community in improving health services, the DHMT hosted a radio show. During the show DHMT members addressed concerns and comments voiced by community members through suggestion boxes used at health facilities. Community members were encouraged to call in and engage directly with the DHMT. The photo above depicts DHMT members and RFHP staff hosting the radio show.

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One of the successes of The Rwanda Family Health Project (RFHP) during its first year was the operationalization of 17 District Health Management Teams (DHMTs) in Rwanda. The DHMT is a forum that was created through the 2011 District Health System Re-organization Guideline that aimed to decentralize the Rwandan Health System and increase efficiency and accountability at the district level. While in theory the DHMTs were to serve as the main forum for collaboration and coordination of all health activities by key district stakeholders (hospital, district pharmacy, health insurance, administrative health directorate, etc.), the reality was that the guideline largely remained un-operationalized and stakeholders were not coordinating enough to promote efficiency and effectiveness.

In March 2013, Rwanda Family Health Project supported the MOH Planning Department and M&E Directorate to organize workshops to launch the DHMTs. The workshops brought together 140 participants from 17 districts for the very first time to discuss practical issues around DHMT operationalization. Some of the topics discussed at the workshops included the purpose of the DHMT, the functional roles of its different members and the logistics and challenges of its operationalization.

Since the launch workshops, the DHMTs have been holding meetings at least once per quarter to discuss priorities, challenges and brainstorm solutions pertaining to HIV and other health services in their respective districts. RFHP technical staff have been participating in these meetings to provide technical support in areas such as management, leadership, planning, quality improvement, and monitoring and evaluation. In addition, RFHP has been working with individual DHMT members to build their capacity. For example, the project's M&E team has been training DHMT members to use national databases such as TRACNET, which compiles HIV data. Then the DHMTs were trained to aggregate district level data, interpret it and use it to make important decisions related to improving the quality of HIV and other health services in each district.

RFHP believes operationalization of the DHMTs will promote coordinated planning of HIV and other health related activities and harmonized implementation of those activities at the decentralized level. Furthermore, good management of HIV and other health services, through the DHMT forum, will lead to improved health outcomes for Rwanda. Providence Kirenga, the Vice-Mayor of Ngoma District and head of the Ngoma DHMT also believes that the forum will lead to health improvements in her district. At the close of her first DHMT meeting she stated "This is the right time to have an effective and really needed forum like the DHMT. DHMT helps managers from district health sector to sit together and plan, implement, evaluate health activities; and to discuss existing challenges in order to address them so that we can meet the health goals and needs of our population."

VII. LESSONS LEARNED FOR FORWARD IMPLEMENTATION

Below are five key lessons that were learned during project year one. We provide examples of how we arrived at these lessons during our first year of implementation and then discuss how they will underpin our approach to year two implementation.

- *Move from supervision to mentoring and coaching.* During the first year of implementation the project supported implementation of the country's existing supervision model by providing funding for travel and logistics (mostly through grants) and technical assistance (through joint supervision visits). Through this process our technical staff identified some flaws with the model, namely that it was not financially sustainable, that it was done by vertical program areas which led to multiple, time consuming visits, that it was top down and did not necessarily reflect the needs and priorities at the facility level, and that there were no real mechanisms in place to address gaps identified during visits. FHP plans to address these issues in the following year by scaling up an integrated mentoring and coaching model that is closely tied to facility and district level quality improvement initiatives. Through this model, which is described in more detail in the project's year two work plan, facilities will identify gaps in service delivery and will work through quality improvement teams to develop solutions to address those gaps. Facilities will then be empowered to request targeted capacity building from qualified mentors and coaches (who will come from within the health system and be trained by the project). The Ministry of Health also recognizes the need for provision of more targeted capacity building and quality improvement efforts and is in full support of this initiative.
- *Increased focus on data use and need for capacity building in this area.* During our first year of project implementation we recognized that, while great quantities of data are being collected, they are not being used effectively to drive quality improvement and to inform decision making. Through our work at various levels of the system we came to realize that district level staff do not know how to use existing systems to aggregate data, interpret it, and use it to make evidence-based decisions related to management of health services. We also realized that facility level staff are not rigorously incorporating data into their quality improvement processes and, as such, they are not realizing the full potential of those processes. We began addressing these issues in year one, by developing and conducting trainings on data use at the district level. In the coming year we plan to roll out those trainings to additional districts as well as to provide targeted mentoring and coaching on data for decision making to DHMTs and other health system staff. In addition, we will continue our quality improvement efforts with more of a focus on data. Each facility will receive hands on coaching through the QI process so that data can be analyzed and used effectively to improve services.
- *Need for strengthening of all management functions, at all levels.* It is our understanding that, in the past, facility and district level support has focused on clinical service delivery. Through our work with grantees, the site and supervision

visits we have conducted and our support to the Facility Capacity Assessment, we recognize that strong management is required to ensure quality service delivery and will work during year two to build management and operational capacity within the health system. FHP plans to conduct training in areas such as accounting, management and leadership, and resource management that will build the capacity of managers so that they can better support service provision. In addition, FHP will integrate management and operations into its quality improvement and mentoring and coaching programs, which will enable districts and facilities to identify management issues that are affecting service delivery and hindering achievement of targets and then request targeted capacity building to fill those management and operational gaps.

- *Integration* - both of services and across levels of the health system – and implementation of cross cutting approaches - requires effective coordination across health desks and departments. For example, implementation of the FP/MCH and HIV integrated model requires coordination between the MCH desk of the MoH and the RBC. Also, community level initiatives, such as iCCM, require coordination between the MCH desk of the MoH and the malaria department within RBC. This type of coordination for integration continues to be a challenge, especially when it comes to finalizing decisions for development and roll out of integrated models for delivering care. There is currently a heightened awareness at the MoH for the need for close coordination that needs to happen beyond TWGs. The project will need to continue to advocate for these efforts to take place and to even provide opportunities for this dialogue to happen. This can be done through scheduled meetings to solicit feedback and support, technical workshops with participants from different technical areas coming together to exchange views and quarterly update meetings that are attended by the leaders of the different health desks.
- *Engagement with the districts in preparation for successful transition.* In the last few months discussions around transition has accelerated. There has been a number of meetings with the central level at the MoH to discuss a number of issues surrounding effective transition such as the number of districts to be transitioned, which districts to be transitioned first, the current services that need to be continued, the amount of funds available etc. The district leadership so far has been absent from these discussions. Some districts are not even aware that these conversations are taking place. There is a need for a more focused engagement with the leadership and governance at the district level. An important team that brings together the governance and health leadership of the district in one forum is the district health management team (DHMT). It is made up of the Vice Mayor, the Director of Health, the M&E Director, the District Hospital Director, and a Community Health Worker representative. The DHMT should shepherd, monitor and roll out transition activities in their districts to ensure that quality of services are not impacted. The team constitutes the main mechanism for engaging each technical and managerial arena in the district. For successful implementation of transition plans, it is imperative that we have a comprehensive approach to build the full capacity in the DHMT to prepare for transition roll out.

Annex I

IR 1 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
Sub-result 1.1 National policies, protocols, guidelines, and performance standards strengthened				
Activity 1.1.1. Support the development, review/update, and dissemination of policies, strategic plans, protocols, guidelines, and tools				
1	Conduct a situational analysis of the 2007-2012 maternal and neonatal strategic plan to guide development of the maternal and neonatal strategic plan for 2013-2017.	Supported local and international consultancies to conduct situation analysis and shared findings with the MCH TWG.	MCH TWG members	Completed
2	Support development of the 2013-2017 maternal and neonatal strategic plan.	The strategic plan is completed and will be presented at the October meeting of the MCH technical working group for final approval.	MCH TWG members	Completed
3	Support development of the 2013-2017 child survival strategic plan.	Technical inputs to the strategic plan provided through the TWG.	MCH TWG members	Completed
4	Review and update the 2013-2017 nutritional policy through close participation in the nutrition TWG.	Provided technical support through nutrition TWG.	MCH TWG members	Completed
5	Distribute FP, adolescent health, gender-based violence, and other new policies and strategic plans in FHP-supported districts/ health facilities and hold dissemination workshops at the central level.	Provided technical support through a work shop to elaborate the <i>FP</i> policy. This policy was validated in May 2013 and an electronic version was disseminated to all hospitals. Provided technical support for the elaboration of the <i>Adolescent Health Policy</i> , which was completed. Provided technical support for the elaboration of the <i>Gender-Based Violence (GBV) Policy</i> . The document has been validated and an electronic version was disseminated to district hospitals.	MCH TWG members	Completed
6	Provide technical assistance through the BCC TWG to update and finalize the national health promotion strategy.	Supported the development of the Health Promotion Strategy with an international consultant. Health Promotion Strategy finalized, waiting for validation once the policy is ready.	MoH, RBC	Completed
7	Support the Rwanda Health Communications Center to organize consultative and validation meetings to finalize and disseminate the national health promotion strategy at the central level.	RFHP facilitated several consultative meetings in the review process of the health promotion strategy. These meetings includes several meetings with the Head of	MoH, RBC	Completed

IR 1 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		RHCC, a 2 day workshop with all Health Promotion TWG members in Musanze (Jan 22-23,2013), with the MCH Director, the former DDG of RBC, and the Heads of HIV and TB Divisions. The strategy was also presented to the management team of RBC and the senior management of MoH by the Head of RHCC. The final draft has been validated.		
Activity 1.1.2. Ensure that services provided are in line with existing national guidelines				
Comments				
8	Support production of specific tools (ANC cards, partographs, and PNC cards) for supported district hospitals and health centers (HCs).	140,000 ANC Cards (70,000 for providers and 70,000 clients), 70,000 partographs, and 70,000 PNC cards printed for 14 district hospitals.	14 district hospitals (Gakenke, Gasabo, Gatsibo, Gicumbi, Kamonyi, Kayonza, Kicukiro, Muhanga, Nyamagabe, Rulindo, Ruhango, Rutsiro, Rwamagana)	Completed
9	Distribute tools to supported district hospitals and health centers where they are not currently available.	140,000 ANC Cards (70,000 for providers and 70,000 clients), 70,000 partographs, and 70,000 PNC cards distributed to 14 district hospitals.	14 district hospitals (Gakenke, Gasabo, Gatsibo, Gicumbi, Kamonyi, Kayonza, Kicukiro, Muhanga, Nyamagabe, Ruhango, Rulindo, Ruhango, Rutsiro, Rwamagana)	Completed
Sub-result 1.2 Functional linkages between services strengthened to support "smart integration"				
Activity 1.2.1. Support implementation of the FP, MCH, and HIV/AIDS integration model				
10	Support the MoH to organize a central-level workshop to share results and best practices from the current evaluation of the FP, MCH, and HIV/AIDS integration model.	Conducted preparatory meetings with supervisors from Ngarama and Kibungo district hospitals and delivered trainings to other districts.	Gicumbi, Nyagatare, Kayonza, Gatsibo, Rwamagana	Completed
11	Based on evaluation results and workshop consensus, adapt current tools (integrated registers and patient charts) and adjust rollout plan if needed.	The MCH desk proposed an integrated tool and so there was no longer a need to adapt a tool.	Districts hospitals in Gasabo, Gatsibo, Kamonyi, Kayonza, Nyagatare, Nyamagabe, Rulindo, Rwamagana	Completed
12	Produce FP, MCH, and HIV/AIDS integration model materials to selected FHP-supported health facilities.	Procurement occurred for materials including integrated registers and files. Received technical specifications from Dr. Anicet. Tools have been distributed.	Districts hospitals in Gasabo, Gatsibo, Kamonyi, Kayonza, Nyagatare, Nyamagabe, Rulindo, Rwamagana	Completed
13	Support the MoH and districts to disseminate materials and roll out the	Conducted preparatory meeting with supervisors	Districts hospitals in Gasabo, Gatsibo, Kamonyi, Kayonza,	Completed

IR 1 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
	FP, MCH, and HIV/AIDS integration model in selected FHP-supported districts.	from Ngarama and Kibungo District Hospitals beginning the integration process. Follow-up will continue into the following year.	Nyagatare, Nyamagabe, Rulindo, Rwamagana	
Activity 1.2.2. Ensure implementation of integrated pediatric interventions in FHP-supported health facilities, including HIV and TB co-infection				
14	Disseminate new integrated HIV/AIDS and TB pediatric guidelines, protocols, and tools to target health facilities.	3,096 integrated TB/HIV treatment tools were disseminated in 8 districts, including: TB Screening Tool, TB Treatment Tool, and TB/HIV Diagnosis Algorithm Tool.	8 district hospitals: Rwamagana, Kayonza, Gatsibo, Nyagatare, Bugesera, Ngoma, Kamonyi, Nyaruguru, Nyamagabe, Rulindo, Gasabo	Completed
15	Organize training-of-trainers using new tools (HIV/AIDS and TB tools, guidelines, and protocols) in collaboration with RBC and target districts hospitals.	This training had been completed by RBC by the time the project started (2 people per district hospitals were trained).	All 43 district hospitals	Completed
16	Support integrated mentorship at the health facility level, including implementation of the new pediatric guidelines, viral load use, TB screening, etc.	This activity is not yet completed. We have been informed by RBC/HIV division that the approval of the names of mentors is pending at MoH.	Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana	Ongoing
Activity 1.2.3. Support implementation of integrated service delivery at the community level by CHWs				
17	Work with MoH to update IMCI/ICCM training materials for CHWs.	Supported through the Community Health TWG.	Community health workers	Completed
18	Conduct refresher training for CHWs on iCCM, including RDT use and quality control, in FHP-supported districts (including pre- and post-assessment review of competency).	TOT on iCCM has been completed. Training of CHWs will begin the second week of October.	CHWs	On going
19	Support printing and dissemination of CHW training tools.	Printing and distribution completed in August/September.	CHWs	Completed
20	Support health centers to conduct quarterly integrated supervision and reporting of CHWs' community-level activities.	USAID initial consent was required to give grants to government entities. Consent was requested on May 21 st and received on July 9 th . Pre-award assessments and budget discussions occurred thereafter. Grants to be issued pending USAID guidance on 2013-2014 budget and subsequent USAID approval.	96 health centers from Kirehe, Ngoma, Rwinkwavu, Nyarugenge, Kicukiro, Gasabo, Ruhango	Ongoing
Sub-result 1.3 Rwanda quality management strengthened				
Activity 1.3.1. Support quality improvement coordination and supervision at all levels				

IR 1 Progress

No	Activity and Description	Achievement	Beneficiary	Status
21	Collaborate with MoH to establish and operationalize district DHMTs through workshops to discuss roles/responsibilities (especially with respect to District Hospital leadership) and to share a minimum package of information on quality policies and procedures.	Supported multiple training sessions for 158 participants from Gasabo, Kicukiro, Rulindo and Gakenke; for 55 participants from Bugesera, Kamonyi, Muhanga, Ruhango, Nyaruguru, Nyamagabe, and Rutsiro; and for 54 participants from Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare, and Gicumbi.	DHMT members from Gasabo, Kicukiro, Rulindo, Gakenke, Bugesera, Kamonyi, Muhanga, Ruhango, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare, and Gicumbi	Completed
22	Collaborate with MoH to review quality indicators in integrated supervision and reporting tools.	Discussion with MoH took place, focused on how best to ensure integrated supervision. Meeting held with MoH and all district hospitals. Recommendations were made and will be followed up together with the MoH.	Gasabo, Kicukiro, Rulindo, Gakenke, Bugesera, Kamonyi, Muhanga, Ruhango, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare, and Gicumbi	Ongoing
23	Support supervision visits at decentralized levels (including DHMT, district hospitals, and health centers) through grants and mentoring.	The meeting with MoH, districts and hospitals to analyze current situation, challenges and possible solutions was done. Site visits by District Coordinators with District Health Unit have commenced. Supervision is occurring in most of the FHP supported sites and is being supported by the project, both through grants and through technical support.	Gasabo, Kicukiro, Rulindo, Gakenke, Bugesera, Kamonyi, Muhanga, Ruhango, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare, and Gicumbi.	Completed
Activity 1.3.2. Support quality committees at district hospitals and health centers; operationalize community-based quality councils in FHP-supported districts				
24	Support district hospitals and health centers to organize initial and follow-up meetings with quality management committees according to the MoH quality management framework.	Supported QI training for 136 participants from district hospitals in 9 districts.	Health providers from Rulindo, Gakenke, Gicumbi, Kamonyi, Nyaruguru, Muhanga, Ruhango, Nyamagabe, Rutsiro district hospitals	Completed
25	Conduct orientations for decentralized quality councils so that members (from the community) become familiar with their roles and responsibilities, reporting structures, and MoH expectations related to quality.	Supported the training of 84 members of quality committees from 14 district hospitals on QI. FHP district coordinators are continuing to support the district hospitals to conduct those quality committees internal meetings	Health providers from Gasabo, Kicukiro, Rulindo, Gakenke, Bugesera, Kamonyi, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare.	Completed

IR 1 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
26	Institutionalize the effective use of suggestion boxes at health facilities; ensure that boxes are opened with regularity by quality committees and that reports on suggestions are sent by the committees to the supervising institution.	Sensitized DHMTs to ensure that suggestion boxes are used at all levels (i.e. Districts Hospital and Health Centers). Quarterly DHMT meetings were initiated and members started to discuss the content of the suggestions boxes. Supported a community radio program in Nyagatare and Ngoma districts to engage the population in the process and give feedback to the suggestion box content. Additional community radio programs are planned for next year.	Gasabo, Kicukiro, Rulindo, Gakenke , Bugesera, Kamonyi, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare	Ongoing
Activity 1.3.3. Support the continuous quality improvement accreditation process				
27	Host a national workshop for dissemination of national district hospital quality standards.	Supported workshops to disseminate national district hospital quality standards to 158 health providers from 16 district hospitals	Gasabo, Kicukiro, Rulindo, Gakenke , Bugesera, Kamonyi, Nyaruguru, Nyamagabe, Rutsiro, Rwamagana, Kayonza, Ngoma, Gatsibo, Nyagatare, Gicumbi, Muhanga	Completed
Activity 1.3.4. Roll out PDSA quality improvement methodology at selected health facilities				
28	Organize training in PDSA cycles.	Supported PDSA training for 342 health providers	Health providers from 9 districts (Rulindo, Gakenke, Gicumbi , Kamonyi, Nyaruguru, Muhanga, Ruhango, Nyamagabe, Rutsiro)	Completed
29	Through collaborative forums, share successful practices across health facilities implementing PDSA.	Initiated PDSA cycle in 89 health centers. Promising practices were identified. Sharing meetings planned for October 2013.	Health center staff from 14 districts (Bugesera, Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza , Kicukiro, Ngoma, Nyagatare, Nyamagabe, Nyaruguru, Rulindo, Rutsiro, Rwamagana)	Ongoing

Annex II

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
Sub-result 2.1 Availability of facility-based services expanded				
Activity 2.1.1. Reinforce neonatal services in collaboration with the MoH				
1	Conduct a desk review of available assessments to map out neonatal needs.	Assessment and results shared with the neonatal subcommittee.	MCH TWG	Completed
2	Organize a meeting with district hospitals, implementing partners, and the Rwanda Pediatric Association to share information and decide on neonatal priority focus areas.	Results from the assessment shared with the DH and then with the partners through the neonatal subcommittee. The outcome was the development of the neonatal joint action plan.	MCH TWG	Completed
3	Identify procurement needs to USAID for neonatal equipment and tools for FHP-supported district hospitals.	Equipment needs submitted to USAID. Procurement is being processed by USAID but not by FHP.	11 DH: Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana	Completed
4	Support MoH to conduct theoretical training on neonatal care from the Emergency Triage Assessment and Treatment (ETAT) course , including resuscitation, in collaboration with Rwanda Pediatric Association.	Supported the neonatal training for 27 physicians and nurses from 10 DH	27 health workers in Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyamagabe, Rulindo, Rutsiro, Rwamagana	Completed
5	Facilitate a study tour with key members of the MoH to exchange best practices in neonatal care.	Terms of reference for the study tour were sent by the MoH after the close of the first project year.	MoH staff and FHP staff Rwandan population	Ongoing
6	Conduct on-the-job training (that reinforces theoretical training) and provide mentorship and monitoring in selected health facilities.	Training sessions for HC from the 14 DH completed in September.	Health providers from HC for the 14 DH	Completed
7	Conduct midterm and final term evaluations for each on -the -job training cycle.	Done in September.	Health providers from HC for the 14 DH	Completed
8	Certify (qualify) trained health providers who have received and passed on-the-job training.	Certification is contingent upon completion of the evaluations that occurred in September. As such, this activity was moved to the year two	Health providers from HC for the 14 DH	Not started

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		work plan.		
Activity 2.1.2. Reinforce child health services in collaboration with the MoH				Comments
9	Support production and dissemination of a child register and protocol for health facilities in FHP-supported districts.	Production completed and tools distributed in 11 districts.	Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Completed
10	Identify training needs in supported health facilities for in-service training in IMCI.	Training needs assessed in for Gakenke and Rutsiro districts	Health providers from Gakenke and Rutsiro	Completed
11	Organize and conduct training of district hospital health providers on IMCI.	IMCI training completed for Gakenke and Gatsibo districts. 61 health providers trained in Gakenke, 60 health providers trained in Gatsibo	121 health providers from Gakenke and Gatsibo	Completed
12	Conduct post-training follow-up of trained health providers on IMCI.	Trained 16 providers to conduct clinical IMCI follow up. Follow up visits conducted in all 14 districts. All health facilities were visited for follow up on clinical IMCI training. Analysis completed in mid-August.	Health providers from Gasabo, Kicukiro, Bugesera, Rutsiro, Kamonyi, Nyamagabe, Nyaruguru, Gakenke, Rulindo, Nyagatare, Gatsibo, Kayonza, Ngoma, Rwamagana	Completed
Activity 2.1.3. Expand access to FP services, including LAPM, at the health facility level				
13	Support printing and distribution of FP cards for FHP-supported health facilities.	20,000 FP cards printed and distributed in 11 districts	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Completed
14	Support review and update of FP training kits and organize a workshop to validate updated FP kits.	Supported revision of the community based provision of FP training module. This module was validated, and the tubal ligation module revision is ongoing. This was done through the FP TWG.	Health providers from all DH across the country /Rwandan population	CBP Training Kit Completed Tubal Ligation Training Kit Ongoing
15	Procure necessary equipment for provision of LAPM FP methods for selected health facilities.	Met with MoH staff to determine specifications. Currently in the procurement process.	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Ongoing

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
16	Provide mentorship, monitoring, and follow-up of on-the-job FP training in selected health facilities.	This activity was contingent upon the results from assessment of the challenges in current implementation of EMONC, FP, PAC, and PPH. The analysis of the assessment was finalized in September and will be presented to the technical working group.	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Not Started
17	Conduct midterm and final evaluations of each on-the-job FP training cycle.	This activity was contingent upon the results from assessment of the challenges in current implementation of EMONC, FP, PAC, and PPH. The analysis of the assessment was finalized in September and will be presented to the technical working group.	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Not Started
18	Certify (qualify) trained health providers.	This activity was contingent upon the results from assessment of the challenges in current implementation of EMONC, FP, PAC, and PPH. The analysis of the assessment was finalized in September and will be presented to the technical working group.	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Not started
19	Support target districts in training health providers on LAPM, including tubal ligation and vasectomy.	Training on semen analysis completed for 80 nurses and lab technicians from 7 districts. Training on vasectomy for 16 people in 4 districts. Tubal ligation trainings are contingent upon procurement of TL equipment.	80 nurses and lab technicians in semen analysis 16 providers in vasectomy	Completed
Activity 2.1.4. Support EMONC, PAC, and PPH care				
20	Conduct an assessment of the challenges in current implementation of EMONC, FP, PAC, and PPH care to support further planning in collaboration	Assessment conducted in 161 health facilities, analysis completed and will be presented	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
	with MoH and implementing partners.	to MCH TWG.		
21	Provide recommendations and develop an action plan to address identified challenges.	The project and the MCH desk used the assessment to plan activities for the following year.	Health providers from Gakenke, Gasabo, Gatsibo, Kamonyi, Kayonza, Kicukiro, Nyagatare, Nyamagabe, Rulindo, Rutsiro, Rwamagana districts	Completed
22	Scale up PPH and PAC through targeted training of health care providers and identify equipment needs to USAID.	160 nurses from 8 districts trained in PAC. PPH trainings are contingent upon results from pilot study (Jhpiego).	160 Nurses from Nyamagabe, Rwamagana, Gatsibo, Gakenke and Kamonyi	PAC Training Completed PPH Training Not Started
23	Support fistula prevention activities through grants to local and international organizations that support women with fistula.	RFA released and grant provision projected to start in November after receiving guidance from USAID. Pre-application/ orientation workshop held with applicants.	Nyagatare, Gatsibo, Kayonza, Rwamagana	Ongoing
Activity 2.1.5. Support provision of focused antenatal care (FANC)				
24	Scale up FANC services through targeted training of health care workers and procure necessary equipment.	Procurement ongoing for Nyagatare, Nyamagabe and Kamonyi. FANC training completed in the following districts: Ngoma: 28 health providers trained Nyarugenge: 24 health providers trained Ruhango: 27 health providers trained Kicukiro: 20 health providers trained Nyarugenge: 15 providers trained, Ngoma: 42 providers trained Kamonyi: 26 health providers Nyamagabe: 40 health providers	222 nurses	Training Completed Procurement Ongoing
Activity 2.1.6. Support implementation of the national EMTCT strategic plan				
25	Provide technical support to EMTCT district strategic planning in FHP-supported districts.	Supported development of EMTCT district plans for all FHP supported districts.	Health providers from Bugesera, Rwamagana, Kamonyi, Kayonza, Nyagatare	Completed
26	Procure SMS printers (which will	RBC requested to	Rwandan population	Not started

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
	ensure more rapid receipt of test results from the national lab) for early infant diagnosis in FHP-supported health facilities.	replace those machines by with Viral Load machines.		
27	Support printing of rapid finger prick testing materials (tools and instructions) for supported health facilities in FHP districts.	RBC carried this out.	Health providers in Bugesera, Nyaruguru, Ngoma, Rwamagana, Gatsibo, Kamonyi, Kayonza, Nyagatare, Rulindo, Gasabo, Nyamagabe	Completed by RBC
28	Distribute national EMTCT tools and instructions to FHP-supported health facilities and ensure correct implementation of EMTCT activities, including Option B Plus and early infant treatment.	The project provided technical support for the elaboration of the district EMTCT plans. RBC is planning to hire a consultant to finalize the plans. The project cannot support distribution until the plans are finalized.	Health providers in Bugesera, Nyaruguru, Ngoma, Rwamagana, Gatsibo, Kamonyi, Kayonza, Nyagatare, Rulindo, Gasabo, Nyamagabe	Ongoing
29	Train counselors in rapid finger prick testing in collaboration with RBC and district hospitals in supported districts.	Waiting for RBC to provide reagents for practical sessions.	Health providers in Bugesera, Nyaruguru, Ngoma, Rwamagana, Gatsibo, Kamonyi, Kayonza, Nyagatare, Rulindo, Gasabo, Nyamagabe	Not started
Activity 2.1.7. Provide on-the-job training and mentoring of nurses in task-shifting in HIV/AIDS				
30	Collaborate with RBC and district hospitals to organize on-the-job task-shifting training based on needs.	Trainings completed for 55 nurses from Nyamagabe, 23 from Nyaruguru, 29 from Gasabo, and 25 nurses from Rulindo.	132 nurses from Nyamagabe, Nyaruguru, Gasabo, Rulindo	Completed
31	Conduct post-training follow-up.	Completed in Nyamagabe and Nyaruguru, Kamonyi, Gasabo and Rulindo.	Health providers Nyamagabe, Nyaruguru, Gasabo, Rulindo, Kamonyi	Completed
Activity 2.1.8. Support establishment of youth corners in selected HCs				
32	Work with MoH to determine the equipment package needed to set up youth corners.	Health centers visited in Gatsibo April 17 and Kamonyi June 10 to assess gaps in necessary equipment. MoH has provided a list of necessary equipment	Health workers from Kamonyi and Gatsibo	Completed
33	Procure necessary equipment for two youth corners in selected HCs.	List created for 2 youth corners (YCs), approved by MoH and procurement process ongoing. should be finalized by November.	2 HC from Kamonyi and Gatsibo	Ongoing
34	Support the MoH adolescent sexual reproductive health and rights (ASRHSR) desk to conduct district-level meetings to orient	This activity began in July and ended in September.	Health workers from Kamonyi and Gatsibo	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
	HCs on how to reorganize services to accommodate youth corners.			
35	Support mentoring of health providers on sexual and adolescent reproductive health in the two FHP-supported HCs with youth corners.	This cannot begin until the orientations occur. As such, this activity is being considered for the following year.	Health workers from Kamonyi and Gatsibo	Not started
36	Provide ongoing support and mentorship to ensure smooth operations.	This cannot begin until the orientations occur. As such, this activity is being considered for the following year.	Health workers from Kamonyi and Gatsibo	Not started
Activity 2.1.9. Establish new sexual and gender-based violence one-stop centers in two FHP-supported districts				
37	Support the MoH/DHMT to conduct a situational analysis in two FHP-supported district hospitals to guide establishment of one-stop centers in collaboration with the Rwanda National Police.	Assessment completed in December for Gakenke and Bugesera.	Bugesera and Gakenke districts	Completed
38	Carry out needed procurements for one-stop-centers in two hospitals.	Materials have been purchased and distributed in July.	2 one stop centers for Bugesera and Gakenke	Completed
39	Support the training of one-stop - center health providers in two hospitals.	Theoretical and practical trainings held for 46 providers from Gakenke and Bugesera districts April 22-26, May 6-10, May 20-31	Health providers from Nemba and Nyamata DHs	Completed
Activity 2.1.10. Support fistula prevention and care				
40	Provide training in fistula clinical treatment through grants to local and or international organization to train surgeons and nurses in fistula repair.	This activity was reformulated and efforts are now focused on fistula prevention, which is being done through grants that are in process.	Rwandan population	Ongoing
41	Support access to and quality of emergency obstetric care to reduce the need and improve the quality of C- Sections.	Theoretical training May 22-24, practical training June 3-12 in Musanze for 22 health providers from Bugesera, Nyamagabe, Ngoma, Gasabo, Rwamagana, Gatsibo, Gakenke, Kamonyi, Nyaruguru, Kayonza, Rulindo, Ruhango, Kicukiro, Muhanga and Rutsiro	22 health providers from Bugesera, Nyamagabe, Ngoma, Gasabo, Rwamagana, Gatsibo, Gakenke, Kamonyi, Nyaruguru, Kayonza, Rulindo, Ruhango, Kicukiro, Muhanga and Rutsiro districts	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		districts.		
42	At the national level, work with the MoH to improve fistula prevention by integrating fistula messages with other maternal health and family planning awareness programs.	RFA released and grantee selected	Rwandan population	Ongoing
43	Provide technical support to the National Safe Motherhood Technical Working Group and the fistula subcommittee, which provides a forum for groups working on fistula to coordinate their efforts and support the development of national norms, protocols, and tools for treatment and prevention.	Continuing activity.	TWG	Ongoing
Sub-result 2.2 Availability of community-based services expanded				
Activity 2.2.1. Scale up maternal and neonatal verbal autopsy; plus child, neonatal, and maternal death audits in FHP-supported districts				
44	Support training of in-charge of social affairs at the sector level, nurses, and CHW in-charge in verbal autopsy in two districts.	49 and 47 Health providers from Rutsiro and Nyagatare Districts have been trained on death audits from April 15th to 18th 2013 and from 2nd to 5th April, 2013 respectively.	Health providers and local leaders	Completed
45	Train health providers in FHP-supported HCs on maternal, child, and neonatal death audits (which are conducted by CHWs) in collaboration with MoH and district hospitals in supported districts.	Combined with the activity above	Health providers and local leaders	Completed
Activity 2.2.2 (continuation of 2.1.5). Expand access to FP services at the community level				
46	Support operations of secondary posts in FHP-supported facilities' catchment areas to provide FP services.	This is an ongoing activity because all secondary posts of family planning are operational now and continue to receive support in quality improvement by our district based staff.	Rwandan population	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
47	Support the MoH to conduct CHW training on community-based provision of FP in one district.	FHP supported the validation of 489 CHWs in Nyagatare district, and conducted training of trainers of 28 providers and 946 CHWs in Rwamagana District. Among them 833 CHWs have been validated and all needed material distributed to help them start to provide services.	Community Health Workers in Nyagatare, Rwamagana, Ngoma and Gasabo.	Completed
Activity 2.2.3. Strengthen implementation of community-based nutrition programs in FHP-supported districts				
48	Distribute copies of community-based nutrition program training materials in selected health facilities in FHP-supported districts.	Training materials have been distributed in Rulindo, Gasabo, Gakenke, and Kicukiro districts by end September 2013.	Health facilities	Completed
49	Train health care providers to train CHWs on CBNP using maternal, infant, and young child nutrition (MIYCN) training materials.	We initiated cascade training of CHWs by training 25 health care providers on CBNP using maternal, infant and young child nutrition training materials.	Health providers	Completed
50	Organize CHWs' training on community-based nutrition programs using MIYCN training materials.	This training has been completed for CHWs from 2 districts (1234 from Gakenke and 1021 from Rutsiro) on CBNP using MIYCN training materials. Training for CHWs includes promotion of breast feeding, nutrition for mothers and identifying & categorizing malnutrition.	Community Health Workers	Completed
Activity 2.2.4. Build capacity of CHWs to address gender-based violence issues at the community level				
51	Support the review and validation process of the CHW gender-based training module through the gender-based violence TWG.	Supported the review and validation process of the CHW gender-based training module, which was finalized and accepted by December 2012	GBV TWG	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
52	Train trainers on gender-based violence for community health in-charge and gender-based violence focal person from HCs in collaborate with district hospitals in targeted districts.	Established of sexual and gender-based violence one-stop centers in Nyamata in Bugesera and Nemba in Gakenke. We trained a total of 63 trainers (28 in Bugesera and 35 in Gakenke) on gender-based violence	63 trainers from 2 districts (Gakenke and Bugesera)	Completed
53	Support training of CHWs on how to orient and refer gender-based violence cases from the community to health service delivery points.	In close collaboration with MoH we trained 2,990 CHWs: 1,742 in Bugesera and 1,248 in Gakenke, on how to orient and refer gender-based violence cases from the community to health service delivery points.	Community health workers from Bugesera and Gakenke	Completed
54	Support the launch and introduction of the newly established one-stop centers to the community through a district-led event.	Two one stop centers were identified and staff trained. The launches occurred in September.	Rwandan population	Completed
Activity 2.2.5. Strengthen availability of CHW kits in target districts				
55	Consult with community health desk to assess CHW supply needs (e.g., medical supplies, torches, gum boots, umbrellas).	This assessment was completed and the list of needed kits (bags, cupboards and torches) has been shared by the CH desk.	Community health workers of FHP-supported districts	Completed
56	Procure and distribute CHW kits in Gasabo, Kicukiro, Nyarugenge, Ruhango, Kirehe, Kayonza and Ngoma districts	Procurement in process and will be completed by end of October	CHW of Gasabo, Kicukiro, Nyarugenge, Ruhango, Kirehe, Kayonza and Ngoma districts	Ongoing
Activity 2.2.6 (continuation of 2.1.3). Reinforce antenatal and neonatal care at the community level in collaboration with the MoH				
57	Collaborate with the MoH to organize refresher training for community health workers on ANC, neonatal care, and post-birth activities at the community level in two districts.	Training of trainers has been completed for 27 trainers from 8 health centers of Nyarugenge district and Muhima District Hospital. The training of Community Health Workers in charge of Maternal and newborn health has also been completed. This activity was conducted in close collaboration	27 Health providers and 341 ASM	Completed

IR 2 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		with MoH/CHD and Muhima District Hospital		

Annex III

IR 3 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
Activity 3.0.0. Improve coordination with BCC stakeholders				
1	Collaborate with the MoH to set up an integrated national health BCC TWG.	FHP initiated the Health Promotion (HP) Technical Working Group (TWG) in collaboration with MoH, RBC and other implementing partners including Imbuto Foundation, faith based organizations, local NGOs such as URUNANA technical staff. We developed the terms of reference to define its functions, organizational and operational arrangements and proposed the permanent members of the group. RBC/RHCC decided after consultations that the leadership and coordination team will include the Chair of the HP TWG who is the head of RHCC, the Co-Chair as FHP and the secretary from RHCC. The HP TWG meets every month and is active in reviewing and approving policies (HP), strategic plans (HP, 1000 Days of Nutrition), health related messages (e.g. PAC and Nutrition) and organizing different campaigns (WAD, Nutrition, MCH).	Central level	Completed
2	Contribute to action planning for the integrated TWG.	Through the Health Promotion TWG and in close collaboration with Aimee Naganze from RHCC, drafted action plan with accompanying budget for the first year. The budgeted work plan for the HP TWG was submitted to the head of RHCC and shared with MoH, RBC and implementing partners to request their financial contribution to the budget.	Central level	Completed

IR 3 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
3	Contribute to national campaigns and national sensitization days as agreed with the BCC TWG and USAID.	Contributed to the preparation for and organization of the Health Sector Open Day with the media on February 7, 2013. Contributed to the preparation for and organization of the World Aids Day campaign through its steering committee (Sept-Dec 2013), MCH Week through the socio-mobilization committee (October 2012) and the 1000 days of Nutrition campaigns through HP TWG (April-September 2013).	Central and district level	Completed
Sub-result 3.1 Awareness and motivation to seek provider services in a timely manner improved.				
Activity 3.1.1. Support the development of BCC/information, education, and communication (IEC) packages				
4	Conduct a desk review of all IEC and BCC materials developed for use in communities and by CHWs and health facility staff.	A draft with over 100 items is available at RHCC level and is being updated as new materials are produced. The activity was included in the Health Promotion TWG work plan. The draft will be presented in the next HP TWG. Anticipated to be completed by end of October 2013.	Central and district level	Ongoing
5	If needed, support the development/updating, pretesting, and validation of new materials.	Designed and printed 5,573 Malaria posters on bed net use in 89 health facilities.	89 health facilities	Completed
Activity 3.1.2. Create awareness regarding FP, ANC, and nutrition services at the community level by utilizing various communication materials and strategies				
6	Produce a short educational video with a focus on known issues related to FP, ANC, and nutrition and distribute to all HCs, hospitals, and the national TV network.	Malaria campaign was also included in this integrated campaign after discussions with RBC/Malaria division team. A detailed plan as part of the request for proposal (RFA) for the campaign was developed in collaboration with MCH department and RBC. The goal of the RFA is to prepare the integrated campaigns on FP, ANC, Nutrition and Malaria. It was approved and posted in newspapers. The team found that it is strategic to use theatre and use	Kayonza and Rwamagana Districts	Ongoing

IR 3 Progress

No	Activity and Description	Achievement	Beneficiary	Status
		available videos during the campaign. The theatre play will be produced as soon as the procurement/ grantee selection process on the local NGO to work with is done. The FHP technical evaluation team evaluated all 13 applicants and a pre-award assessment was organized on October 3, 2013. The winner is expecting to start with November 2013.		
7	Print evidence-based communication materials focused on ANC, FP, and nutrition developed by the Rwanda Health Communications Center.	All communication materials will be printed after the development process, which will include a local NGO (Grantee). Review and approval will be done by a steering committee on FP, ANC, Nutrition, Malaria, RHCC (that was identified during preparation meetings). Anticipated to be completed by November 2013.	Kayonza and Rwamagana	Ongoing
8	Develop and print a checklist to be used during follow-up home visits by CHWs to evaluate changes in awareness and motivation created by the campaign.	A draft was developed and is awaiting harmonizing with the campaign messages. Anticipated to be completed by November 2013.	Kayonza and Rwamagana	Ongoing
9	Conduct a pre-survey using the checklist developed in the previous task	Will be conducted after a local NGO is selected. Anticipated to be completed by mid-November, 2013.	Kayonza and Rwamagana	Ongoing
10	Collaboration with MoH to conduct orientation and planning meetings for local leaders (including the Rwanda Association of Local Authorities), media representatives (community radio), and CHWs to increase community awareness of the availability, accessibility, and utilization of FP (including LAPM), ANC, and nutrition services.	The steering committee that was identified during the preparation meeting on July 5, 2013 in collaboration with MCH department recommended to organize the orientation and planning workshop after the local NGO grantee is selected so they can be involved in this important process. Budget prepared. Anticipated to be completed by Mid-November 2013.	Kayonza and Rwamagana	Ongoing
11	During implementation of sensitization campaigns, organize screening of video followed by facilitated debates and distribution of leaflets.	A local NGO (grantee) is being selected and will facilitate this activity in collaboration with the	Kayonza and Rwamagana	Ongoing

IR 3 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		campaign steering committee and the CHWs. Anticipated to be completed by Mid-November 2013.		
12	Begin producing a film documenting community discussion around the educational film and focusing on community-oriented solutions and best practices related to FP, ANC and nutrition issues.	Recruitment process of the firm that will work with the grantee during the campaign activities is ongoing. They will start activities as soon as the Grantee is selected. Anticipated to be completed by Mid-November 2013.	Kayonza and Rwamagana	Ongoing
13	As part of the sensitization campaigns, organize a weekly radio quiz for one month on ANC, FP, and nutrition and provide prizes for the three best-performing families per district.	The weekly radio quiz will begin the month after the campaign to continue spreading the messages to the community and see if they really captured something. Anticipated to be completed by December 2013.	Kayonza and Rwamagana	Ongoing
14	Support CHWs to conduct home visits and use checklist to evaluate the effects of the campaign.	Home visits will be conducted after the campaign to evaluate its effect. Anticipated to be completed by Mid-November 2013 after guidance from USAID is secured.	Kayonza and Rwamagana	Ongoing
Activity 3.1.3. Support health facilities to conduct HIV-focused sensitization activities with relevant members of the community				
15	Support the health facilities in four selected districts to organize sensitization meetings with people living with HIV/AIDS (PLWH) associations/cooperatives to discuss and share experiences related to positive living and transmission prevention.	The FHP team supported all health facilities that provide ART services to conduct sensitization meetings for 98 PLWH and 60 nurses in charge of ART from Nyaruguru, Bugesera, Ngoma and Nyagatare districts. This activity was completed in June 22, 2013.	Nyaruguru, Bugesera, Ngoma and Nyagatare	Completed
16	In four selected districts, organize disclosure meetings between parents/guardians with children and adolescents living with HIV in collaboration with supported district hospitals and health facilities.	These meetings are being conducted monthly in Nyaruguru, Bugesera and Ngoma. Nyagatare requires extra training for better implementation.	Nyaruguru, Bugesera, Ngoma and Nyagatare	Completed
Sub-result 3.2 Family implementation and follow-up healthy behaviors strengthened				
Activity 3.2.1. Support implementation of the community-based environmental health program in two FHP-supported districts				
17	Support districts to organize orientation workshops of relevant local authorities (administrative district, district hospital,	These meetings helped in identifying the needs for printing training materials	Kicukiro and Rulindo	Completed

IR 3 Progress

No	Activity and Description	Achievement	Beneficiary	Status
	and HCs) on community-based environmental health.	and organizing trainings at district, sector, cell and village level.		
18	Provide support to print training materials, manuals, dialogue tools, membership cards and cloths for CBEHPP program.	Printed 51 training manuals for ToTs, 910 training manuals for hygiene clubs executive committee members, 853 dialogue tools and 109,902 membership cards for hygiene club members.	Kicukiro and Rulindo	Completed
19	Support MoH and the district to organize training of trainers for environmental health officers and in-charge of social affairs.	27 ToTs organized and conducted in Kicukiro (March 4-8, 2013) and 42 in Rulindo (March 11-15, 2013).	Kicukiro and Rulindo	Completed
20	Support training of CHWs and in-charge of socioeconomic development (cell level) on environmental health pending revisions to CHWs role.	Trained the in-charge of social affairs (ASOC) at cell and village level in Kicukiro (365, on March 18-29, 2013) and Rulindo (565 on April 15 – 27, 2013).	Kicukiro and Rulindo	Completed
21	Facilitate CHW training of executive committee of hygiene clubs on environmental health.	Trained Executive Committee members from hygiene clubs from Kicukiro (1902 on April 15-19, 2013) and Rulindo (2963 on May 6-17, 2013) on CBEHPP.	Kicukiro and Rulindo	Completed
22	Identify, document, and share best practices of hygiene clubs in communities of supported districts.	Success stories and best practices were shared during coordination meetings organized in August and September for Kicukiro and Rulindo districts. Supervisors of community hygiene clubs at sector level also shared ideas on how to solve identified challenges during the implementation of the program. It was determined that coordination meetings are the best way to follow up the implementation of the program and share best practices. These meeting will be held quarterly at district level after village, cell and sector level supervision.	Kicukiro and Rulindo	Completed
23	Provide technical and financial support to the M&E process (supervision visits and data collection) .	We printed reporting books (821) for Kicukiro and Rulindo districts and supported supervision and coordination meetings during which CHC monthly reports are collected by the district.	Kicukiro and Rulindo	Ongoing

IR 3 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		All Kucukiro sectors developed annual work plans on implementation of CBEHPP during the last coordination meetings. Rulindo district sectors will develop their annual work plans during a coordination meeting planned for October 9-10, 2013.		
Activity 3.2.2. Use lessons learned to create a plan for scaling up community mobilization activities in other service areas in Year 3				
24	Work with MoH to develop an action plan for scaling up the community-based environmental health model to other service areas.	During the trainings and the implementation of the program, we have been collecting lessons learned and challenges from different villages. Together with MoH/MCH/EHD team, we planned to review existing materials, increase involvement of administrative and health facility authorities and use media to contribute to the success of the program.	Kicukiro and Rulindo	Completed

Annex IV

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
Sub-result 4.1 Facility functionality and equipment, supply, and logistics systems improved				
Activity 4.1.1. Support implementation of the new LMIS at the district and health facility level in FHP-supported districts				
1	Collaborate with MoH and partners in providing input through the Logistics Management Office to develop and plan roll out of LMIS in the districts and health centers	Provided national level Logistics Management System support through Logistics Management Office (LMO). Three meetings were organized with Logistics Management Office (LMO) lead by Joseph Kabatende. The meetings were also attended by Philip, eLMIS project Manager, and the LMIS roll out plan was shared by the LMO. The team also participated actively in the 3 day workshop for eLMIS review involving senior MoH officials.	LMO	Completed
2	Advocate for appropriate support (training, support systems, supervision, etc.) during planning and rolling out of LMIS on behalf of end users at the health center level.	Advocacy was achieved through meetings held with Logistics Management Office (LMO). Three meetings with members of the LMO were successfully organized and eLMIS roll out plans were shared.	LMO	Completed
3	Collaborate with MoH and partners to develop, test and roll out an integrated logistics management supervision tool.	FHP discussed supervision with MoH and districts. All parties are cognizant of the need to reinforce existing mechanisms including development of appropriate tools. The process will be informed through LMIS roll out. Supervision Tool development will follow the implementation of eLMIS.	LMO and supported Districts	Not Started
Activity 4.1.2. Scale up Open MRS in target districts				

IR 4 Progress

No	Activity and Description	Achievement	Beneficiary	Status
4	Assess facilities' capacity to implement Open MRS (minimum staff, hardware, software).	Assessment was carried at health facilities (12 district hospitals and 21 health centers) across 15 supported districts in line with the list of system requirements obtained from eHealth team. Assessment of health facilities to establish equipment and infrastructure needs was successfully conducted.	Health Facilities	Completed
5	Identify HCs with basic capacity to implement Open MRS.	31 health facilities were selected to implement Open MRS including (11 DH and 20 Health Centers). Staff at Kibagabaga hospital (already fully equipped with IT equipment and local area network) were oriented on site on the use of Open MRS. FHP's Medical Records Specialist and Health Systems Specialist are providing ongoing support to ensure the system is utilized.	Health Facilities	Completed
6	Develop a cost proposal and deployment strategy for rolling out Open MRS in some or all facilities with basic capacity (depending on budget implications).	A cost estimate of the equipment and cabling for 30 health facilities was developed.	Health Facilities and system end users	Completed
7	Deploy Open MRS infrastructure in selected HCs in FHP-supported districts.	A supplier of IT equipment and cabling services was selected and submitted to USAID for approval. Server installation, set up and Open MRS configuration were completed for 25 facilities. LAN signal and connectivity tested for 8 facilities as well as mapping of workstation computers at 10 facilities. Regular updates were provided to the EMR team. The project also set up equipment and installation to allow health centers to start using Open MRS	Health facilities	Ongoing (Servers and Open MRS installation was completed on computers that were already available in these sites. Extra cabling and equipment is still needed and will be completed

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
				in Q1 FY 14)
8	Train health facility data managers/data entry clerks in management, administration, and use of Open MRS.	Onsite orientation is complete for all sites which includes 124 end users oriented to use the Open MRS system. A formal group training of all users will be held after equipment deployment and installation.	Open MRS end users	Ongoing
9	Facilitate retrospective data entry or importation from existing health information systems into Open MRS.	Patients' records have been imported from IQChart at 25 facilities and data entry of complementary data sets and overall system data updates is in progress. The project supported the EMR team to develop a data importation module (from IQChart to Open MRS) which is being used to import data in sites where IQChart was being used (supported by former implementing partners). The system will continue to be updated on a regular basis. District Coordinators closely followed to ensure that challenges are reported to IR4 team to help the sites overcome those challenges.	Health facilities	Completed
10	Develop user queries or reports to be generated at the facility to inform clinical and management decisions.	Liaised with EMR team to update and fix bugs in VCT/PMTCT modules, and oriented end users at facilities on how to use various queries and reports populated in the system to inform clinical and management decisions. In addition, the IR4 team continues to provide ongoing support.	Health facilities	Completed
Activity 4.1.3. Strengthen health facility safety and waste management systems				

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
11	Conduct an assessment of health facility waste management systems to identify needs and develop an action plan.	Preparation for this activity was initiated. A scope of work for the consultancy was developed, and potential candidate consultants have been identified. The IR4 Team Leader is gathering information about assessments done in the past in the area of waste management in Rwanda so that information can be used during the desk review once the assessment begins. It is estimated that the consultant will be identified and mobilized by the end of October.	Beneficiaries are the district hospitals and Health centers. The number of health facilities to be assessed will be determined through a sampling methodology which will be designed in close collaboration with the MoH once the consultant is on board.	Ongoing
Sub-result 4.2 Facility management improved				
Activity 4.2.1. Support district-level planning and decision-making (encompassing district hospitals and health facilities)				
12	Liaise with districts to include data analysis findings from health management information systems on the DHMT meeting agenda to increase evidence-based decision-making at the district level.	FHP organized and facilitated meetings with each of the 17 project supported districts. These meetings took place from April 23 to June 13. At the meetings, the District M&E Officer presented data and a member of the project M&E team facilitated the discussions. In addition, FHP trained 300 health providers (data managers and in-charge of antiretroviral therapy [ART] clinics) from 160 health facilities including 7 district hospitals to ensure that they have requisite skills to maintain data quality and use. This is a continuing activity whereby DHMTs will hold discussions based on data to inform the decisions they make at the district, health center and community level.	Beneficiaries were all members of DHMTs in 17 supported districts. On the other hand beneficiaries of TRACnet, DHIS2, Documentation, reporting and data demand and information use (DDIU) training were the health facility data manager and in-charge of ART clinic	Completed

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
13	Strengthen DMHT capacity to use data for evidence-based decision-making through mentoring on use of the existing health management information system to create and use information dashboards.	The FHP M&E team leader organized and finalized the training with the Director General of Planning, M&E and Health Information System.	38 members of DHMT, namely the District Health Director and the District M&E officer	Completed
Activity 4.2.2. Improve management functions of DHMT through capacity building				
14	Conduct training in management, operational systems (financial, human resources, etc.) in supported district hospitals.	The training took place from June 17-19, 2013 in Musanze for 49 trainees including 25 hospital accountants and 24 human resource managers. FHP in collaboration with MoH continues to collect information to inform other areas of operational systems to be focused on.	49 hospital management staff (25 accountants, 24 Human resource managers	Completed
15	Support organization of quarterly DHMT management meetings in supported districts.	The launch of the operationalization of the DHMT took place in Musanze on March 27th and attended by DHMT members for Gakenke, Rulindo, Gasabo and Kicukiro. The second workshop took place in Muhanga on March 28th. Districts represented there were Muhanga, Kamonyi, Ruhango, Rutsiro, Nyaruguru, Nyamagabe and Bugesera. The last DHMT operationalization workshop took place in Rwamagana on April 2nd. Districts present were Rwamagana, Gicumbi, Kayonza, Gatsibo, Ngoma and Nyagatare. The launch workshops were followed by district level quarterly DHMT meetings organized by the DHMTs in collaboration with the project District Coordinators from April 23 to June 13. The project organized another round of quarterly DHMT meetings in August and September.	DHMT members from 17 supported districts	Completed
Activity 4.2.3. Build operational system management capacity of health facilities				

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
16	Conduct an assessment of supported facilities operational systems	The project has discussed with the MoH the need to assess other areas of operational systems that can be supported in the second year and the project is waiting for MoH concurrence before proceeding.	Health Facilities	Ongoing
17	Use the results of the operational systems assessment to develop a capacity building plan for sharing with USAID and MoH	This element will be informed by the above activity.	Health Facilities in supported districts	Ongoing
18	Once approved, implement the operational systems building plan	Although the project has not assessed operation systems capacity and developed a plan, we have done systems level capacity building through trainings in HR and accounting in collaboration with the MoH.	Health Facilities in supported districts	Completed
19	Support the implementation of the site capacity assessment (including data collection and analysis)	Discussions were held between FHP, USAID and MoH. The assessment will be conducted after further guidance is provided from MoH/USAID.	Selected districts (administrative districts and health facilities)	Not Started.
Activity 4.2.4. Improve commodity supply management at the facility level				
20	International consultant to use the results of the capacity assessment (see above) to identify or develop a training module on commodity supply management for health facilities. Close collaboration with IPs on the ground to ensure streamlined approach.	This element will be informed by the above Facility Capacity Assessment (FCA). The module already exists as confirmed by Mr. Joseph Kabatende. The need to update it will be clear once results of the assessment are available.	Health Facilities	Ongoing
21	Commodity management trainings to be implemented	Planning for this training began in collaboration with Logistics Management Office. However this activity is on hold per instructions from USAID. FHP will continue to engage with USAID and MOPDD to reach a consensus on what areas to focus on in FY 2014	All health Facilities in supported districts	Ongoing
22	On-going support and mentoring provided by FHP staff, including district coordinators	FHP's District Coordinators conducted site visits with the District Health Unit members	All health Facilities in supported districts	Completed

IR 4 Progress				
No	Activity and Description	Achievement	Beneficiary	Status
		(DHU), and as part of the overall oversight of health providers to ensure progressive skills development through supervision. Commodity and supply management supervision in integrated with other supervisions taking place.		
Sub-result 4.3 Management of CHW Cooperatives strengthened				
Activity 4.3.1. Build capacity of CHWs to manage and improve cooperatives' performance				
23	Issue competitive bids and select organizations to continue supporting existing cooperatives and improve cooperative implementation through capacity building and training.	There was considerable dialogue about cooperative activities between USAID, FHP and MoH prior to approval on May 8th. Following the approval, the project, in collaboration with the Community Health Desk finalized and published the Request for Application (RFA). A pre-application workshop was completed with potential bidders. The two best bidders were selected to receive grants to support CHWs cooperatives in two districts.	30 CHWs cooperatives in Rwamagana (14) and Nyamagabe (16) districts	Completed
24	Organize initial training for all grantees on cooperative development (income generation, business planning, value chains, financial markets, basic accounting/finance, private sector linkages, etc.) and USAID grant regulations.	This activity will be implemented after selection of local NGOs (at most two or one if it has optimum capacity), and orientation on the scope of work and USAID regulations. Training of the winner(s) of the bid will be conducted before they start implementation of activities on the field.	2 best bidders	Not started
25	Support and monitor grantees providing support and training to CHW cooperatives.	Monitoring is a continuing activity whereby grantees will collect and report information on how support provided has been beneficial to CHWs cooperatives. This task is to be done after the above step is completed.	30 CHWs cooperatives in Rwamagana (14) and Nyamagabe (16) districts	Not started