

Ingobyi Activity

FY19 Quarter 3 Progress Report

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1. Acronyms and Abbreviations

| | |
|----------|--|
| ANC | Antenatal Care |
| ASRH | Adolescent Sexual and Reproductive Health |
| CEHO | Community Environmental Health Officer |
| CHWs | Community Health Workers |
| DH | District Hospital |
| DHMT | District Health Management Team |
| DG | Director General |
| DFI | DHMT Functionality Index |
| DQA | Data Quality Audit |
| EmONC | Emergency Obstetric and Neonatal Care |
| EMR | Electronic Medical Records |
| FCC | Family Centered Care |
| FGDs | Focus Group Discussions |
| FP | Family Planning |
| GBV | Gender-Based Violence |
| GOR | Government of Rwanda |
| HBB | Helping Babies Breathe |
| HC | Health Center |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| HP | Health Promotion |
| IOSCs | Isange One Stop Centers |
| IR | Intermediate Results |
| ISS | Integrated Supportive Supervision |
| JADF | Joint Action Development Forum |
| LDHF | Low Dose High Frequency |
| M&E | Monitoring and Evaluation |
| MCCH | Maternal, Child and Community Health |
| MCH | Maternal and Child Health |
| MNCH | Maternal, Neonatal and Child Health |
| MINALOC | Ministry of Local Government |
| MOH | Ministry of Health |
| MPs | Members of Parliament |

| | |
|------------|---|
| NISR | National Institute of Statistics of Rwanda |
| OB&GYN | Obstetricians and Gynecologists |
| PNC | Post-natal Care |
| QA | Quality Assurance |
| QI | Quality Improvement |
| QoC | Quality of Care |
| RAM | Rwanda Association of Midwives |
| RBC | Rwanda Biomedical Center |
| RHCC | Rwanda Health Communication Center |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| RMNCH | Reproductive, Maternal, Newborn and Child Health |
| RPA | Rwanda Pediatric Association |
| RPRPD | Reseau des Parlemantaires Rwandais pour la Population et le Development (Rwandan Parliamentary Network on Population and Development) |
| RSMP | Rwanda Social Marketing Program |
| RSOG | Rwanda Society of Obstetricians and Gynecologists |
| SARA | Service Availability and Readiness Assessment |
| SBC | Social Behavior Change |
| SFH | Society for Family Health |
| STTA | Short Term Technical Assistance |
| TWG | Technical Working Group |
| UNFPA | United Nations Fund for Population Activities |
| Urunana DC | Urunana Development Communication |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

2. Activity Description

Activity information

| | |
|---|--|
| Activity title | Ingobyi Activity |
| Agreement number | 72069618CA00005 |
| Name of prime implementing partner | IntraHealth International |
| Names of sub-awardees | Akros Ingenuity Ltd. Society for Family Health (SFH) Urunana Development Communication World Vision Rwanda Rwanda Association of Midwives (RAM) Rwanda Pediatric Association (RPA) Rwanda Society of Obstetricians and Gynecologists (RSOG) |
| Activity start date | July 27, 2018 |
| Activity end date | July 26, 2023 |
| Report period | April 1, 2019 to June 30, 2019 |
| Total estimated budget amount | \$48,494,690 |
| Total funds obligated to date | \$14,807,993 |
| Actual expenditure to date (June 30, 2019) | \$3,888,931 |
| • FP | \$1,513,037 |
| • MCH | \$1,970,893 |
| • Malaria | \$255,877 |
| • Water | \$141,619 |
| • Ebola | \$7,505 |
| Estimated remaining obligated funds | \$10,919,066 |

Activity description, objectives and expected results

The Ingobyi Activity is a five-year cooperative agreement to improve the quality of reproductive, maternal, newborn and child health (RMNCH) and malaria services, in a sustainable manner with the goal of reducing infant and maternal mortality in Rwanda. The Ingobyi Activity builds upon the tremendous gains Rwanda has made in the health sector as well as previous USAID investments in the health sector.

Ingobyi’s efforts aim to contribute to the reduction of infant and maternal mortality and incidence of malaria in Rwanda by improving the availability, quality and utilization of RMNCH and malaria services with resilience and sustainability. The Activity partners with the Government of Rwanda (GOR) to build on the country’s considerable achievements, guided by national health strategies, goals, objectives and data. Beyond building capacity and capability, the Activity is focused on achieving shared understanding of patterns and systemic structures that underlie the health system and where and how to bring about measurable, sustainable improvements.

Ingobyi Activity is expected to deliver three Intermediate Results (IR) as outlined below in its results framework.

| Strategic Objective: To improve the utilization and quality of RMNCH and malaria services in a sustainable manner | | |
|---|--|--|
| <u>IR 1: Increased equitable access to RMNCH and malaria services in targeted districts</u> | <u>IR 2: Improved quality of high impact RMNCH/malaria services along the continuum of care in targeted districts</u> | <u>IR 3: Strengthened performance of the health system at central and decentralized levels</u> |
| Sub-intermediate results: | | |
| 1.1 Increased availability of RMNCH and malaria services | 2.1 Improved provider skills in RMNCH and malaria (doctors, nurses, midwives and CHWs) | 3.1 Strengthened capacity at the national and decentralized levels to plan and manage RMNCH and malaria services |
| 1.2 Improved health-seeking behaviors for RMNCH and malaria services | 2.2 Institutionalized quality improvement approaches for RMNCH and malaria interventions | 3.2 Strengthened capacity of hospitals to achieve RMNCH and malaria-related accreditation indicators |
| 1.3 Strengthened referral linkages for RMNCH and malaria services between, and across different services and levels of service delivery | 2.3 Improved standardization of RMNCH and malaria services | 3.3 Strengthened capacity for district planning, reporting, and evaluation (M&E) frameworks |

To deliver intermediate results, Ingobyi applies a strategic, results-oriented, and multi-pronged technical approach that addresses key bottlenecks and inspires the health system to respond to RMNCH and malaria prevention and treatment needs of the Rwanda population. Ingobyi Activity works with the GOR to improve the resilience and sustainability of the health system, and thereby improve the availability, quality and utilization of RMNCH and malaria services. Technical support, provided at all levels of the health system, is based on national policies, clinical protocols, and global evidence relevant to integrated reproductive health/family planning, maternal health, neonatal health, child health and malaria prevention and treatment. The strategy is built upon the understanding that the Rwandan experience and leadership, supported by the Activity's resources and knowledge, will strengthen the health system and the services it provides to more effectively contribute to a healthier population. Ingobyi grounds its strategy in a country-led partnership with stakeholders in the Rwandan health system, USAID and other implementing partners.

Key Interventions delivered by Ingobyi Activity to achieve expected results include the following, among others:

- Competency-based skills building through clinical training and mentorship. This is a tailored approach aimed to build the capacity of health care providers. Using an onsite “Low Dose High Frequency” (LDHF) training approach, Professional associations provide training and mentorship to health providers at district hospitals, and District based mentors conduct mentorship for health center providers.
- Systems strengthening focused on supporting district health units to organize regular DHMTs meetings to prioritize and respond to key health challenges, strengthening the referral system to improve case management, advocacy for improved infrastructure, HRH and equipment maintenance, contribution to the development of policies and guidelines, and integration of quality improvement across all services.
- Training community health workers (CHWs) on community level packages, including integrated community case management (iCCM), community-based maternal and newborn health (CB-MNH), and community-based program on family planning (CBP-FP).
- Technical support to health providers through clinical mentorship delivered by experienced medical specialists in infection prevention and control at facility levels to reduce infections and contribute to reduction in morbidity and mortality.
- Promoting healthy behaviors and demand creation through radio broadcasts (drama series, talk shows and spots), community outreach – integrated RMNCH/M messaging and service delivery, and health communication for clients at health facility level.

Additionally, Ingobyi promotes high impact globally approved RMNCH and malaria interventions to increase access to high quality services for mothers, newborn, children and adolescents. In maternal health, Ingobyi promotes antenatal care (ANC), postnatal care (PNC), Emergency Obstetric and Newborn Care (EmONC), safe C-sections, Respectful Maternity Care (RMC), management of pre/eclampsia, management of post-partum hemorrhage (PPH), and obstetric fistula screening and repair. For newborn health, the Activity promotes Essential Newborn Care (ENC) – Helping Babies Breathe (HBB), Essential Care

- Ingobyi conducted integrated community outreach events in 10 districts during which a total of 13,378 people were reached with integrated RMNCH messages, and out of 7,215 women reached, 1,569 women received FP methods, which represents an FP uptake of 22%. The women were referred to the nearest health center for subsequent monitoring and will also be followed up by CHWs in their communities to assure method continuation.
- Integrated messaging intended to improve health-seeking behaviors for RMNCH and malaria services were delivered through various channels, including Umuganda gatherings, awareness campaigns at health posts, reproductive health education sessions for youth, interpersonal communication sessions targeting young couples at vaccination sites and through “inteko z’abaturationge” (community gathering) reaching an estimated 130,000 individuals. In addition, integrated messaging through radio broadcasts, including Urunana serial drama Umuhuza radio magazine and sketches were delivered.
- Ingobyi Activity supported production and/or finalization of posters and chartbooks on RMNCH and malaria that will be validated during the next Health Promotion TWG meeting, and participated in a related workshop to finalize ASRH messages.
- To strengthen referral linkages for RMNCH and malaria services between and across different services and levels of service delivery, Ingobyi Activity worked with MoH/RBC to customize existing facility level referral forms for key RMNCH services by including additional information from international referral form templates (WHO and USAID). The revised/customized referral form incorporates referrals for ANC, delivery and PNC, child health, neonatal and OPD services.
- To improve provider skills in RMNCH and malaria services, Ingobyi trained additional district-based child health/malaria and FP/ASRH mentors (34 and 26 mentors, respectively); continued to facilitate district-based mentorship (a total 357 MNH, 536 FP/ASRH, and 359 CH/malaria mentees were mentored); and supported LDHF and mentorship for hospital-based providers through partnership with the three medical professional associations – Rwanda Pediatricians Association (RPA), Rwanda Society of Obstetricians and Gynecologists (RSOG), and Rwanda Association of Midwives (RAM).
- Ingobyi Activity continued to conduct routine monitoring and supportive supervision to strengthen quality of mentorship by the district-based mentors and professional associations. During this quarter, Ingobyi conducted 574 supportive supervision visits.
- Ingobyi Activity adapted existing CHW training materials to develop content and scripts for the eLearning course on ICCM for community health workers (CHWs). The ICCM course will be used as a template for developing subsequent eLearning courses (FP and CBMNH)), and an upcoming workshop will provide a platform to test its effectiveness. The course content and scripts will be submitted to the eLearning technical committee at MoH for approval after which the Ingobyi team will launch the eLearning course in supported districts.
- As part of efforts to engage communities in the improvement of RMNCH and malaria services, Ingobyi Activity conducted orientation sessions for key stakeholders on the Citizen Voice and

Action (CVA) approach in 16 Ingobyi supported districts, a training of CVA committee members on the CVA model in six districts (424 individuals trained), and community engagement meetings in the same districts to engage community members to use the CVA approach as a platform to discuss common health issues, identify potential solutions, and seek support of district authorities to address them.

- Efforts made to improve standardization of RMNCH and malaria services include dissemination of electronic copies of the national protocols/guidelines by email to all supported health facilities, orientation of deaths audit committee members from all Ingobyi supported hospitals on the new comprehensive MPCDSR Guidelines as well as participation in an RBC confidential inquiry into maternal deaths that occurred in health facilities in 2018. Key findings of the inquiry were presented to the RMNCH TWG and will also be presented to hospital directors for action. The findings show that the four leading direct causes of deaths are obstetric hemorrhage, pregnancy related infections, hypertensive disorder and unanticipated complications.
- Ingobyi hosted a workshop to support MOH/RBC to develop EmONC guidelines. The draft is still under review by the MCH TWG. Ingobyi also hosted and provided technical support to Safe Motherhood and ICCM-CBMNH sub TWG. In addition, Ingobyi participated in the neonatal TWG that updated and consolidated the neonatal protocol to reflect most recent evidence and provided technical support to RMNCH, Family Planning, and ASRH TWGs.
- Upon further refinement, Ingobyi presented the HealthAppex – a system developed to support functionality of District Health Management Teams (DHMTs) - to MoH and partners during the Planning Health Financing and Information Systems Technical Working Group (PHFIS TWG), obtained feedback and discussed plans for the roll out of the system.
- Ingobyi Activity trained 24 data managers from all supported hospitals on creation and customization of DHIS-2 dashboards and on the new WHO data quality App, supported national ISS and DQA at hospital, health center and community levels in Ingobyi supported districts, and conducted routine monitoring and supportive supervision for health facility data managers and in charge of CHWs to ensure quality data collection and management for improved delivery of RMNCH and Malaria services.

Quarter 3 results for most performance indicators reported by Ingobyi Activity were on target, while a few slightly deviated from the planned target. The possible reasons for the observed deviations include deferment of some planned activities to quarter 4, underestimated target for the number of individuals attending outreach events, seasonal increase for childhood diseases, and others explained in detail in Annex A (*indicator performance table*).

Key activities and achievements by Intermediate Results

1.1 Increased availability of RMNCH and malaria services

Activity 1.1.2. Work with health facilities and CHWs to implement integrated (ASRH, FP) action plans and provide TA (supportive supervision) through RRTs

RRT visits conducted

During quarter 3, Ingobyi Activity conducted two rapid response team (RRT) visits to address service delivery issues identified at supported health facilities. The two RRTs were triggered by a reported stockout of oxytocin in Gasabo District and two maternal deaths within one week at Minini District Hospital. Tables 1 and 2 summarize the root cause analysis conducted by the RRTs and recommended actions.

Table 1: RRT in Gasabo District

| Root cause | Recommendation and action | Follow up plan |
|---|---|--|
| Issue reported: two-month stockout of oxytocin | | |
| The MoH/RBC withdrew IV oxytocin which did not meet standards conditions for use in the third stage of labor and there wasn't any other option given to the health facilities, therefore AMTSL wasn't done at health facilities as recommended. | MoH/RBC should always provide an alternative option in case an essential drug is put in quarantine | Report was shared with RBC. RBC/MPPD agreed to conduct regular supervision for district pharmacists. As a result, RBC and partners developed triggers to alert providers and managers every time a life threatening issue is observed. |
| Inadequate communication between the health centers and the district pharmacy | Improve communication with health facilities by using the official communication channels when there is a stockout of any medication at the district pharmacy and provide guidance on the alternative option to be used by the health facilities during stockout. | Feedback provided to district pharmacy |
| | Ensure that the mode of administration for received medications is always verified and documented on the store cards upon receipt. | Same as above |
| | Always raise the alarm on time when there is a stock out of an emergency medication like Oxytocin. | Same as above |

Table 2: RRT at Munini District Hospital

| Root cause | Recommendation and action | Follow up plan |
|---|---|--|
| Issue reported: Two maternal deaths reported in one week | | |
| Delay in taking decision and mismanagement of the cases | Midwives to closely collaborate with medical doctors and raise alarms on time | |
| Poor c-section technique with difficulty controlling hemostasis | RSOG will train new GPs during mentorship visits | 2 GP mentees undergoing training by RSOG |
| Lack of knowledge in management of bleeding after birth | On the job training with Ingobyi MNH specialist | 9 nurses and midwives received on job training on Helping Mothers Survive |
| Poor surveillance of a patient with danger signs | Assign a midwife/nurse and ensure availability of materials in Post Anesthesia Care Unit (PACU) for improved monitoring of mothers in the immediate post c/section period | A midwife is now assigned in recovery room |
| Lack of monitoring machine for critical patients in theater (no anesthetist machine). | Avail anesthetic machine with monitoring accessories | Anesthetist machine and monitor are now available |
| Avoid stockout of blood for transfusion | Increase the quantity of blood from transfusion center | The blood transfusion center has increased provision of O negative from 15 to 25 |

Development of triggers for RRTs

This quarter, Ingobyi Activity participated in a meeting to develop triggers for RRTs, at the invitation of RBC. In addition to MCCH/RBC and Ingobyi Activity, the meeting was also attended by RSOG, RPA, RAM, UNFPA and TSAM. RBC called upon all stakeholders in the meeting to expand the RRT concept in in RMNCH and malaria services.

After an overview on the RRT concept and subsequent discussions and clarifications, all partners involved in mentorship activities were requested to adopt the approach to respond to key RMNCH and malaria issues. It was agreed that the RRTs will be based on specific triggers and emergency situations and not merely in response to increased cases of death. Emergency situations were defined as those that put the lives of clients in danger and thus require immediate and rapid attention to prevent morbidity and avoidable mortality.

Lack or insufficiency of the items listed below are the triggers that mentors will be required to report immediately to alert the Mentorship Officer at MCCH/RBC who will in turn share the information with the head of MCCH Division to immediately constitute and deploy response teams.

Table 3: Minimum requirements at hospital level below which RRT visits will be triggered

| Items and recommended quantities | | |
|----------------------------------|---|--|
| | Neonatology | Maternity and Operating Room |
| Equipment and materials | 3 incubators | 2 Ambu bag |
| | 2 radiant warmers | 2 Radiant warmers |
| | 1 Ambu bag | 1 Aspirator |
| | 1 CPAP machine | 2 Oxygen concentrators and accessories |
| | 1 Infusimeter | 2 delivery beds |
| | 1 Oxygen concentrator and accessories | 1 Anesthesia machine |
| | 2 KMC beds | Hand washing station and alcohol hand rub |
| | 1 Aspirator | |
| | Hand washing station and alcohol hand rub | |
| Essential medications | Aminophylline | 1 PPH Kit |
| | Disinfectant for equipment | Blood transfusion |
| | Iron syrup | Magnesium sulfate |
| | | Anesthesia drugs |
| | | Anti-hypertensives |
| Human resources | 2 permanent nurses/midwives per shift | 1 permanent GP |
| | 1 GP responsible of neonatal service who doesn't change every day. He should not be the same working in maternity but can be the same for pediatric | 3 Nurses/midwives per shift in delivery room 2 Nurses/midwives per shift in the labor ward 1 Nurse/midwife in immediate post-partum room/space |
| Patient outcomes | | More than 1 uterine rupture per month |
| | | More than 1 post C/section peritonitis per month |
| | | More than 4 fresh still births/neonatal deaths after birth per month |

1.1.5: Support mobile outreach by facility personnel for integrated health services in hard-to-reach, vulnerable communities

Integrated outreach activities in hard to reach communities

Even though increased equitable access to RMNCH and malaria services for all Rwandan citizens has been at the fore front of the GoR initiatives, challenges remain, especially limited service hours (e.g., some services that do not work at night), limited primary health care (PHC) package at some health centers, as well as poor geographical accessibility to primary health care services in some communities.

To reduce access barriers and increase demand for RMNCH and malaria services, Ingobyi Activity accelerated efforts to reach hard-to-reach communities with integrated RMNCH and malaria messages and services. During this quarter, Ingobyi organized mobile integrated community outreaches in 14 districts. The outreach events primarily targeted remote and underserved populations. Organized in collaboration with local authorities, health centers and community health workers, the integrated

outreaches combined demand creation and service provision in form of information and education sessions, as well as provision of select services, such as FP methods to voluntary acceptors/adopters, HIV testing, pregnancy testing and nutritional counseling. Referrals to the nearest HF for services not provided at the sites, such as long-acting and permanent methods FP methods, were conducted. Identification and selection of the outreach sites involved collaborative effort between the district health office, district hospital, local authorities and Ingobyi staff through preparatory meetings organized in the district prior to the outreach events, based on existing challenges like furthest distance from an established health facility, highest unmet need, high teenage pregnancies and other FP barriers, including culture and religion. In addition, community mobilization was conducted jointly with the local authorities and community health workers using existing platforms (cell offices, HCs, village announcements, WhatsApp groups etc.) to enable good turn out and promote community ownership of the activity. Mobile sound systems that go around the selected cell and village targeting markets and trading centers were used to boost the mobilization efforts. During these announcements, the activity details, including locations, dates and expected services were communicated.

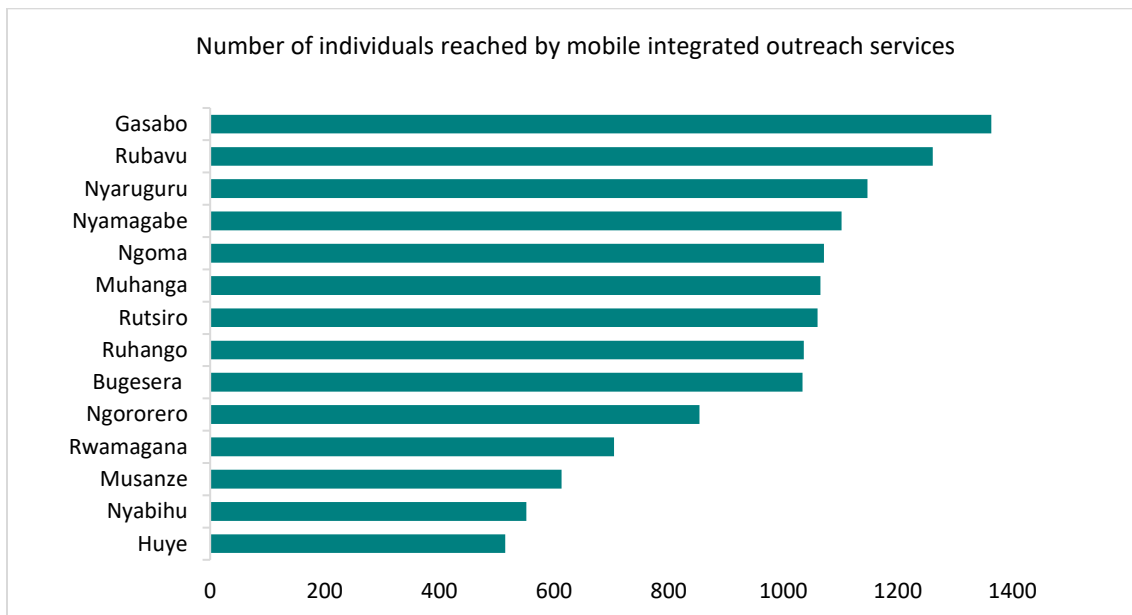


Figure 2: individuals reached through integrated mobile outreach services

Different color-coded papers (red for male and green for female) were distributed to each attendee to count the exact number of people reached. In total, 13,378 people (6,163 males and 7,215 females) were reached with integrated messages and 1,569 women received FP methods with an FP uptake of 22%. Implant (implanon and jadelle) was the highest chosen method during the outreach events, with 49% of the women choosing the method. Women initiated on FP methods were referred to their CHWs for the next refill, and those needing facility FP initiation/follow up were referred to the nearest facility. Ingobyi will continue to work with these health facilities to ensure that referred cases reach the facilities.



Photo 1: Integrated community outreach activity in Muhanga District

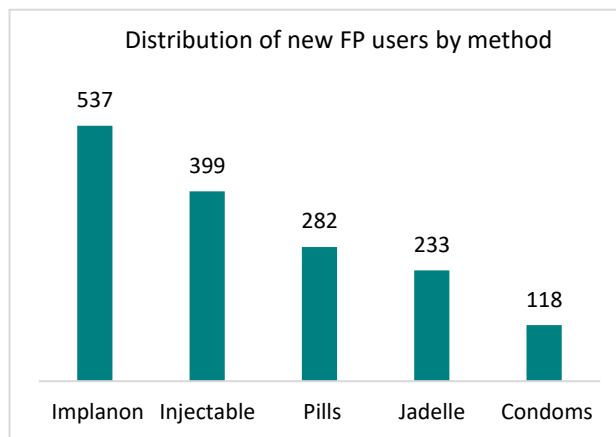


Figure 3: Distribution of new FP users per method in outreach events

Support MOH/ RBC to conduct the “Baho Neza (Live healthy)” Maternal and Child Health week

In response to a request from MoH to support the “Baho Neza” MCH week, Ingobyi Activity assigned one staff from each zone to supervise the MCH week activities on behalf of MCH Division. During this integrated health campaign, various activities were conducted, including provision of family planning counselling and services, malnutrition screening for children aged 6 months to 5 years, provision of vitamin A supplements, deworming of children aged 1 to 15 years, community sensitization on hygiene, post-natal care, and antenatal care, among others. During the Baho Neza campaign in 20 districts supported by Ingobyi Activity, 929,734 children under five years received vitamin A supplements, 841,801 received mebendazole and 493,438 received food supplements. In total, 29,511 women received FP methods of which 9,873 were new acceptors. Screening for malnutrition was done for 916,468 children under 5 and information was collected using paper-based data capture sheet. Data entry in a designed database is still ongoing.

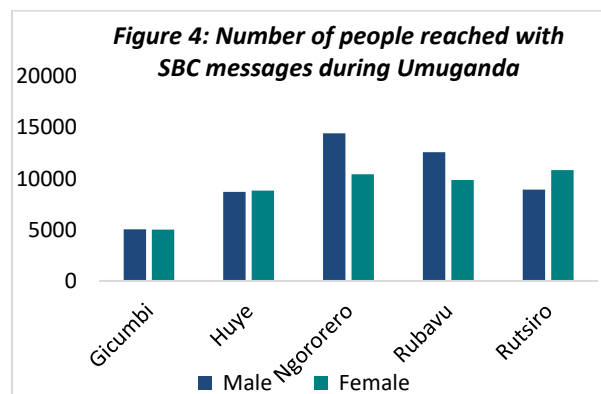
1.2 Improved health-seeking behaviors for RMNCH and malaria services

Activity 1.2.1. Coordinate, collaborate with and leverage related USAID activities and existing structures to design an integrated strategy, develop and disseminate key SBC approaches related to RMNCH/M

Dissemination of integrated RMNCH messages through Umuganda gatherings

In May 2019, Ingobyi staff worked in partnership with leadership of five districts (Gicumbi, Huye, Ngororero, Rubavu and Rutsiro) to disseminate RMNCH and malaria messages during Umuganda gatherings. Key messages during these events focused on: encouraging community members to attend 1st standard ANC visit on time in order to be able to complete the 4 standard ANC visits; on male involvement in ANC visits; promoting family planning; and on prevention of teenage pregnancy, among others. In total, 94,692

individuals, including 49,719 males and 44,973 females, were reached.



Finalization of posters and chartbooks on RMNCH and malaria messages

This quarter, Ingobyi organized a series of technical meetings with RBC/MCCH and RHCC to finalize key RMNCH and malaria communication and education materials, including posters and chartbooks. Ingobyi team provided technical input on message content and illustrations. Ingobyi Activity also worked with a graphic designer to finalize the materials and to integrate all the input from the RBC team and other stakeholders. The tools will be validated during the next Health Promotion TWG meeting next quarter before they can be distributed to health facilities and subsequently used during community outreach campaigns.

RMNCH and malaria awareness campaigns at health posts

Ingobyi worked with local authorities and health posts in 13 districts (Gicumbi, Kamonyi, Gasabo, Muhanga, Musanze, Nyabihu, Ngororero, Nyaruguru, Nyamagabe, Ruhango, Huye, Rwamagana, and Ngoma) to conduct an awareness campaigns on RMNCH and malaria services. The aim of this activity was to create awareness of RMNCH services and foster behavior change. Community health workers and local authorities supported the campaigns through mobilization of their communities, while health post nurses conducted education sessions. Local artists provided integrated RMNCH and Malaria messages to the community through entertainment (songs and drama) aimed at educating the audience. In addition, participants were given a chance to ask questions and provide feedback on quality of health services.

Thirteen events were conducted and 5,136 people, including 2,820 males and 2,316 females, were reached with the integrated RMNCH and malaria messages.

1.2.2: Develop/adapt and communicate youth- focused SBC approaches to increase health care-seeking behavior, including for sexual and reproductive health (SRH) services

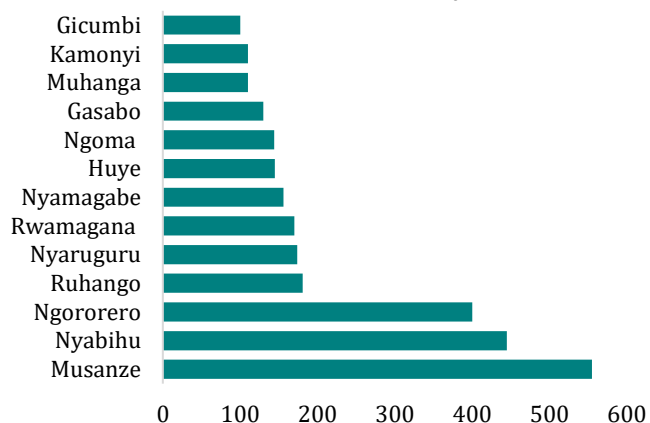
Youth education events on RMNCAH

To improve young people’s access to sexual and reproductive health knowledge and services, Ingobyi, in collaboration with the National Commission for Itorero, conducted reproductive health education and counselling events among youth in five districts – Gasabo, Huye, Nyabihu, Musanze and Rwamagana.



Photo 3: Youth being educated on adolescent, sexual and reproductive health during Ingando

Figure 5: Individuals reached by SBC messages at health posts



During the events integrated messages on reproductive, maternal, newborn, child and adolescent health were delivered by health professionals in collaboration with Ingobyi staff. In total, 1,780 youth, including 945 males and 835 females, were reached with the integrated messages. Specific messages delivered during these events include sexual and reproductive health, HIV prevention, and gender-based violence. This activity will continue in other districts over the next quarter.

Activity 1.2.3: Mobilize and create Savings Groups (SGs) to promote saving for medical expenses and emergencies

Strategy to guide implementation of savings groups (SGs) for vulnerable individuals

Ingobyi Activity plans to introduce the SG model to vulnerable individuals and communities in remote areas to strengthen human, social, and financial assets to increase resilience to economic shocks. The saving group model will allow households to better absorb medical expenses, pay health insurance premiums, afford food and improve housing and sanitation. To this effect, Ingobyi developed a draft strategy to be used in identifying eligible families to participate in savings group activities. The strategy includes the criteria of selection, the roadmap to follow during the selection, roles and responsibilities of key players at each level, from the village to district level, and the approaches Ingobyi Activity will take to support implementation of the savings groups.

The next steps to be completed in the next quarter include: finalize the strategy, orient staff and local community leaders, use it to identify eligible families and share the final list with districts and other stakeholders for validation prior to initiating subsequent savings activities.

1.2.4: Conduct interpersonal communication sessions targeting young couples at health centers and vaccination sites supported by CHWs and provide integrated messages

Training of hospital MCH supervisors and health center FP focal points on interpersonal communication

This quarter, Ingobyi Activity, in collaboration with RBC, conducted a three-day training of hospital MCH supervisors and health center FP focal points on interpersonal communication and on management of FP side effects. The objective of the training was to improve their communication skills and counselling techniques as they play a key role in promoting FP uptake and retention.

The training was held from July 19-21 in five districts (Gasabo, Kicukiro, Gicumbi, Muhanga and Kamonyi) and was facilitated by national FP trainers provided by RBC. In total, 78 health center nurses and 5 hospital MCH supervisors were trained. Following the training participants were supported to develop action plans showing how they will improve service delivery at the health facilities based on the knowledge gathered and new skills acquired. Ingobyi zonal teams will follow up with each facility to ensure that the actions are implemented by the participants. The training will be conducted in the remaining Ingobyi districts during the up-coming quarter.

Orientation of CHWs on interpersonal communication

Ingobyi Activity conducted orientation sessions for CHWs on interpersonal communication to improve their communication and counselling skills thereby contributing to improved delivery of integrated messages in their communities. This activity was conducted in 18 districts and a total of 522 CHWs participated. Meeting participants recommended that community members living in faith-based health center catchment areas should be sensitized to seek FP services at health posts in the same area.

Education sessions on RMNCH and malaria for young couples

During this quarter, Ingobyi conducted education sessions on RMNCH and malaria targeting young couples in health facilities across five districts (Muhanga, Kamonyi, Kicukiro, Gasabo and Gicumbi districts). Key messages delivered during these sessions were: malaria prevention, family planning, ANC, PNC, child health, SGBV prevention, nutrition and hygiene and sanitation. Young couples were encouraged to access RMNCH services, particularly those mentioned in the messages from the CHWs and

at the nearest health facility.

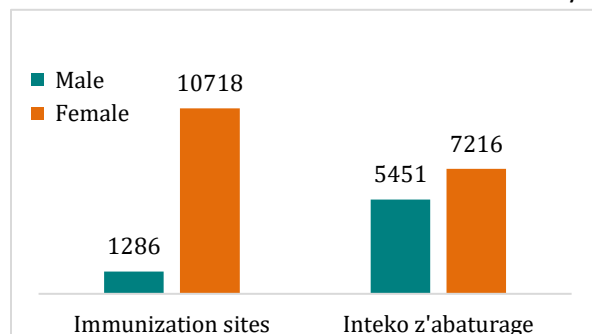


Figure 6: Individuals reached through health education

In total 24,671 people (6,737 men and 17,934 women) were reached, including 12,004 reached during vaccination sessions and 12,667 reached through “inteko zabaturage” (community gathering). The main purpose of this activity is to increase RMNCH and malaria service awareness/utilization by young couples.

Activity 1.2.5: Promote key RMNCH and malaria messages in interpersonal communication sessions through Umuganda and Community Knowledge Centers

Assessment of community knowledge center

An assessment was conducted at Kinishya Community Knowledge Center (CKC) to determine its functionality, feasibility for integrating health education for youth, and to initiate collaboration between Ingobyi Activity and Kinishya CKC in disseminating RMNCH and malaria messages.

The Kinishya CKC is one of 40 other centers that were supported by World Vision Rwanda to promote information technology programs in rural areas, especially in schools. It was built within Kinishya Groupe Scolaire, a 12-year basic education school located in Gicumbi District. The center has 12 desktops that have been used by students for research since 2016. The school is currently facing a problem of internet connectivity due to financial constraints and suggested that the messages be offline for greater impact.



Photo 4: Ingobyi team visiting GS Kinishya CKC

Moving forward, Ingobyi will work with the CKC managers to integrate RMNCH messages in the center and establish a register to document users at the center and track positive changes amongst the students. Collaboration with, and support to, CKCs will involve provision of posters with RMNCH related messages and loading easy to read ASRH messages in the local language (as well as videos) in the computers to facilitate access to RMNCH and malaria messages by students and youth living and partners, to review previous productions that were broadcast during the past quarter and to gather input to improve future productions and broadcasts. During the workshop additional content for future soap opera episodes were developed.

Ongoing broadcast of Urunana serial drama containing key RMNCH malaria messages

Ingobyi continued to broadcast Urunana serial drama on a weekly basis on Radio Rwanda and Radio 10 that contain key RMNCH and malaria messages. During the broadcasts, listeners are provided with different feedback channels they can use, including e-mails, SMS and Facebook, to provide their feedback about the program and seek further information. Most feedback provided and questions asked during the quarter centered on ASRH, relationship between a newly married couple (discussions on when to have a baby), FP and antenatal care (discussions on balanced diet during pregnancy and birth preparedness), and

malaria prevention for pregnant women, among others. Ingobyi uses listener feedback to improve content and presentation of future episodes.

Umuhaza Radio Magazine interactive broadcasts

Umuhaza Radio Magazine is a 15- minute interactive program broadcast on Radio 10 every Tuesday (7:15 p.m) that explores issues raised in the Urunana soap opera in more detail. This radio magazine also serves as an advocacy tool. Vox pops, interviews, drama extracts, testimonies, and debates are some of the formats used in the program. During quarter 3, three radio magazines with RMNCH and malaria messages were produced and broadcast. The first radio magazine focused on post-natal care for mothers and was broadcast on 4th June 2019. The content of the broadcast highlighted how to care for a woman who has just delivered as well as how to identify and address danger signs. The second was broadcast on 11th June 2019 and focused on post-natal care of a newborn. The main issues covered included care for newborns, how to ensure that the newborn remains warm, what to do when the newborn comes prematurely and the Kangaroo Mother Care method for low birth weight babies. The third radio magazine was broadcast on 18th June 2019 and focused on early and exclusive breastfeeding.

Production and broadcast of five-minute radio sketches on RMNCH and malaria

Ingobyi produced and broadcast five- minute mini drama radio sketches containing RMNCH and malaria messages and runs at least three times a week. The sketches were broadcast on four community radio stations: Radio Izuba, RC Huye, Radio Isangano and RC Musanze starting on May 13, 2019. So far, a total of 10 radio sketches have been produced on RMNCH and malaria and are being regularly broadcast on the above-mentioned radio stations in almost all the Ingobyi Activity intervention districts. A few districts (Gicumbi, Gasabo, Kamonyi and Nyagatare) are not yet covered completely, but plans are in place to cover them in the next quarter. Issues tackled in the 10 radio sketches produced included: use of condoms, avoiding “sugar daddys” and peer pressure for youth, identifying danger signs for pregnant women and after delivery, use of Kangaroo mother care for premature and low birth weight babies, child abuse, teenage pregnancy, antenatal care, family planning for new couples, and all methods of family planning.

Audience surveillance to gather public perception of messages broadcast through Urunana soap opera

Ingobyi production team conducts audience surveillance or audience surveys on a monthly basis to pre-test messages to be incorporated in the serial drama, post-test messages that have been communicated using the soap opera/serial drama, and to explore myths, misconceptions and attitudes towards health issues that need to be addressed through the Urunana soap opera. Qualitative data is obtained largely through focus group discussions with youth and parents, and key informant interviews with opinion leaders and health care providers. In May, audience surveillance was conducted in Huye district, Rusatira sector community members exposed to Ingobyi radio broadcasts. Ingobyi production team discussed with four different groups – adults, CHWs, youth and nurses.

Discussions with the group of adults (three men and seven women) focused on family planning and on teenage pregnancy. Regarding family planning, parents from Kiruhura cell said they were facing problems

with their young daughters aged between 13 and 17 getting pregnant. In the end they still had to raise their children along with grandchildren yet they themselves had adopted FP methods. They suggested that this issue should be addressed through different channels, including Urunana soap opera to sensitize the youth on accessing FP services and STIs prevention.

The second group consisted of CHWs (males and females). The major point of discussion was on services CHWs offer pregnant women and the youth. They said the youth do not trust them and it is not easy to help teenagers and adolescents to adhere to family planning methods though they continue to get early pregnancies. The CHWs encouraged the Ingobyi team to always remind young people through radio productions that CHW are ready to help them.

The third group consisting of youth (6 girls and 4 boys) focused on unwanted pregnancies among the youth, how young girls behave after getting pregnant, youth corners and where the youth can access ASRH services whenever necessary. The youth raised the following issues during the discussion included limited access to youth corner due to the fear of being seen due to limited privacy, and fear of disclosure of the services they may have received by CHWs they recommended that condoms should be provided through dispensers that are in private unmonitored locations.

The fourth group consisted of four nurses in charge of maternal and child health, reproductive health, immunization and nutrition from Rubona Health Center. They discussed findings from all four FGDs and the need to keep on informing women and youth about services that are available to them at health facilities. In addition, they suggested that Ingobyi should continue to use radio as a channel to spread RMNCH and malaria messages and to educate communities on the importance of seeking care at health facility whenever necessary.

The feedback from the four discussion groups will help Ingobyi script writers to develop stories and content that responds to the issues raised by the groups. Ingobyi will continue conducting quarterly surveillance activities to determine people's perceptions on the messages and use findings to tailor messages accordingly.

1.3 Strengthened referral linkages for RMNCH and malaria services between, and across different services and levels of service delivery

Activity 1.3.1: Assess and improve the current functioning of the referral system for RMNCH/Malaria services

Revision of existing facility level referral forms for RMNCH Services

Ingobyi Activity customized existing facility level referral forms for key RMNCH services by including additional information from international referral form templates (WHO and USAID). The revised form includes referrals for ANC, delivery and PNC, child health, neonatal care, OPD and other services.

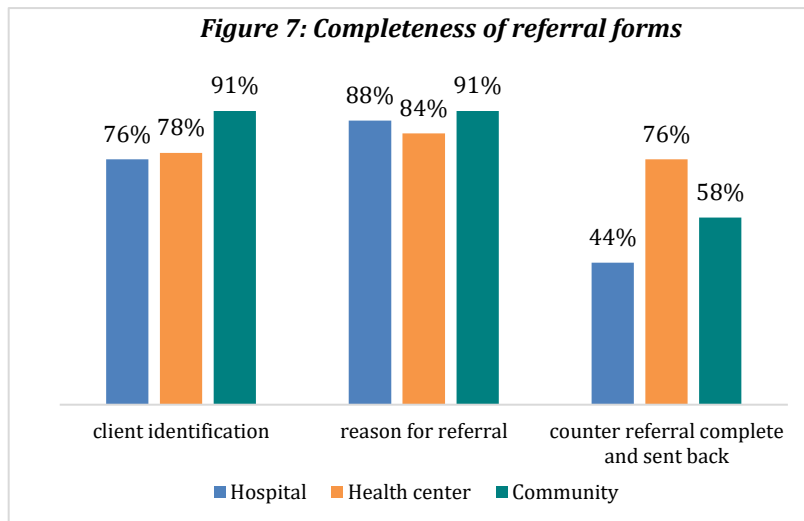
Information added on each form included: timing of events during referral, receiving providers, transportation, interventions performed during transfer and referral outcome. In addition, a guidance on how to fill the forms with clear roles and responsibilities during the referral and counter referral process was developed. All those forms will help to improve the current referral system by adding the missing information on the form and providing guidance on how to use the forms. The next step will involve review and input by the MoH Clinical and Public Health Services, Health Services Quality Assurance Divisions before submission to TWGs for validation.

Furthermore, during this quarter, RBC/MCCH provided feedback on a referral form that was designed by Ingobyi Activity for facility to community referrals. After gathering more feedback and recommendations from the facility level, the form was revised accordingly and will be shared with MCCH health facility unit as well as the MoH Clinical and Public Health Services and Health Services Quality Assurance divisions for input before submission to TWGs for validation.

Referral system assessment through integrated supportive supervision

Ingobyi Activity successfully advocated for inclusion of questions to assess referral services in the national ISS (Integrated Supportive Supervision) tool, with a focus on accreditation standards for referrals, policy and procedures for transfer, referral of patients and reasons for transfers. The accreditation standards guiding referrals recommend verification of the referral/transfer forms to ensure that they reflect the following elements: patient identification (name, age, and sex); reason for referral/transfer; significant findings; procedures and treatments; a list of current medications; the patient's immediate condition; where the patient is being transferred; the type of transportation and required monitoring during transport; and counter referral section and feedback. The proposed questions were subsequently added to the ISS tool to capture compliance with each of these requirements.

Findings from the ISS conducted from April to June 2019 revealed that while all assessed facilities and CHWs were using referral forms to document client transfers, the referral form templates used were not harmonized across the assessed facilities. In addition, while completeness rate of referral forms seemed high, the counter referral sections were not completed at all the visited facilities.



Based on these findings, Ingobyi will work with MCCH/RBC and MoH Clinical and Public Health Services to ensure harmonization of referral templates being used at health facilities and work with the district-based mentors to support improvement of completeness of referral and counter referral forms at all levels.

2.1. Improved provider skills in RMNCH and malaria (doctors, nurses, midwives and CHWs)

Activity 2.1.1: Support mentorship and LDHF training for providers

Training of trainers for district-based child health/malaria and FP/ASRH mentors

Ingobyi conducted a training of trainers for district-based child health/malaria and FP/ASRH mentors on May 20 - 24, 2019. In total, 34 (18 males and 16 females) child health and malaria, and 26 (3 males and 23 females) FP/ASRH mentors were trained. The trained mentors in turn conducted mentorship in health centers. However, Ingobyi conducted training for providers in 13 districts where gaps in coverage had been identified by zonal technical teams. The five-day training involved hands-on practical sessions on all FP methods, including Interval IUD, PPIUCD and implant methods. In addition, quality improvement (QI) methodology and gender integration were also covered. The training included theory and practical sessions and the average performance was 80.4% for child health/malaria mentors and 80.9% for FP/ASRH mentors.

District-based mentorship

During this quarter, Ingobyi supported district-based mentorship continued in the three technical areas (MNH, FP/ASRH and CH/malaria) and was conducted at all supported health facilities. Each mentor is assigned and supports between two and three health centers during one-day visits on a monthly basis.

Some of the key activities accomplished include introduction of mentors to health center managers, assessment and selection of mentees, checking availability of drugs, equipment, and guidelines/protocols.

This was followed by LDHF lectures, especially during morning staff meetings at health centers and mentorship using simulation, case observation as well as structured practical sessions with mannequin where available.

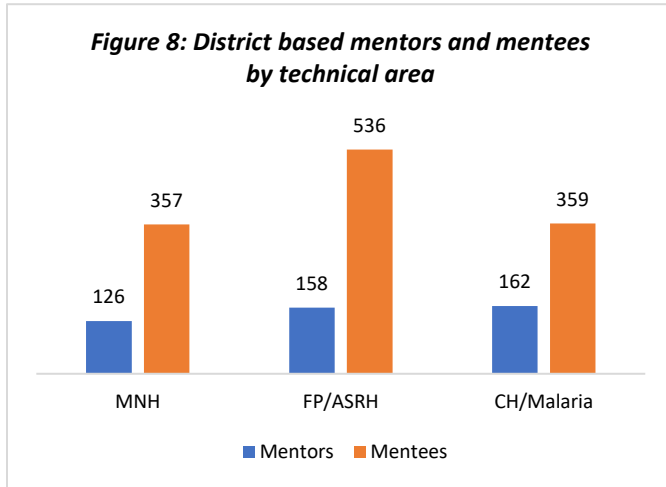


Photo 5: Mentee being mentored on manual removal of retained placenta at Kabuga HC/Kamonyi

To date, a total 357 MNH mentees, 536 FP/ASRH mentees, and 359 CH/malaria mentees have been supported by Ingobyi. Since mentorship started, there is evident improvement in their performance. For instance: no stock out of essential commodities like oxytocin, MgSO₄, Vit k, gloves etc. reported. Moreover, positive practices were observed across the supported facilities: triage, adequate assessment of under 5 children, resuscitation of newborns, management of third stage of labor and management of PPH, provision of loading dose for pre-eclampsia prior to transfer, integration of FP in maternity (PPFP), and availability and use of guidelines/protocols.

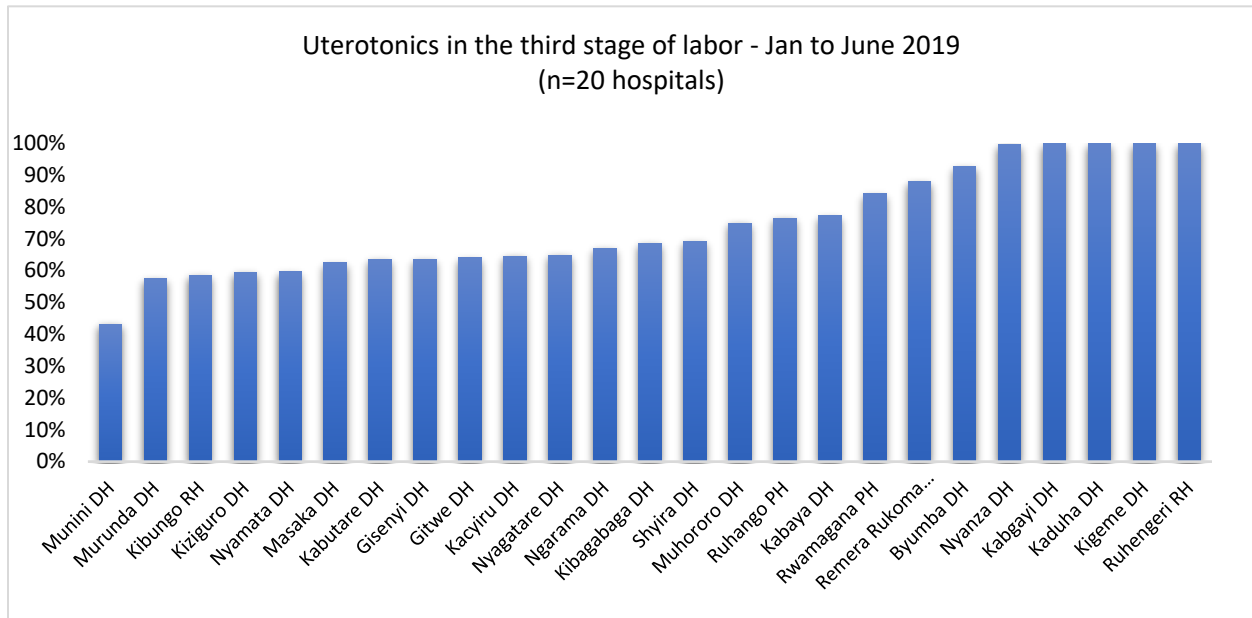


Figure 9: Uterotonics in the third stage of labor in Ingobyi supported districts

Comparison between Ingobyi supported districts revealed a variation with some districts providing uterotonics after all deliveries and other districts only offering the medication to a fraction of the women. Ingobyi will work with the district based MNH mentors and professional associations to investigate the root causes for this observation and implement corrective actions accordingly.

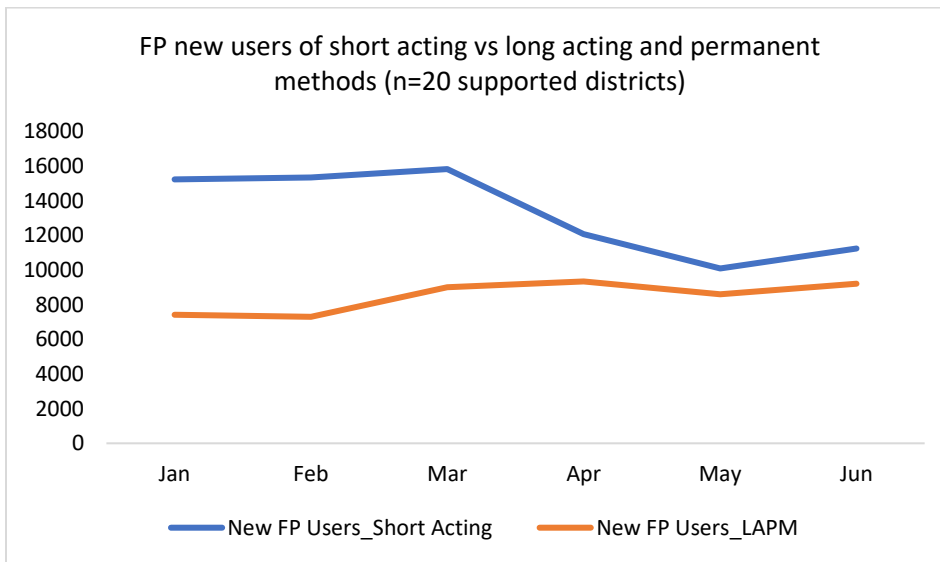


Figure 10: FP New users of short and vs long acting and permanent methods

Over the past six months the trend of new FP users adopting long acting and permanent methods appears to be rising while short acting methods are slightly declining.

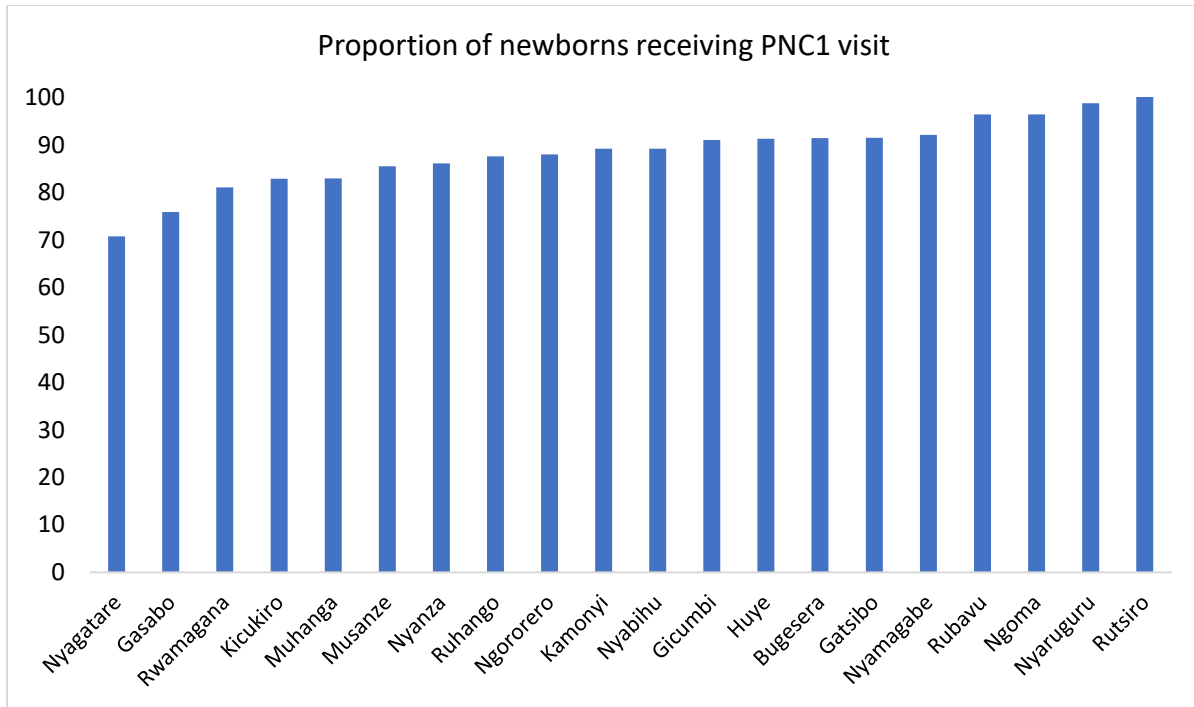


Figure 11: Proportion of newborns receiving PNC1 visit in Ingobyi supported districts

The first visits are completed for most newborns in Ingobyi supported districts, with exceptions such as Nyagatare and Gasabo. Over the up-coming period Ingobyi will investigate and address the challenges in these districts. Nevertheless, major challenges are still encountered at some facilities. These include: shortage of staff and high staff turnover which makes it hard to offer ANC services daily; insufficient essential materials such as timers, scales and registers the IMCI service; lack of PPIUD kits; lack of hand washing facilities; malfunctioning radiant warmers; limited space in maternity; old delivery tables; poor documentation of PNC, among others. The shortage of staff and heavy workload also affects the mentorship in some cases where the mentee is unavailable during the mentorship visit.

Routine monitoring and supportive supervision of district-based mentorship

Ingobyi zonal technical specialists in maternal and newborn health, FP/ASRH and child health conducted supportive supervision for district-based mentors in the three technical areas to ensure that they deliver quality LDHF training and mentorship in accordance with the mentorship guideline and associated clinical protocols. Districts supported during this reporting period include: Gasabo, Kicukiro, Kamonyi, Nyanza, Huye, Nyamagabe, Bugesera, Rwamagana, Kiziguro and Nyagatare).



Photo 6: Feedback session after formative supervision at Gihogwe HC in Gasabo

The approach of visiting mentors onsite as they conduct mentorship provided Ingobyi zonal technical specialists with an opportunity to assess implementation of previous recommendations, to discuss service delivery challenges with health facility managers and to conduct advocacy as needed.

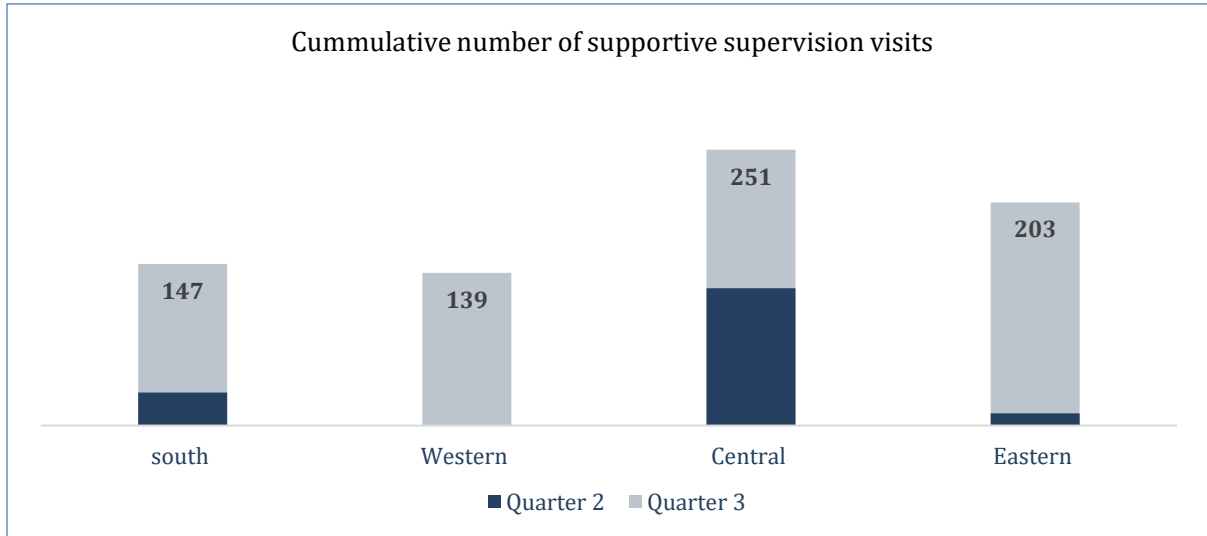


Figure 12: Number of supportive supervision visits

Zonal specialists identified some challenges during supportive supervision visits, including: gaps in infection prevention and control (IPC), lack of updated protocols and guidelines, incompleteness of some registers and other documents, a disconnect between the facility FP service and community-based FP program, no ASRH service in most health centers, ANC services not provided on a daily basis, lack of essential drugs and equipment. These challenges were discussed with health facility leaders, and some were addressed (availability of guidelines, provision of hand washing facility and waste bins). The outstanding challenges were presented during district coordination and DHMT meetings to seek appropriate solutions, particularly regarding equipment and staffing. DHMTs decided to advocate for more staff starting with health centers with the highest burden. For example, Kairos HC in Kicukiro was very low staffed and during the discussion with DHMT, the District decided to hire 6 health care providers using savings that were made on the District salary budget.

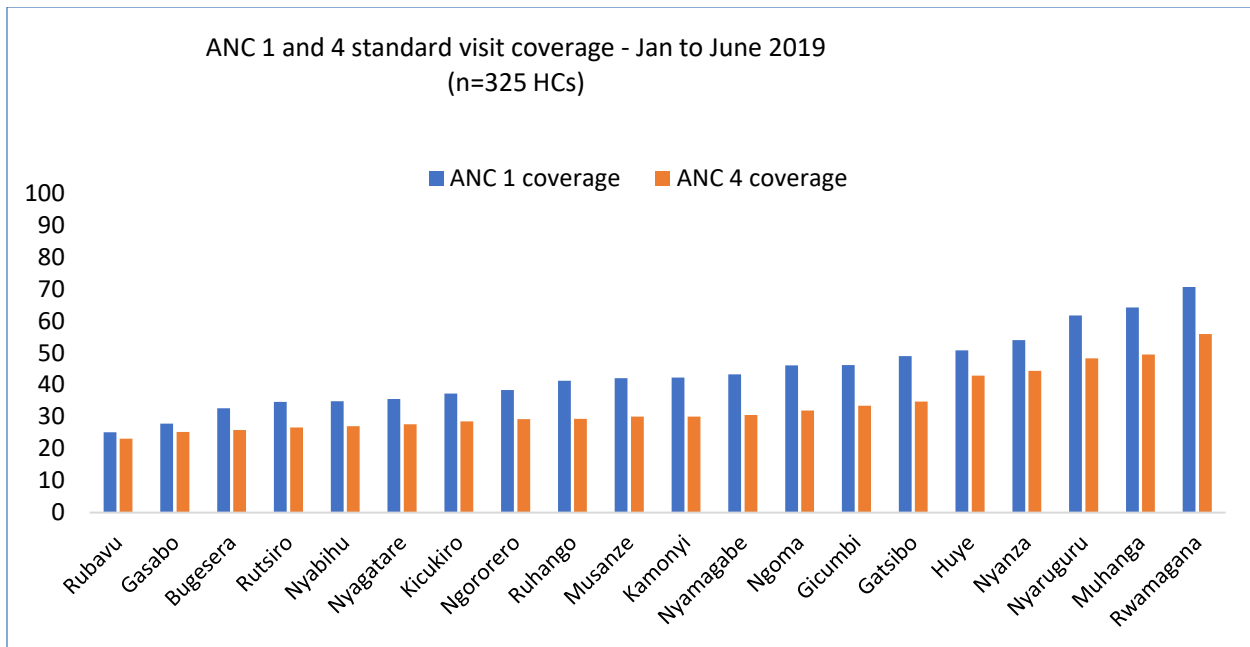


Figure 13: ANC 1 and 4 standard visit coverage

Figure 13 shows consistency between attendance of ANC 1 and ANC 4 standard visits across the supported districts, with some districts showing low attendance, while others report higher attendance for both visits. Ingobyi will continue to reinforce SBC interventions aimed at increasing ANC 1 attendance, especially in the underperforming districts.

LDHF and mentorship for hospital-based providers

Ingobyi continued to support LDHF and mentorship for hospital-based providers through partnership with the three medical professional associations – Rwanda Pediatricians Association (RPA), Rwanda Society of Obstetricians and Gynecologists (RSOG), and Rwanda Association of Midwives (RAM). The mentorship approach involves integrated visits conducted by all three mentors (one from each associations) for three days each month and entry/exit briefings with mentees and health facility management to discuss findings and recommended actions at the end of the visits. The ongoing LDHF and mentorship is provided to an average of six health workers per hospital in each of the 25 supported hospitals.

LDHF and mentorship through Rwanda Society of Obstetricians and Gynecologists (RSOG)

A total of 25 obstetricians conducted monthly hospital level mentorship visits to build the capacity of general practitioners on performing safe caesarian sections and managing obstetrical complications. Each RSOG mentor is assigned one hospital and, in addition to building mentee skills, the mentors work with mentees to develop quality improvement projects within respective department and performance indicators are used to track the progress of these interventions.

Under LDHF, predefined topics are covered. Two mentees are consistently followed for each visit to ensure continuous exposure. In addition to this, the mentor also supports the hospital's death audit team, advises in organization of the services, and conducts advocacy for issues identified that require involvement of leadership. So far, a total of 60 mentees, i.e. 2-3 mentees per hospital are being mentored by Ingobyi through RSOG.



Photo 7: A mentor is making a presentation during a staff meeting

Near miss cases

During this quarter, 24 near misses were reported in the supported hospitals. Per WHO definition, a near miss refers to "a woman who nearly died, but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy." The survival of these cases can be attributed to increased competencies health providers have gained through Ingobyi's mentorship activities. Near misses are analyzed to identify gaps and best practices that are shared with other hospitals for learning. Below is a list outlining reported near misses during this reporting period.

Table 4: Near misses by diagnosis

| Diagnosis | Number |
|------------------------|-----------|
| PPH | 5 |
| Uterine rupture | 3 |
| Placenta abruption | 3 |
| Severe PE | 4 |
| Bladder rupture | 1 |
| Miscarriages | 2 |
| Ectopic pregnancy | 4 |
| Peritonitis | 1 |
| Severe malaria Hb2g/dl | 1 |
| Total | 24 |

Quality improvement projects in hospitals

The quality improvement projects consist of continuous actions aimed at achieving measurable improvement in health care services and health outcomes. The mentors help mentees to improve their services by being able to analyze the root cause of each problem and finding appropriate solutions. This is accomplished using the Plan Do Study Act (PDSA) cycle/approach. Currently, 20% of the projects are completed, 40% are making good progress towards their target while the remaining 40% had poor outcomes and require revision. (See Annex D for a detailed list of QI projects in each hospital.)

LDHF and mentorship by Rwanda Association of Midwives

Rwanda Association of Midwives continued to build the capacity of health providers, primarily midwives, in 25 supported hospitals on maternal health using mentorship and LDHF approach. Each of the 25 hospitals receiving mentorship was allocated a RAM mentor and received three days of mentorship visits per month from their respective RAM mentors.

The visits started with pre-test assessments to establish a baseline of the mentees' knowledge and skills and to guide the emphasis of the mentorship on the areas where the mentees clearly have low level of knowledge and skill. This was followed by ongoing LDHF in HBS and HMS modules and mentorship.

The mentors interact with mentees as they go about their routine work and observe their skills and knowledge in conducting procedures, the infection control measures and respectful maternity care. The LDHF training was conducted according to the pre-designed teaching plan and topics.

Table 5: Topics covered by RAM and performance of mentees

| LDHF Topics | Pre-test | Post-test |
|---------------------------------|----------|-----------|
| Helping Babies Breathe | 82.05% | 95.33% |
| Essential Care for Every Baby | 79.11% | 93.11% |
| Essential Care for Small Babies | 72.25% | 92.76% |
| Bleeding After Birth -Complete | 72.38% | 92.85% |
| Overall | 76.45% | 93.51% |

The mentors regularly documented success stories, near misses, best practices, gaps and challenges observed in health facilities and health care providers, and recommended actions to improve quality of care. Mentors also reviewed hospital monthly HMIS data on outcomes and quality of care indicators relating to the day of birth and observed that a high number of newborn hypothermia cases were reported by most facilities. Some of the successes/best practices reported by mentors include: encouraging mothers to do skin to skin for babies during transport to prevent hypothermia, creation of admission rooms in 90% of the hospitals after advocacy done by professional association mentors, routine triage of high risk mothers, management of post abortion care using MVA is being performed by mentees. The near misses reported include 8 post-partum hemorrhage, 4 newborn and 2 pre-eclampsia/eclampsia cases. Ingobyi is using these successes and best practices to promote improvements in service delivery in all supported health facilities. Pre and post-test in HMS and HBS modules were performed to measure the progress of mentees.

LDHF training and mentorship by Rwanda Pediatric Association (RPA)

Similar to the other two professional associations, RPA mentors conducted LDHF training and mentorship visits for three-days each month in all 25 Ingobyi supported hospitals during the quarter. During the visits, RPA mentors conducted LDHF training and mentorship on pre-determined topics for the neonatology and pediatric staff. Six pre-selected topics were covered this quarter, as show in the below table:

Table 6: LDHF neonatology and pediatric topics

| Month | Area | Topic |
|----------|-------------|--|
| January | Neonatology | Hyperbilirubinemia |
| | Pediatrics | Dehydration |
| February | Neonatology | Fluids, electrolytes and nutrition of the newborns |
| | Pediatrics | Severe malnutrition |
| March | Neonatology | Infection |
| | Pediatrics | Respiratory distress |

Bedside teaching: During ward rounds in the neonatology, pediatric and emergency departments, RPA mentors discussed with staff about complicated cases and used the opportunity to transfer knowledge to mentees on management of sick newborns and encouraged them to use national protocols. They also

conducted practical sessions on topics covered during theoretical/presentation sessions. This approach allows mentees to gain advanced knowledge and/or skills in the management of various cases. Mentors observed mentees at work and provided direct feedback and support to improve their skills. During the ward rounds mentors also assessed mentees using the mentorship assessment tools.

Progress of mentees: Each pediatrician is assigned three mentees, one each from neonatology, pediatrics and emergency room. Some mentees had to be replaced for various reasons, such as unavailability during the mentorship period, resignation or transfers. The hospital director general, clinical directors and heads of nursing were involved in their selection. Mentees included nurses, medical doctors, some midwives and intern doctors (in facilities with high shortage of staff). In total, 75 mentees were mentored during the quarter and nine graduated with knowledge scores of 85% and above. The mentees who graduated were replaced by new mentees. This happened in Masaka Hospital (2 mentees), Kabgayi Hospital (1), Nyanza Hospital (1), Ruhango Hospital (1), Rwamagana Hospital (1), Remera Rukoma Hospitals (1), Kibungo Hospital (2). Availability of mentees during LHF and mentorship visits remains a continuing challenge. Some mentees had to be replaced because they were absent for a prolonged period of time. A total of nine mentees left the program during this quarter and were subsequently replaced: Gitwe Hospital (1), Ruhango Hospital (1), Byumba Hospital (1), Nyagatare Hospital (2) and Munini Hospital (4).

Supported QI projects: RPA mentors facilitated the development, implementation and measurement of QI projects during the quarter. After root cause analysis using the PDSA cycle, they encouraged staff to develop QI projects. All supported hospitals have an ongoing QI project. A summary of QI projects undertaken during the quarter is presented in the Annex. *(See Annex D for a detailed list of QI projects in each hospital.)*

Mentors also reported observed successes and best practice during their visits. For instance, a mentor at Remera Rukoma Hospital developed and displayed education materials to remind staff, mothers and caregivers to wash their hands before touching a baby. The message was placed on the incubators and beds. This helps in maintaining measures of infection prevention control as many babies, especially small babies die of infections.

Advocacy: After each visit, the RPA mentors developed action plans with recommendations that were shared with hospital leadership. For example, in Nyamata Hospital, the mentor advocated to move maternity ward and create a corridor between the theater and neonatology to decrease the number of

hypothermic cases. This is now under construction and it will shorten the distance from 110 meters to 15 meters.

Near miss case: In Nyagatare Hospital, a 6-year-old child in hypovolemic shock was managed by a mentor during a ward round in the emergency ward. The mentor showed all the signs of shock to the mentee and managed the case with the mentee, using the opportunity as a teaching moment. The child improved and was discharged alive. The mentor used the case to stress the need for triage.

Supportive supervision for professional association mentors

Ingobyi conducted supportive supervision for professional association mentors in five hospitals (Rwamagana, Nyamata, Nyagatare, Ngarama and Kiziguro) during the quarter. The aim was to ensure the quality of mentorship delivered by professional association mentors. Below is a summary of findings and observations from the supportive supervision visits.

In Rwamagana Hospital, the maternity emergency, pediatric and neonatology heads of service expressed their appreciation for the support they received from the RPA mentor - mentees had a good relationship with the RPA mentor and ward rounds were conducted together with mentees (doctors, interns and nurses) during each mentorship visit. The head of the emergency ward recognized that the mentee was sharing new knowledge acquired from the RPA mentor with her peers, especially on the use of CPAP. She showed good progress in knowledge with an increased assessment score from 65% in February to 85% in April. The mentee will soon be transferred to the neonatology ward. The head of the pediatrics service also appreciated the support from the RPA mentor. She stated that *“when she is there, all complicated cases are discussed with mentees and nurses.”* All the planned training sessions were performed, and measures of infection control put in place. One challenge identified in the hospital is that no doctor is assigned to conduct ward rounds daily in the neonatal department. At the end of the visit, the Ingobyi supervisors advocated with hospital leadership to assign a doctor in neonatology department to ensure that ward rounds are performed every day of the week and quality care is delivered for all sick babies.

During the visit in Nyamata Hospital, the Ingobyi supervisors found a good relationship between the mentor and the mentees. The mentor was giving a lecture on the management of severe malnutrition. In pediatrics, three cases had been admitted for severe malnutrition and they were all well managed. The hospital had previously reported one case of severe malnutrition who had died after readmission. One intern doctor and one nurse working in neonatology had already scored over 96% in their pre/post-test assessments. In neonatology, infection control measures were in place. However, there were many admitted babies (approximately 40). Observed challenges and recommendations were shared with the clinical director. One recommendation was to encourage mothers or caregivers to use skin to skin during transfer from maternity to neonatology because the delivery room is so far from the neonatology department and more than a half of the babies were hypothermic at admission. The clinical director promised to ensure that the maternity ward is moved closer to the neonatology department.

In Nyagatare, the neonatology ward had one nurse caring for 20 babies and no separation of in-born and out-born babies due to limited space, which increased the risk of infection significantly. The mentees also expressed concern with insufficient staffing. In addition, there is no laundry (leading to lack of surgical drapes for the delivery table), lack of bed sheets and a high number of neonatal hypothermia cases. Mentees agreed to encourage mothers or caregivers to use skin to skin during transfer from maternity to neonatology. Staffing shortage was discussed with leadership and they promised to raise it in their next DHMT.

In Ngarama, there were improvements in prevention of post-operative infections. Whereas the hospital previously had 6-8 surgical site infections each month before mentorship, there had only been one case over the last three months. Mentees implemented measures in accordance with guidance from their mentors. Following advocacy by mentors the hospital had begun to renovate the neonatology unit because it had very small space. During the visit, inadequate separation of waste in the maternity ward was observed and the clinical director promised to request maternity staff to adhere to the waste management protocol.

In Kiziguro, the clinical director mentioned having observed an improvement in the knowledge and skills of the mentees, and the mentees expressed appreciation of ongoing mentorship activities. However due to the shortage of staff, mentees are not consistently attending the mentorship sessions. This hospital has serious challenges including small space in the post-partum and neonatology service, three malfunctioning incubators, no functional CPAP, high number of hypothermia cases, mothers whose newborns have no clothes due to poverty and neonatal infections. These challenges limit the ability of the hospital to provide quality care. As result of Ingobyi advocacy, the hospital is attempting to solve some of the issues by using their own budget to construct a structure an extension for post-partum room because currently up to three mothers may be placed on the same bed. The hospital was also able to purchase a machine to supply water to the theatre.

LDHF and mentorship challenges

As mentioned in the sections above, the professional association are limited to only supporting one component of health system, which involves the capacity building of health workers. However, there are other health service challenges unrelated to competency of health workers that affect health outcomes. For example, due to insufficient human resources, some department such as the recovery and the immediate post-partum rooms are not covered by any staff leading to inadequate follow up. Other challenges include insufficient space in the post-partum ward where, in some cases, two clients were placed on the same bed after undergoing a caesarian section, lack of running water which can contribute to post-operative infection, lack of commodities and equipment (oxygen cylinder, CPAP, radiant warmers), lack of water in theater rooms, lack of surgical boots and gynecology gloves to conduct safe delivery, lack of disinfection liquid, lack of a laundry machine.

Ingobyi worked in collaboration with the professional association mentors to advocate with hospital leadership to address these issues. However, while the hospitals showed willingness to address them,

some of these problems, such as infrastructure, laundry etc., require significant funds, which the hospitals may not be able to mobilize. Ingobyi will bring these issues to the attention of MOH/RBC during the next quarterly review meeting, and will continue to advocate for them through different high-level meetings, including TWGs, and to explore possible collaboration with other partners that may have resources to support these needs.

Dissemination of the helping babies survive (HBS) and helping mothers survive (HMS) training modules

During the quarter, Ingobyi staff presented the Helping Babies Survive and Helping Mothers Survive training modules to the safe motherhood and newborn TWGs, respectively. The HMS is a hands-on, simulation-based learning module designed to be delivered on-job to build the capacity of health workers and improve/sustain the critical skills of midwives, nurses, doctors, and those who assist them to care for women during pregnancy, labor, and delivery. The HBS is a suite of evidence-based educational training programs to address the three most common causes of preventable neonatal deaths. It is composed of Helping Baby Breathe (HBB) 2nd edition; Essential Care for Every Baby (ECEB); Essential care for small babies (ECSB); Improving care of mothers and babies (ICMB). The materials were also approved in the larger RMNCH TWG and are being used by district-based mentors for LDHF and mentorship.

Activity 2.1.3: Build competency and institutionalize continuing professional development (CPD) of health workers.

Continuous Professional Development (CPD) credits for Ingobyi supported mentees

Ingobyi applied to the Rwanda Medical Council to become a certified CPD provider and the request was accepted. The certificate was provided and Ingobyi will henceforth award CPD credits to all health workers who received LDHF trainings in supported health facilities.

Activity 2.1.4: Support the MOH to operationalize the recommendations of the 2016 Community Health Program external evaluation

Validation of CHWs' integrated curriculum, assessment tools and guidelines

Ingobyi Activity staff participated in the five-day workshop to validate the integrated curriculum for CHWs. This included validation of the competence-based assessment tools and guidelines. In 2016, an evaluation of the Rwanda Community Health Program was conducted. Following the evaluation, the 15th National Leadership Retreat held in February 2018 created a related resolution (#11) that calls for "support for the Community Health Workers (CHWs) in order to improve health services." As a result of the evaluation and resolution, it was recommended to upgrade CHWs through a diploma/certification and possible financial reward (LSTM, 2016). The MOH, in collaboration with its partners, has initiated the certification process for CHWs in piloted districts: Kicukiro, Musanze, Burera, and Kirehe in order to shape their career development. The process will result in the delivery of certificates to CHWs who pass the assessment.

Through the assessment and certification process, gaps will be identified to guide future programming for CHWs across the country.

The assessment and certification process started in February, 2019 when a team composed of representatives from MOH, Rwanda Biomedical Center (RBC), the Workforce Development Authority (WDA), Rwanda Polytechnic (RP), UNFPA, UNICEF, WHO, JHPIEGO, PIH, Ingobyi Activity, and DH supervisors of CHWs from the selected districts participated in a workshop to accomplish the following: provide feedback on the newly developed curriculum for CHWs; develop the CHW assessment tools and translate them in Kinyarwanda; develop the CHW assessment tools guidelines/translate them in Kinyarwanda so that they can be useful for assessors; and test the CHW assessment tools in order to verify if they are in line with the CHW's activities implemented in Rwanda.

The Ingobyi Activity played an active role in developing the CHW curriculum, assessment tools, and guidelines. It also supported the translation of the assessment tools into Kinyarwanda. The workshop resulted in the validation of the CHW integrated curriculum, assessment tools and guidelines to be used in the assessment process.

CHWs competence-based assessment

Following validation of the CHW assessment tools mentioned above, Ingobyi Activity provided technical and financial support to conduct CHW competence-based assessment in Kicukiro district. The assessment was conducted in all 10 health centers in the district, and targeted 520 CHWs, including binomes (male and female CHW pairs) and Animatrice de Sante Maternelle (ASMs), who were assessed on the full community health package. Binomes were assessed on ICCM, CBP-FP and CB-nutrition, while ASM were assessed on CB-MNH, CBP-FP and CB- nutrition. Of the 520 CHWs targeted, 477 CHWs were assessed including 323 Binomes and 154 ASMs. Among Binomes, 110 were assessed on the full package while 213 were assessed on one or two competences only. Among ASMs, only six were assessed on the full package and 158 were assessed on one or two competences only. The CBP-FP is the major weakness among CHWs, based on the assessment, but it is not the only area for improvement. Other weaknesses identified are data recording and adherence to infection prevention measures. The assessment results will be officially published by Rwanda Polytechnics and the next step will be CHW certification and scale up in other districts countrywide.

Activity 2.1.5: Support implementation of eLearning approach to enhance CHW performance, focused on ICCM and health promotion refresher training

Development of e-learning multimedia content in the ICCM module

Ingobyi, in collaboration with stakeholders from RBC/MCCH, MoH and other partners developed and finalized course content for iCCM, FP and CBMNH to be used in developing the eLearning platform for CHWs. Ingobyi hired a graphic designer/eLearning consultant and engaged a facilitator from RBC/MCCH to develop scripts for multimedia content starting with the ICCM curriculum (photos, illustrations, cartoons, and videos). In mid-June 2019, the graphic designer submitted all iCCM contents to be uploaded

on the eLearning platform (*Moodle*). The eLearning team is preparing a second iCCM workshop with stakeholders to comprehensively review the iCCM course and provide feedback where necessary. The workshop is scheduled to take place during the up-coming quarter. After the workshop, the module will be submitted to the eLearning technical committee at MoH for approval. Once approved, the team will launch the iCCM course and use it as a model for developing the other modules.

2.2. Institutionalized quality improvement approaches for RMNCH and malaria interventions

Activity 2.2.3: Strengthen client feedback mechanism to improve quality of care

CVA orientation meeting

The Citizen Voice and Action (CVA) is a local level advocacy and social accountability approach that facilitates dialogue between communities and government to improve public services (like health care and education) that impact the daily lives of children and their families. Ingobyi uses CVA approach to increase awareness and uptake of RMNCH and malaria services in targeted communities, empowering them to play an active role in their health. Key elements of CVA include information, voice, dialogue and accountability. The communities work with other stakeholders to influence decision-makers to improve services, using a simple set of advocacy tools. As government services improve, so does the well-being of community members that seek health services.

Citizen Voice and Action orientation sessions was conducted in 16 Ingobyi supported districts for key stakeholders. During the sessions, the CVA approach was presented and discussed with participants, who greatly appreciated the engagement approach and committed to supporting its implementation. The orientation sessions we followed by selection of CVA working group members.. In total, 297 individuals were oriented on the CVA approach including (107 males and 190 females)

Training on the CVA Approach

A five-day training was conducted in six districts (Kamonyi, Gicumbi, Musanze, Rubavu, Nyagatare, and Rwamagana district) to equip selected CVA committee members with knowledge and skills on the CVA model and to develop detailed implementation plans. The selected CVA committee members include a sector representative, a representative of school directors, two representatives of CHWs, two representatives of the national committee of women, two representatives of the national committee of youth, a representative of the sector council, two representatives of health centers, a representative of the executive secretary of the cell, representatives of village leaders, a representative of faith-based organizations and a representative from “Inshuti z’umuryango” (friends of the family - a Ministry of Gender and Family Promotion initiative for monitoring GBV and child abuse at household level). The following topics were covered during the training: definition of the CVA model and its objectives, 3 phases of CVA, which include enabling citizens engagement, engagement via community gatherings and improving services/influencing policies. At the end of the training, participants developed action plans for CVA activities within their sector which include raising awareness of the community on the CVA model through existing community gathering such as *inteko z’abaturage* (community gatherings) in different

cells, planning health center level CVA meetings that will be held at least once quarterly and planning close follow up of the implementation of corrective actions of identified.

CVA community engagement meetings

Trained CVA working groups/committees in the districts mentioned above conducted community engagement meetings in their respective cells to engage community members in the CVA process. The CVA efforts are not only aimed at improving the quality health services delivered at health centers but also increasing health seeking behaviors in the community.

Prior to the group discussion, members receive explanations on how the feedback will be provided, including not mentioning staff names. Community groups are separated from the leaders in listing the issues and the feedback represents group rather than individual perspectives. If any member wants to provide confidential or anonymous feedback, they are encouraged to use suggestion boxes or approach any of the 3 elected trustees/committee members.



Photo 8: CVA committees facilitating community dialogues on health services in Kamonyi district

Meeting with the MOH quality assurance team

Ingobyi Activity staff and the MOH quality assurance team met to define the areas of collaboration for CVA model implementation. The meeting was led by the Director of quality assurance department. During the meeting, the CVA model and the PVP were discussed as two options for health services users to provide feedback through an established mechanism.

The Ingobyi team presented the CVA model and the MOH team presented the patient voice program model. The discussions around using these mechanisms were a response to a report completed by the Rwanda Government Board called Citizen Report Card 2018. The report detailed the level of citizen satisfaction with health services and made recommendations. One of the recommendations that the Rwandan parliament took up was to commit to, and reinforce, a feedback mechanism. The recommended mechanism would include health services users being mobilized to identify gaps and proposing corrective actions to address them. This strategy to address the satisfaction with health services aligns well with the CVA model. For that reason, the MOH quality assurance department is interested in using the CVA model

as one of the feedback mechanisms to link health services users, healthcare providers, and local authorities.

The meeting ended with consensus to continue ongoing CVA implementation and expand it beyond the Ingobyi Activity districts. The MOH agreed to participate in CVA activities moving forward so that they have a full understanding of the model. In addition, the CVA reports will be considered as valid feedback from health service users by the MOH. The MOH plans to scale up CVA model in other districts not supported by Ingobyi Activity.

2.3. Improved standardization of RMNCH and malaria services

Activity 2.3.1. Support health facilities to operationalize most recent RMNCH and malaria policies and procedures for the 2017 Health Services Package

Distribution of the most recent MNH national protocols/guidelines

To ensure that all health facilities have the most recent MNH policies and procedures, Ingobyi distributed electronic copies of the national protocols/guidelines by email to all supported health centers to be printed and availed in various service delivery points. Verification of whether health facilities had printed copies of the protocols/guidelines is done routinely during monitoring and supportive and monthly mentorship activities.

Orientation of deaths audit committees on the new MPCDSR guidelines

Ingobyi conducted a workshop to orient representatives of maternal perinatal and child death audit committees from all Ingobyi supported hospitals on the new comprehensive MPCDSR guidelines from April 29 to May 3, 2019. Each hospital was represented by three death audit committee members, including one medical doctor who is the deaths audit focal point of the hospital. During the workshop, participants were oriented on how to fill the new updated death audit data collection tools, how to identify gaps that may be linked to the occurrence of death, develop recommendations to specific responsible individuals and allocate timeline for their implementation. After the workshop, all Ingobyi supported hospitals started to implement the new guidelines using new deaths audit data collection tools to audit deaths that occurred since January 2019.

Confidential inquiry into maternal deaths in health facilities in 2018

Ingobyi provided technical support to RBC to conduct confidential inquiry into maternal deaths that occurred in health facilities. This is cross-sectional health facility survey that was conducted from March 11 to 22, 2019 and covered all hospitals countrywide. The newly updated maternal death review data collection form was used during the exercise. It is based on the WHO application of ICD-10 for deaths during pregnancy, childbirth and puerperium: ICD MM classification of causes of deaths. Providers are

currently using ICD-10 classification to document diagnosis and data capturing tools are updated. Ingobyi will continue to support the MOH to build capacity of providers to roll out documentation of cause of death through ICD-10 and ICD-MM classification.

The findings show that the leading direct causes of deaths are obstetric hemorrhage, pregnancy related infections, hypertensive disorders in pregnancy, and other unanticipated complications like complication of anesthesia, obstetric surgery and procedures etc. Delays within the health facility account for most maternal death and mismanagement. Delays in taking the right decision and inadequate follow up after admission and during hospitalization were identified as factors associated with avoidable maternal deaths. The key findings were presented to the RMNCH TWG on June 13, 2019 and participants recommended that the findings be presented to hospitals through the coordination meeting with director generals of all hospitals and to work through the Safe Motherhood sub-TWG develop a paper on the findings for publication.

3.1. Strengthened capacity at the national and decentralized levels to plan and manage RMNCH and malaria services

3.1.1 Strengthened national-level planning and management:

Supporting MOH to update RMNCH guidelines and protocols

The EmONC technical approach has been implemented in Rwanda since its introduction by MOH in 2005. Despite various trainings conducted for health providers, there is no document guiding its implementation. During quarter 3, Ingobyi provided support to MOH/RBC to develop the EmONC guidelines through a workshop held in May 2019. The workshop was attended by 22 national experts in EmONC, including participants from the MOH (RBC/MCCH), professional associations (OB-GYN and RAM), higher learning Institutions (UR) and partners (USAID, UNICEF, WHO, PIH, TSAM and Ingobyi Activity). Participants developed a draft guideline describing EmONC functions, service organizations, including staffing, equipment and commodities, as well as monitoring and evaluation of services. The guideline is intended to serve as a reference document for all health providers providing training and services based on EmONC principles, with the ultimate goal of improving maternal and newborn health towards achievement of Sustainable Development Goals in the country.

In June 2019, Ingobyi participated in the consolidation workshop for the draft neonatal protocol. The protocol document was compiled by a UNICEF consultant and reviewed by other paediatricians in the previous quarter. Ingobyi staff, RPA mentors and RAM midwives provided input to ensure the final document covers all the required and critical neonatal guidance. During the workshop, the document was reviewed and concurrently cleaned up by the consultant based on participant feedback.

Supporting national technical working groups

During quarter 3, Ingobyi Activity hosted and provided technical support to various technical working groups as described below.

RMNCH TWG: In June 2019, Ingobyi hosted the RMNCH TWG and presented the new Maternal Perinatal and Child Deaths Surveillance and response guideline. The participants reviewed the guideline, provided an initial validation and recommended to present the guideline to the Senior Management Meeting of the Ministry of Health for last approval before its national dissemination. In addition, both HBS and HMS have been presented and the TWG approved the use of the materials in LDHF and Mentorship. The main discussion of the TWG was around the sector targets and related policy actions for Year 2019/2020. Ingobyi contributed to the discussions and provided feedback to the target proposed by the RBC/MCCH division. The findings from the confidential inquiry into maternal deaths occurred in health facilities in 2018 also was presented. (See section 2.3 for main findings.)

Family Planning sub-TWG: The main achievement from this sub-TWG was the finalization of handout for FP/ASRH strategic plan that is expected to be disseminated in all HFs. This will be a small pocket book containing key activities of the FP/ASRH strategic plan that are expected to be implemented by the all districts. The handout is still under review and will be approved in the next TWG meeting in the upcoming quarter. The FP sub-TWG also discussed progress of the ICDP@25 preparation, the validation of FP Service Delivery Point (SDP) survey 2018 and updates of the ECHO trial study, as well the data quality in family planning. The findings from SDP survey showed a huge improvement in the supply chain management of modern contraceptives. All the health facilities included in the survey had no stock out in the five modern methods on the day of the survey. The methods include Pills, IUDs, Implants, injectables and Permanent methods (Tubal Ligation and Vasectomy) which shows effective supply chain. However, the survey showed remaining gaps, especially in the availability of FP permanent methods.

The RBC, in collaboration with Avenir Health, presented FP data as updates on FP 2020 using data from HMIS as of end of December 2018. According to the data presented, modern contraceptive use is at 50%, and CBP-FP contribution is decreasing. In addition, there is a high district variability in the contribution of PFP to the FP uptake. Nyanza District has the highest contribution at 75%, and Kicukiro has the lowest contribution at 14%. Implementing partners were reminded to support health facilities to identify challenges and ensure every mother in the post-partum period in the need of FP is facilitated to receive the service. Finally, the FP TWG validated the FP 2020 indicators, following the recommendations of the FP 2020 indicators consensus meeting in which Ingobyi participated. The aim of the meeting was to review progress on FP2020 indicators and determine data to use in evaluating performance at national level. Additional recommendations from the meeting were to enhance mentorship program and, periodically conduct client exit interviews to assess their level of satisfaction, to identify the health facilities with data discrepancy, missing report or abnormal data, and plan for field visits to support facilities in the implementation of corrective measures.

ASRH Sub-TWG: Ingobyi Activity participated in in the ASRH Sub-TWG meetings. During this TWG, results from a formative evaluation on First Time Young Mothers Pilot Project in Rubavu district has been presented and validated. The key findings showed that the integrated package of services, including

Family Planning methods, Parent Adolescent Communication (PAC) sessions, outreach campaigns, psychological support were cited to be the most important in effectively re-integrating teen mothers back in their families and communities. Findings from this evaluation will serve as evidence in implementing ASRH services to teen mothers.

Neonatal TWG: Ingobyi participated in the neonatal TWG of June in which the neonatal protocol was presented. Participants reviewed and validated the protocol. It was recommended to proceed with the next MOH validation and approval processes and update neonatal training materials.

Safe motherhood TWG: Ingobyi hosted a two-day TWG workshop in April 2019. The main objective was to review the RMNCH Electronic Medical Record module. The ANC, Intrapartum, PNC, neonatal and child codebook were finalised and approved. The next step will be to finalise the digitalisation and test it in a few districts before approval by the MOH.

ICCM-CBMNH Sub TWG: Ingobyi Activity hosted and participated in the ICCM-CBMNH sub-TWG. The discussion focused on determination of ICCM and CBMNH indicators from the Community Health Information System to be maintained or removed. The final list of indicators will be shared in the next TWG meeting. All partners shared the list of activities planned in their respective projects during the quarter and their upcoming implementation plans. The Ingobyi Activity staff presented their work in CHW supportive supervision as one way to improve RMNCH/malaria services at community level.

Transmission strata map development

A key focus of Ingobyi support to the MOH is the development of useful spatial maps to optimize resourcing, intervention targeting, and generally expanding utilization of spatial intelligence and the power of maps in programming. To showcase the variety of spatial map displays available and to share with various stakeholders for feedback and input, Ingobyi team developed sample maps applying GIS software using the enumerated satellite imagery (household footprint maps, Figure 10) developed during Q1. The household mapping process resulted in mapping of 752,542 household structures across Rwanda in 10 districts. These household maps combined with administrative and health facility boundaries and layered with ecological and health data have significant relevance and will provide visual assistance for intervention planning and monitoring. Given one of the specific focuses of the Ingobyi project is around ANC and malaria, the maps developed for showcasing to the project and stakeholders focus on these programmatic areas.

Note: the full map showcase can be viewed at this hyperlink:

https://drive.google.com/file/d/1ZT5gwRGllvbkLon9UXzmws_BuRKQrPnN/view?usp=sharing

Ingobyi applied household mapping technique and used freely available satellite imagery to map 752,542 household structures across Rwanda through a desk-based household mapping exercise. The yellow polygons show the outline of each household structure mapped. Maps created by this approach will be used to understand population distribution in a catchment, to validate census figures, and to guide the planning and monitoring of intervention campaigns – both at the community and household level.

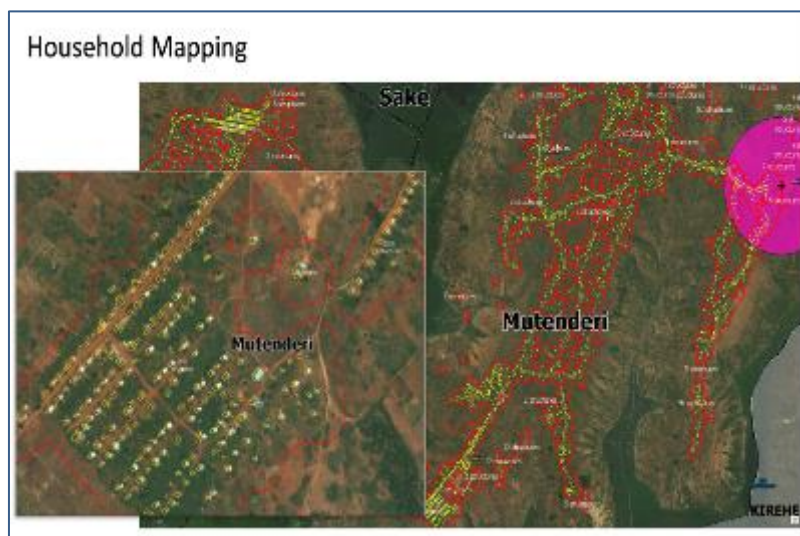


Figure 14: Sample household mapping

Currently the MOH utilizes maps at district and sector area to display malaria incidence. These maps provide a strong understanding of where incidence is greater (e.g. the southeast area of the country), and which districts and sectors display higher risk of transmission; however, displaying data aggregated to sectors can limit the ability to see actual transmission patterns that do not adhere to administrative boundaries. More granular and refined maps can, however, improve intervention planning, targeting and monitoring. For example, relating to community-based ANC programming, more refined maps can be valuable. A key aim for the Ingobyi Activity is to support the MOH to increase early initiation and adherence to ANC standard visits thereby improving the health outcomes of women and their pregnancies.

The below map displays expected pregnant women per sector and ANC visits to facilities for Ngoma District. The dark red sectors indicate the highest pregnancies expected. These areas also show fewer attendees to the 4th ANC visit compared to the 1st ANC visit meaning its likely women are not following through to attain all the recommended visits during their pregnancies.

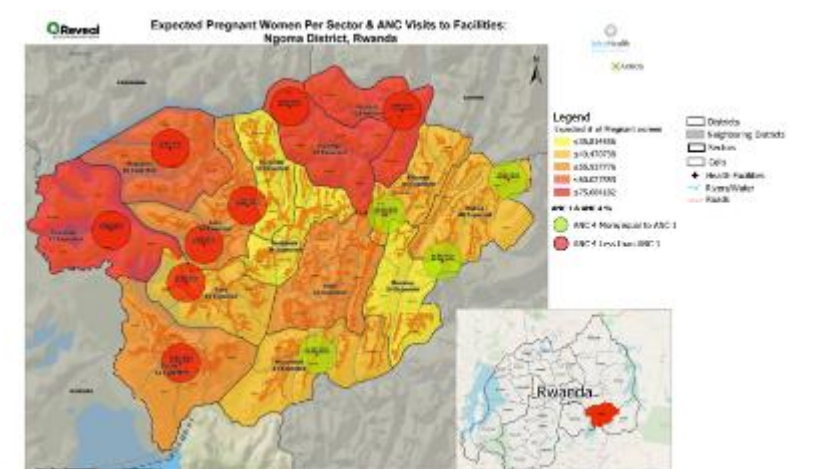


Figure 15: Expected pregnancies vs ANC visits in Ngoma District

The map illustrates how planning, targeting and implementation can go a step further by estimating the

number of women in reproductive age in each cell. By looking at the expected number of pregnancies by cell, Ingobyi and health facilities will effectively target SBC campaigns to improve the understanding and uptake of ANC by women.

Aggregation at the sector level may not provide the granularity needed to make accurate programmatic decisions. More disaggregated data within a sector or cell may be required to prioritize interventions.

Applying the household structure level data will enable Ingobyi and MOH/RBC to understand how many structures are located within each cell, and the estimated number of women of reproductive age residing within those cells. With this information, SBC activities can be targeted towards cells with highest number of women of reproductive age, thus improving their understanding and uptake of ANC.

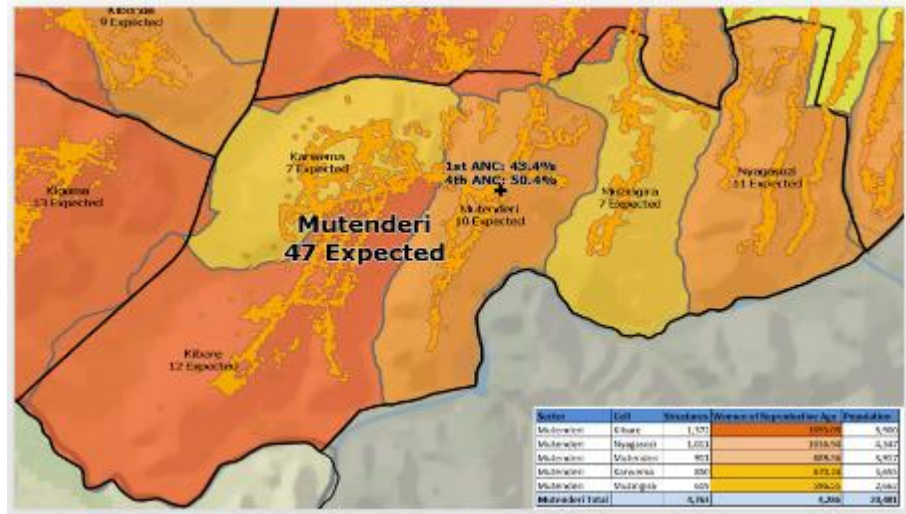


Figure 16: Expected pregnancies vs ANC visits in Mutenderi Cell

Ingobyi also created maps that display the risk of malaria transmission (probability of finding a malaria vector, anopheles gambiae, in this case) and layered in incidence data to show areas of greatest risk of transmission. Having these data at sector level will (like ANC) not be extremely useful for planning purposes at the health facility level. However, by adding in the household structure layer, data can be disaggregated to cell or community level and interventions planned more specifically. In the case of Figure 13, Mutenderi facility in Mutenderi sector reported the highest incidence of malaria and has approximately 4,700 household structures located within.

The greatest number of cases are likely deriving from the three communities in red from Muzingiri and Nyagasozo cells as those areas represent the greatest probability of malaria vector presence.

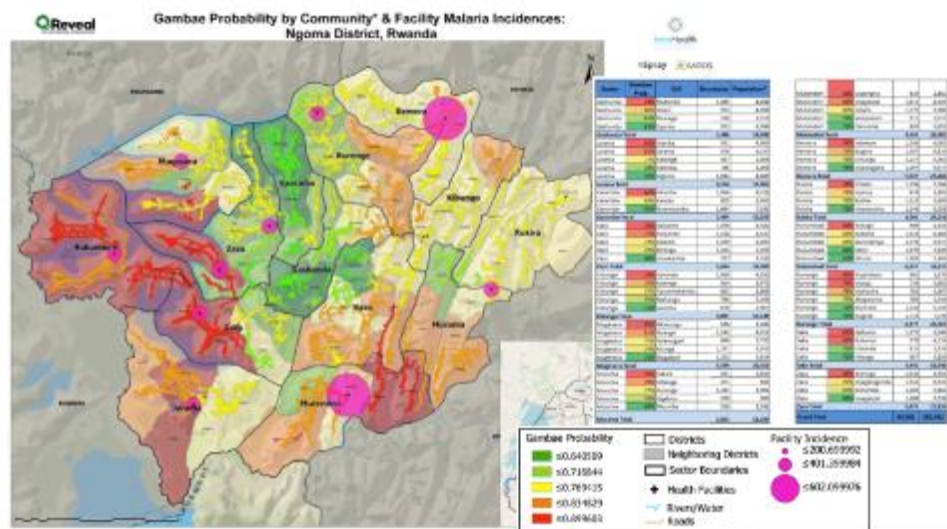


Figure 17: Risk of malaria transmission layered in with malaria incidence data

Activity 3.1.2: Strengthen district-level planning and management.

Assist the RBC and MOH planning directorates to review and rationalize their roles

During this last quarter, Ingobyi activity held various discussions with the planning directorate to find ways of collecting DHMT inputs. The team agreed with MoH to allocate time to this activity during the planned training of DHMT on HealthAppex¹. MoH is in the process of updating the DHMT guideline to reflect changes that have been made since the current one was developed in 2011. The agreement with MoH is that since key DHMT members will be at the HealthAppex training, capturing their views on how to rationalize their roles (also as part of being involved in the update of the guideline) is both a cost-effective and efficient approach. In preparation for the training (scheduled for end of July), the Ingobyi team and MoH have already agreed on topics to guide these discussions. DHMT members will be divided into smaller groups, and based on the identified topics, deliberate on how best DHMTs, DHU and DJAF can fulfil their roles with less duplication and more synergy; and present their findings during a plenary. Ingobyi/Ingenuity team will then compile a summary report and share it with MOH to inform the updating of the DHMT guideline.

Link districts with the Health Sector Working Group at central level

Ministry of Health has the mandate of selecting priorities for the sector and setting targets, used as a guide for districts *Imihigo* and their targets. This kind of deliberation usually happens at the central level, yet implementation on selected priorities and targets takes place at the district. There is therefore, a need for platform to bring this kind of feedback to the districts. During the JHSR meeting held on June 5, 2019, MoH officially communicated the health sector priorities, plans, targets, and budgets for FY20. Ingobyi, having participated in the JHSR meeting, disseminated the final sector priorities with districts through DHMT meetings, to guide decentralized level planning processes.

Conduct district quarterly review meetings for performance monitoring and improvement

Ingobyi worked with and supported four districts (Gicumbi, Ngoma, Rubavu, Rwamagana and Gasabo), to review their plans against set targets as part of the planning process for the FY20, but also to assess implementation progress, identify challenges and propose solutions. The key lesson from this process is that districts are yet to adopt a culture for systematic review and monitoring processes to track progress of plans during the course of the year. In the coming year therefore, Ingobyi team will promote periodic review via existing forums, such as quarterly DHMT, coordination meetings to ensure consistent oversight of implementation of planned activities.

¹ HealthAppex, is a web-based platform that provides a way to qualitatively assess DHMT performance in planning and management, coordination, supervision of health services, financing and resource allocation, and regulation. The system will eliminate paper-based tools currently used by DHMTs.

Upgrade, roll out, and maintain HealthAppex system to assess DHMT performance

In April 2019, HealthAppex was presented and adopted by MoH and other stakeholders for national rollout during the Planning Health Financing and Information Systems Technical Working Group (PHFIS TWG). The MoH committed to fund training and the implementation of the HealthAppex in 10 non-Ingobyi supported districts. In May 2019, Ingobyi conducted a live demonstration of the HealthAppex to a group of MINALOC and district DHMT representatives. At both meetings, the Ingobyi team presented the HealthAppex to all participants, highlighted its genesis in relation to goals of DHMT, how the platform works (its domains, standards and milestones), the reporting and other features. The meetings were chaired by the MoH's Director General of PHFIS. Participants saluted the innovation and usefulness of the system, provided inputs which led to the development of HealthAppex 2.1 that is currently online.

Another meeting related to HealthAppex upgrade was held with the Permanent Secretary (MoH) on May 22 to acquaint him with the system. The PS appreciated the way the tool measures the management side of the health system. He recommended, however, to incorporate an indicator visualization feature to increase the robustness of the tool before the rollout of training. Ingobyi team in collaboration with MoH has since identified 16 indicators and incorporated them into HealthAppex for visualization of their baselines (data for 2018) versus actual achievement and annual targets. The trainings are planned in the next quarter. Ingobyi and MOH engaged the MINALOC and a staff was assigned to be part of the coordinating and implementing team. The team will continue to discuss with MOH with the aim of expanding the coverage of the system in terms of health indicators such as FP, ANC, etc.

Annual health retreat to prioritize health interventions for health facilities, DHMT, and DHUs

Based on the priorities shared by the MOH at the JHSR meeting and district-specific targets (as described earlier), Ingobyi team made visual representations on seven² indicators most relevant to RMNCH to stimulate discussions with district managers during the ongoing planning sessions. The presentations showed current performance per district vis-à-vis next year's target as desired by the MoH. These analyses were presented by the Ingobyi team in planning sessions in 10 districts – namely: Gasabo, Gicumbi, Kicukiro, Muhanga, Musanze, Ngororero, Nyagatare, Ruhango, Rwamagana and Gasabo. This process will continue in other districts as well as they are yet to finalize their FY20 work plans. It is anticipated that discussions and feedback provided during these meetings will help districts to develop responsive plans that respond to the national and district Imihigo targets.

Outside annual planning sessions, Ingobyi used other forums, such as DHMTs, to present and create awareness of the FY20 health priorities in supported districts. This quarter, such presentations were

² a) % graduated from red & yellow; b) FP contraceptive utilization rate, c) ANC 4th standard visits, d) CBHI coverage (mutuelles), e) Facility Based Delivery Rate, f) Total teen pregnancy reported, g) Malaria incidence per 1,000 population

made in three districts (Muhanga, Rwamagana and Kicukiro districts) to stimulate more DHMT involvement in health facility planning processes, adequately reflect sector priorities in annual workplans and advocate for needed resources for health services.

3.2. Strengthened capacity of hospitals to achieve RMNCH and malaria-related accreditation indicators

Activity 3.2.1: Support district hospital quality teams to analyze and operationalize recommendations emerging from accreditation audits.

During this reporting quarter, Ingobyi supported Kibungo Referral Hospital to conduct a training of health providers in cardio respiratory resuscitation, as part of the hospital's efforts to address outstanding recommendations for their accreditation. In total 18 health providers from different services were trained, the average performance score before and after training using mannequin simulations was 46% and 94%, respectively. The training helped to improve provider capacity to manage critical patients that require resuscitation. This is a basic life support exercise that is expected to improve MNCH outcomes.

3.3. Strengthened capacity for district planning, reporting, and evaluation (M&E) frameworks

Activity 3.3.2: Support facility level data quality and use for quality improvement

Monitoring and supportive supervision for health facility data managers

Ingobyi conducted monitoring and supportive supervision for health facility data managers and in charge of CHWs in 21 health facilities in 3 districts (7 in Kicukiro, 6 in Nyabihu, and 8 in Rutsiro). The goal was to support data managers and Community and Environmental Health Officers (CEHO), to address identified data gaps identified during the facility self-assessment and the last ISS/DQA recommendations. During the visits, Ingobyi team reviewed facility strengths, including existence of RMNCH updated data collection tools (delivery, Family planning, PNC and ANC registers), and availability of data validation and verification meeting minutes and reports. The major issue that emerged is poor understanding of the HMIS data elements leading to poor recording in the registers and subsequent issues in data quality.

During the supportive supervision visits, Ingobyi worked with RBC supervisors to go through the HMIS reporting forms with both the data managers and respective persons in charge of services, provided definition of data elements and link to the data sources in registers. In addition, Ingobyi and RBC supervisors demonstrated to the facilities how to visualize data in Rapid SMS and reviewed existing data by triangulating different reporting system (HMIS, Sis Com and Rapid SMS) to ensure facilities had the ability to perform data quality checks themselves.

Configuration of dashboards on WHO DQ tool

During quarter 3, the Ministry of Health introduced a new WHO data quality App in the HMIS that will automate the processes of data checking to identify outliers (suspicious data values), missing data and inconsistencies online. The tool is embedded in the DHIS-2 system and has significantly simplified the data quality verification processes. At the invitation of MoH, Ingobyi participated in a working session with other technical staff from MoH, RBC, WHO and a consultant from the University of Oslo from May 19th to 24th to configure and customize the tool to target priority health indicators and display their data quality issues on a dashboard. The team also developed a facilitator's guide for orientation of hospital data managers on use of the tool.

It was agreed during the session that if after investigation, outliers identified by the tool are found to be erroneous or missing values are found, data managers will be requested to edit their data before the HMIS is locked each month (between 5th to 10th). To correct historic data that have already been locked down, data managers are required to request MoH to unlock the system through a very lengthy and restrictive process. The MoH is now working on finding a more feasible approach to facilitate correction of historical data.

Orientation of central level M&E staff on the WHO DQ tool

Following the configuration of the WHO DQ tool in the Rwanda HMIS instance, Ingobyi staff participated and facilitated a training of RBC division and program statisticians who will use the tool to improve the quality of data reported for their respective programs. During the session participants covered the following: demonstration and practical exercises using the Outliers tab of the WHO DQ tool dashboard; demonstration and practical exercises of the analysis function of the tool; demonstration of the "Monitor Completeness" dashboard; demonstration the "Consistency-Data" functionality of the DQ tool; guidance on how hospital data managers can use the tool; running and interpreting data validation rules and email notifications; and how to define coverage indicators, how to estimate targets/denominators (census-based versus services-based).

During the workshop, participants identified actual outliers, missing values and inconsistencies in data reported by some health facilities during the previous 12 months. Discussions were held about how to use the tool moving forward and it was agreed that it would be added to the data quality SOP to ensure its routine use.

Workshop on DHIS-2 dashboards and the WHO data quality app

Since improved facility level use of data has been proven to be directly improving data quality, MoH, PMEBS/RBC and Ingobyi Activity conducted a 5-day workshop aimed at orienting 24 hospital data managers on creation and customization of DHIS-2 dashboards with priority health indicators and utilization of a new WHO data quality app that identifies data quality issues in the HMIS. The workshop took place in Huye district from June 17 to 21, 2019 and brought together 24 hospital data managers (one data manager from Gitwe hospital was unavailable due to competing priorities).

It began with a day and a half of orientation on new DHIS-2 functionalities (WHO DQ tool and an indicator definitions app) and refresher presentations, demonstrations and exercises on existing DHIS-2 data analysis functionalities (creation of pivot tables, data visualizations, favorites and dashboards).

Over the next two and a half days, the facilitators worked closely with each data manager to conduct a guided exercise that involved three steps: listing district performance indicators (Imihigo) as well as hospital specific priority indicators that are frequently extracted and analyzed; selecting appropriate analysis visualizations for each indicator and creating favorites in the system for display on the dashboards; and creating and populating hospital specific customized dashboards with the favorites. In addition, participants also generated health center level dashboards and shared them with the data managers of the health centers located in their catchment areas.

On the fifth and last day of the workshop, participants were oriented on hospital to health center coaching exercise, which is expected to begin in quarter 4. The exercise is aimed at building the capacity of health center data managers on data quality assurance and on data analysis/use on an ongoing basis. Participants were oriented on the coaching approach as well as the tools to be used during the exercise.

The immediate output of the workshop included: participants ability to utilize the new WHO data quality app to identify facilities with outliers, missing values and inconsistencies; customized online dashboards displaying priority health indicators at all Ingobyi supported hospitals and health centers with exception of Gitwe zone, the Ingobyi district data analyst will conduct coaching visits to build the capacity of the hospital data manager at this facility; and preliminary plans for hospital to health center coaching on data management.

Development of data management coaching support guide

Improving the quality and use of health-related data is a priority of the MoH and requires a supportive and holistic approach in addition to the existing formal training and supervision capacity building strategies. Although traditional forms of training and supervision are critical for increasing knowledge and skills, the skills acquired in workshops and in classrooms are not necessarily translated into practice at health facilities offering services. It is for this reason that Ingobyi has developed coaching support guide for hospital to health center coaching aimed at building the capacity of health center data managers and assisting them in addressing the data quality and data use gaps in their facilities.

The coaching support guide is based on clinical mentorship checklist format and consists of a list of observations/criteria for assessing the data manager's skills with scores. It will be used to document the progress of the data manager over time and the tool consists of two competencies; Data Quality/Documentation and Data Analysis/Use as well as a progress summary form and reference summary. Hospital data managers were oriented on the coaching approach and will begin the exercise during quarter 4 and the exercise will be ongoing during the upcoming years. The cascade approach will have the advantage of reaching all supported health centers.

Conduct routine data quality assessments (RDQAs) on key indicators to assure data quality

At the request of RBC, Ingobyi Activity supported national ISS and DQA at hospital, health centers and

community levels in Ingobyi supported districts. In the previous quarter Ingobyi, participated in the review of the ISS/DQA checklist that was adapted from the WHO SARA tool with additions based on recommendations the MoH received from external evaluators. A standardized excel tool was developed for the data quality assessment to assess the quality of data on selected indicators by comparing HMIS data with the data source. For each identified discrepancy a possible reason was provided. Reasons include: counting errors, misinterpretation of indicators, missing data collection tools, missing information in registers, typing errors, use of non-updated data collection tools, and erasure/overwriting.

Ingobyi staff participated in the ISS/DQA in all selected facilities in supported districts. During the ISS/DQA, Ingobyi staff took the opportunity to provide support to the facilities for improvement of identified gaps. In addition, at the end of each the ISS/DQA in each district, the team held meetings with districts bringing together the DHU, the hospital and all health centers, and presented the findings of the ISS/DQA. Mostly recommendations included: the review of the template used to report in data validation/data quality verification; data validation/data quality verification meeting to be conducted on monthly basis considering key RMNCH and malaria indicators; to conduct regular data quality audit for health centers by hospitals and internal hospital data quality audit on key selected RMNCH and malaria indicators; the ISS/DQA team to leave clear documentation of their recommendations for hospital staff; DQA conducted at the health center level to be signed and validated by HC data managers and Titulaires; provide more explanation regarding ANC indicators definition; and conduct regular DQA on key RMNCH indicators, among others.

Moreover, in June 2019, Ingobyi supported the initial data cleaning and analysis of the ISS/DQA. During the session, the analysis plan was made for both the ISS and the DQA. Questions were grouped into sections and preliminary tables were developed. Most of the data quality issues were found to be coming from both counting errors and misinterpretation of the indicators. In recommendations that are yet to be validated by the MoH, it was suggested that a data element reference document for the HMIS reporting forms be developed to address issues around misinterpretation of indicators/data elements that causes discrepancies in some programmatic indicators.

Activity 3.4: Monitoring, evaluation and supportive supervision, planning and progress reviews

Data review and routine supportive supervision

Ingobyi reviewed quarter 2 HMIS data, specifically its PMP indicators. Based on the results, Ingobyi worked with the facilities that were shown to be struggling on some of the indicators to address observed gaps, including data quality and service delivery. Following the data review, Ingobyi conducted supportive supervision to the facilities and worked with the health care providers, mostly focusing on identifying the root cause of the gaps and brainstormed on the intervention to be implemented.

Common causes of indicator under-performance in visited health facilities include: poor understanding of data element recorded in ANC, PNC, FP, delivery registers and CHWs reporting form (SISCOM); low attendance of ANC 1st and 4th standard visit; lack of knowledge in service delivery both in HFs and at the community level; misinterpretation of some indicators which leads to data quality issues; incompleteness

observed in FP r, ANC and PNC registers; and CHWs in charge and heads of HCs do not receive red alert in RapidSMS, among others. Following subsequent discussions with managers of health facilities the following actions were recommended: use mobilization through outreach, Umuganda, community gathering (inteko y'abaturatione) and CHWs to list all pregnant women in their community focusing on pregnant women in their 1st Trimester; recount very attentively the cases in registers and request to RBC for amendments in HMIS to reflect data corrections in the system; strengthen capacity of health care provider, data managers and CHWs in data quality and management through supportive supervision, mentorship and coaching; review HMIS reporting form with HF staff involved in reporting of ANC, FP, Delivery and PNC (explain the definition of all data elements and link to the data source in registers); demonstrate how to visualize data in RapidSMS and elaborate CHWs activity report; review existing data triangulation for different data elements in HMIS reporting form to ensure data quality; health care providers to update all registers to ensure its completeness; plan and perform data validation meeting before reporting submission; and perform data analysis and use for quality improvement project on monthly basis to see progress of indicators targets.

In addition, during this quarter, the Ingobyi FP specialist seconded to MCCH Division analyzed FP data from January to March for four districts, including two supported by Ingobyi (Gasabo and Kicukiro) – others being Gisagara and Rulindo. The findings from this analysis revealed some data quality issues at many health facilities in all four districts, in term of indicator definitions (new acceptors, new users, PFP before discharge, and stock distributed), discrepancies between users and family planning products distributed, as well low uptake of post-partum family planning before discharge. Following this analysis, a post-training follow-up will be conducted for district mentors in all Ingobyi supported districts during supportive supervision.

Activity 3.5: Conduct quarterly district coordination meetings involving DHMTs, DHU and other district stakeholders to discuss progress, identify and address bottlenecks and gaps

Supporting districts open days

Ingobyi supported, both technically and financially, open day activities in 12 district districts: Gasabo, Muhanga, Kamonyi, Gicumbi, Huye, Nyaruguru, Nyanza, Ngororero, Nyabihu, Musanze, Gatsibo and Nyagatare districts. The open day is an event organized by district administration in collaboration with key stakeholders in the district where all partners showcase and exhibit their activities and services. The event presents partners with the opportunity to inform the population about their activities and services. During these events Ingobyi provided RMNCH and malaria messages and services to participants who visited its stands.



Photo 9: Ingobyi staff (with microphone) explaining services provided at its exhibition stand to Nyaruguru District Mayor and other officials



Photo 10: Ingobyi staff (left) receiving award from Nyanza District official in charge of economic affairs

Ingobyi staff together staff from selected health center and CHWs presented RMNCH messages to the participants who visited its stands and provided FP services, including counselling and FP methods; ANC services, including pregnancy tests; blood pressure measurement; HIV counselling and testing and growth monitoring for children under five.

In total 9,887 participants visited the Ingobyi stands, 357 clients received FP counselling and services (including 107 new users), 35 women tested for pregnancy (among them 4 tested positive and linked with the HC for the 1st standard ANC visit), growth monitoring and screening from malnutrition was done for 234 children (10 who were found in yellow color have been referred to the HC for further management), 861 people were counselled and tested for HIV (among them 14 were tested + and were linked with the HC for further management). Among people who consulted for HIV testing, more than 95% were youth. In addition, Ingobyi received a special award (trophy) from Muhanga and Kamonyi districts in recognition of its performance during the open days, particularly for provision of services most needed by the local populations.

Supporting DHMT meetings

In this quarter, Ingobyi provided technical and financial support to seven districts, namely; Ngoma, Rubavu, Muhanga, Rwamagana, Nyagatare, Gatsibo and Gasabo during their DHMT quarterly meetings. As some DHMTs were inactive they were encouraged to review their plans and operations to improve performance. Key topics discussed during these meetings include: FY 2020 health sector priorities; DHMT functions and responsibilities; DHU plans of actions and reviews; health indicators with a focus on RMNCH; and reimbursement mechanism between RSSB, district pharmacy and health facilities. A singular illustration of Ngoma District articulates how some districts understand the importance of having a strong district health coordination mechanism. In the previous quarter, Ngoma had pledged to be functional, accountable at all levels and to document their best practices and key lessons learned. The district managed to implement their plan with Ingobyi support.

Support development of district action plans 2019/2020

During this reporting quarter, Ingobyi provided financial and technical support in the development of action plans (2019/2020) for health facilities in Muhanga, Kamonyi, Kicukiro, Gicumbi, Gasabo, Nyanza, Nyaruguru, Rubavu, Musanze, Nyagatare, Gatsibo, Bugesera, Rwamagana districts, in collaboration with DHUs. Health centers, represented by their managers, and accountants participated in the planning meetings. Other participants were district administrative and health leaders. During three intensive consecutive days, participants were guided on how to make a situation analysis, target setting, prioritization and costing. Action plan and budgets FY 2019-2020 were elaborated and finalized.

4. Implementation Challenges

The following challenges were encountered during activity implementation in quarter 3:

- **Referral system:** the national level workshop with MoH staff and partners to discuss the referral systems in the health sector could not be conducted as planned due to changes in MoH priorities related to referral system, resulting in the delay in implementation of activities aimed to strengthen the referral system. Ingobyi will continue to engage with MoH to prioritize this activity in the next quarter.
- **eLearning for CHWs:** availability of staff and stakeholders has been a major setback. Availability of national trainers and other technical experts from MoH required to review and approve technical content is delaying the development of the eLearning content and system for CHWs. Some of the necessary content simply could not be finalized in a time sensitive manner. The development of the first course, iCCM, took way longer than planned, and though lessons learned from this process will help accelerate the development of remaining courses, availability of technical persons will remain a continuing challenge. Ingobyi will continue to put discuss with MoH teams and national trainers to make time for reviews, and will consider alternative options, such as virtual review to accelerate these processes. Although this process has delayed the start of eLearning activities at community level, Ingobyi is currently working with health facilities to provide supportive supervision to CHWs while waiting for eLearning to be launched.
- **Delays in approval of Ebola action plan:** implementation of Ebola preparedness was delayed due to the length of time it took to have the work plan approved. Ingobyi worked with multiple offices and had to redo the work plan repeatedly, which significantly delayed implementation. The support of USAID was helpful in moving the process forward, and Ingobyi will continue to seek support to address any future delays and bottlenecks.

5. Cross-Cutting Issues

Gender equality

Integration of gender messages into radio broadcast activities

In April 2019, Ingobyi conducted a learning session to ensure gender integration in radio products considering the messages to be provided to men and women, boys and girls (gender sensitive messages). The session brought together the Ingobyi staff involved in the development of SBC materials, including radio broadcasts. During this session, some Urunana radio soap opera were reviewed, and participants had opportunity to reflect on the content and suggested inputs for the next integrated serial messages to be displayed. As a result of this session, Ingobyi SBC teams incorporated ensures gender considerations in all productions and messages. In all the productions (Urunana serial drama, Umuhiza radio magazines, radio sketches and during field outreach activities, Ingobyi made sure the complementarity between husband and wife is highlighted, ensuring that the role that women and women play in decision making on health at household level is clearly understood.

Learning session on gender integration within Ingobyi Activity

In April 2019, a gender awareness session was conducted for Ingobyi staff to ensure they were knowledgeable and aware of gender-related considerations that affect implementation and provision of RMNCH and malaria services. During the session, staff examined various Ingobyi interventions and actions to determine whether they were consistent with gender integration principles. Key gender concepts were explained, and scenarios used to help staff understand the differences between gender blind, gender aware, exploitative, accommodating and gender transformative interventions or actions. Each staff received a gender integration tool to examine the level of gender programmatic sensitivity across RMNCH and malaria services. Similar learning sessions will be conducted periodically in future to strength Ingobyi staff capacity in gender integration, enabling them to become champions of transformative gender actors. Ingobyi conducted messaging on GBV in the community through integrated outreach activities and supportive supervision in hospitals. During the next FY, Ingobyi will conduct a training of trainers for providers in Isange One Stop Centers to support health centers in their catchment areas.

Family planning compliance

During this quarter, newly recruited Ingobyi staff completed the family planning compliance course - Protecting Life in Global Health Assistance. The staff were also oriented on FP compliance and monitoring. District mentors were oriented on FP compliance during training of new mentors conducted in May and June and through monthly coordination and supervision meetings. District mentors in turn orientation 2,042 health providers and 2,893 CHWs in different health facilities. Family planning compliance monitoring was conducted by zonal staff in 78 health facilities in western and southern zones. (See Annex C for further details of FP compliance monitoring.)

Environmental monitoring and mitigation

In this quarter, environmental monitoring and mitigation efforts focused on provider training/mentorship and waste management at facility and community during outreach events. The waste generated during the outreach activities were managed adequately per the waste management protocols. Materials utilized to gather the waste produced during outreach events (pedal bins, safety boxes, etc.) were provided by health centers. Waste generated at the outreach sites was returned to the health center for proper management and disposal. In addition, during outreach activities, Ingobyi Activity ensured that waste segregation and disposal was done using colored bins as per MoH guidelines.

Environmental monitoring and mitigation was ensured in all Ingobyi activities, including trainings, mentorship, supervision and integrated outreach activities (See annex B). During monitoring and supportive supervision visits to health facilities, Ingobyi teams observed waste management practices to ensure that they complied with the national waste management guidelines. Staff from 53 health facilities in 5 districts (Nyanza, Ruhango, Nyaruguru, Huye, and Nyamagabe) were informed and/or mentored on infection prevention and control, health and safety, protection of work environment by Ingobyi staff and district-based mentors. Ingobyi staff also discussed waste disposal with health providers and facility management.

Hazardous waste generated during training were disposed at the nearest health facility and remaining waste generated, like used and flipchart papers, were collected and returned to Ingobyi Activity office immediately after training for disposal by company specialized in waste collection who carry out office waste collection and disposal with appropriate materials.

Infection prevention and control/Ebola preparedness

In September 2018, the World Health Organization (WHO) declared yet another outbreak of the Ebola Virus Disease (EVD) in the eastern region of the Democratic Republic of Congo (DRC). The current outbreak is considered the worst in the region. Since Ingobyi Activity implements RMNCH and Malaria activities in several districts that either boarder or are proximate to the DRC, where there is a high risk of EVD transmission, there is need for Ingobyi to prepare frontline health workers in the supported district to intensify efforts for EVD prevention. Ingobyi is therefore keen to collaborate with the national EVD preparedness taskforce and other partners to prevent the spread of the disease into Rwanda. During the quarter, Ingobyi received USAID funding to support the government of Rwanda in its efforts to prevent transmission of EVD into Rwanda from neighboring DRC. Ingobyi worked with USAID and MOH to agree on a work plan that will focus on four main areas:

- Upgrade the EVD call center at the Rwanda Health Communication Center (RHCC)
- Conduct minor renovations and equip EVD isolation units in at least eight hospitals in high priority districts to enable them to manage EVD suspect cases, in case they are reported.
- Support EVD risk communication efforts through campaigns and other outreach activities; and
- Provide IPC materials and consumables to 11 hospitals; as well as mentor health providers on IPC and EVD preparedness. The providers were previously trained by MOH and other partners.

Ebola prevention and preparedness activities are expected to further boost regular infection and prevention activities in health facilities which would ultimately lead to reduction of maternal and newborn infections. Infection prevention and control is a running theme during LDHF training and mentorship by professional associations and is a key subject of discussion and coaching by Ingobyi technical staff during monitoring and supportive supervision visits. During the period, Ingobyi Activity hired three of the four staff that will support IPC activities for EVD prevention. One IPC Specialist will be based in Kigali where he will support IPC officers in zones (Western and Eastern) to emphasize IPC for EVD prevention in supported health facilities. The Specialist will also represent the team in the emergency operations center for EVD at central level. All the EVD preparedness activities will be implemented during the next quarter.

Communication

During the past quarter, a communications and documentation plan was finalized. The five-year plan will mainly focus on increasing visibility of USAID-Ingobyi Activity's support while ensuring compliance with USAID marking and branding guidelines. The communication and documentation plan will be implemented through a continuum of joint ventures between the technical teams (implementing), monitoring and evaluation team (monitoring and tracking results), and communications (synthesizing, promoting, targeting content and messages to different audiences). It will be reviewed each year to assess what works and what doesn't in terms of accuracy and effectiveness of support provided, quality of content and effectiveness of channels used.

Collaboration with other stakeholders

Parliamentary advocacy and partnership

Ingobyi Activity provided technical support in the coordination of the RPRPD high-level partners advocacy meeting on family planning and unfinished business of ICPD-International Conference on Population and Development held at the national parliament in June. Apart from members of parliament (MPs), other key partners involved included the Ministry of Health, Rwanda Biomedical Center, Ministry of Finance and Economic Planning, Ministry of Gender and Family Promotion, Ministry of Local Government, Ministry of Youth, Imbuto Foundation, embassies, UN agencies, USAID, international NGOs and development partners, religious leaders, and civil society organization. MPs committed to revise existing laws and provisions to increase access and quality of family planning methods, among other recommendations.

6. Lessons Learned

- Early involvement of health facility managers in planning LDHF and mentorship is an effective approach for generating and sustaining ownership of the interventions by the facilities. Ingobyi has learned that training and mentorship activities can only be successfully sustained if health facilities take the lead in planning and engage in monitoring and improvement efforts.
- In planning key collaborative activities, Ingobyi should anticipate unexpected changes and delays and build in alternative timelines and/or strategies to mitigate potential effect on

implementation. This quarter, several planned activities had to be cancelled or rescheduled due to challenges with availability of key players or competing priorities. This affected timeliness of some activities, such as the development of eLearning materials for CHWs, review of referral system, and data visualization workshop, among others.

7. Short-Term Technical Assistance (STTA)

None this reporting period.

8. Management and Administration

Recruitment of the Malaria Specialist was completed during this reporting period. Dr. Jacqueline Umunyana was selected as the finalist to fill the position following a competitive recruitment process. This being a key personnel position, prior approval was obtained from USAID before an offer was made to the applicant. Jacqueline is expected to start work on July 22, 2019.

9. Key Events/Activities Planned for the Next Quarter

Central level

- Support training of CEHOs in 4 districts on community health full package
- Host and co-chair the safe motherhood sub- TWGs, Child Health TWG and ICCM and CBMNH sub-TWG meetings
- Participate in FP/ASRH, newborn, Health promotion and RMNCH TWGs
- Conduct a workshop to elaborate norms and standards for maternal and update the newborn standards
- Update the PNC guideline
- Conduct a workshop to adapt WHO QoC indicators

Social and behavior change

- Validate the IEC materials developed in Q3. (adapted to the audience: posters, chartbook, etc.)
- Disseminate the IEC education materials for facilities
- Continue production and broadcast of Urunana soap opera episodes
- Continue production of Umuhoza magazine
- Conduct integrated mobile outreach in hard to reach communities to create demand for and access to RMNCH and malaria services

Referral system

- Support MoH and zonal teams to address gaps identified in referral services during ISS and DQA with a focus on facilities with low completeness rate (0% to 80%)
- Finalize referral forms per technical area and instructions on how to fill referral forms and rereferral registers and present finalized version to TWGs
- Advocate for inclusion into HMIS new indicators for tracking referrals and counter referrals per technical area
- Sensitize health care providers at facility and CHWs on the use of updated standard tools, proper documentation and use of referral data for capacity building

LDHF and mentorship

- Conduct LDHF training and mentorship in hospitals and health centres
- Conduct supportive supervision for mentors
- Conduct coordination meetings with Professional Associations

Ebola preparedness

- Renovate and equip isolation units in 8 districts
- Conduct mentorship for health providers trained as district champions
- Disseminate Ebola prevention messages and materials

Gender integration

- Supportive supervision of IOSCs for ensuring the quality of service provision of GBV survivors
- Site visit of community knowledge centers to ensure the dissemination of gender integration messages during community awareness activities
- Dissemination of GBV tools at Ingobyi supported DHs and HCs
- Learning sessions with Ingobyi staff on gender integration and GBV prevention and response

Monitoring, evaluation and learning

- Conduct an annual survey to assess effectiveness of SBC activities in changing behaviors and practices in targeted communities in the 20 districts.
- Conduct workshop involving key eLearning stakeholders, such as MOH/MCCH division, among others to review ICCM eLearning module content and write scripts for CBP and CBMNH.
- Train DHMT members on HealthAppex

10. Annexes

A. Indicator performance table (only indicators reported on a quarterly basis)

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|--|--|----------------|-------------|-----------|----------|-----------|-----------|------------|------------|---|
| Goal: Reduction in maternal and infant mortality in Rwanda, as well as increased self-reliance of the GOR | | | | | | | | | | |
| Strategic Objective: To improve the utilization and quality of RMNCH and malaria services in a sustainable manner | | | | | | | | | | |
| IR 1: Increased equitable access to RMNCH/malaria services in targeted districts | | | | | | | | | | |
| IR-1.1 | Percentage of pregnant women who attend at least 4 ANC visits | Outcome | DHIS2 | Quarterly | 32% | 37% | 36% | 35% | 98% | |
| IR-1.2 | Percentage of pregnant women who attend 1st ANC visit during 1st trimester | Outcome | DHIS2 | Quarterly | 35% | 40% | 39% | 42% | 108% | |
| IR-1.3 | Number of children under 5 tested for malaria at the community level | Outcome | DHIS2 | Quarterly | 774,834 | 790,331 | 197583 | 101,505 | 51% | Ingobyi has shared this observed drop in number of RDT tests done during Q3 with MOPDD for further investigation. |
| IR-1.4 | Number of malaria cases in pregnancy | Outcome | DHIS2 | Quarterly | 3061 | 2939 | | 3895 | 133% | This is the quarterly achievement against the annual target. It was recognized that the target for this indicator did not consider all data elements contributing to the indicator (simple, moderate, severe, |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|---------|--|----------------|-------------|-----------|----------|-----------|-----------|------------|------------|---|
| | | | | | | | | | | hospital and health center cases). The next target setting activity will consider this missing portion |
| IR.-1.7 | GNDR-6 Number of people reached by a USG funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other) | Output | DHIS2 | Quarterly | 16,313 | 18,760 | 4,690 | 4,824 | 103% | |
| | Proportion of new FP acceptors who are accompanied by partner (Male engagement in RH) | Outcome | DHIS2 | Quarterly | 18% | 23% | 22% | 12.4% | 57% | Ingobyi plans to disseminate SBC messages in supported health centers and the communities on RMNCH integrating gender messages expected to increase male involvement in FP. |
| IR-1.10 | Number of new users of FP methods | Outcome | DHIS2 | Quarterly | 254,127 | 279,540 | 69,885 | 60,210 | 86.2% | As a result of data quality supervision conducted during this quarter, two facilities improved the way this indicator was reported. This led to having Ngeruka HC dropping from reporting 19164 new FP users to 77, and Gasange dropping from 1898 to |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|---|--|----------------|-----------------|-----------|----------|-----------|-----------|------------|------------|--|
| | | | | | | | | | | 66. The facilities previously reported current users instead of new users. This caused a major drop in number of cases targeted. |
| IR-1.11 | Proportion of facilities offering both short-term FP methods and LARCs | Outcome | Ingobyi records | Quarterly | 81% | 81% | 81% | 81% | 100% | |
| IR-1.12 | HL.7.1-2 Percent of USG-assisted service delivery sites providing family planning counseling and/or services | Outcome | Ingobyi records | Quarterly | 100% | 100% | 100% | 100% | 100% | |
| Sub-IR 1.1: Increased availability of RMNCH/malaria services | | | | | | | | | | |
| Sub-IR 1.2: Improved healthcare-seeking behaviors for RMNCH/M services | | | | | | | | | | |
| IR-1.2.3 | Number of individuals attended outreach events | Output | Ingobyi records | Quarterly | N/A | 100,000 | 25,000 | 139,657 | 559% | The year one target was estimated by considering 5000 individuals per district. However, Q2 results have revealed that the outreach events are reaching even more individuals than expected. In addition to this, Ingobyi extended the dissemination of messages via CHWs in all the villages of 8 Districts during Umuganda and that hugely increased the |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|---|---|-----------------------|-------------|-----------|----------|-----------|-----------|------------|------------|--|
| | | | | | | | | | | number of individuals reached. |
| IR 2: Improved quality of RMNCH/M services along the continuum of care in targeted districts | | | | | | | | | | |
| IR-2.1 | 3.1.6-64 Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs | Output | DHIS2 | Quarterly | 172,599 | 178,299 | 44,575 | 50,254 | 113% | The analysis of deliveries has revealed that this reporting period register the highest number of deliveries in a year. This might explain the overachievement on all the indicators related to Total deliveries |
| IR-2.2 | HL.6.3-1 Number of newborns not breathing at birth who were resuscitated in USG-supported programs | Output | DHIS2 | Quarterly | 5,813 | 5,523 | 1381 | 1,879 | 136% | The analysis of deliveries has revealed that this reporting period register the highest number of deliveries in a year. This might explain the overachievement on all the indicators related to Total deliveries |
| IR-2.3 | 3.1.6.3-Z01 Number of babies who received postnatal care within two days of childbirth in USG-supported programs | Outcome (3.1.6.3-Z01) | DHIS2 | Quarterly | 171,538 | 180,115 | 45,029 | 50,629 | 112% | The analysis of deliveries has revealed that this reporting period register the highest number of deliveries in a year. This might explain the overachievement on all |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|--------|---|----------------|-------------|-----------|----------|-----------|-----------|------------|------------|---|
| | | | | | | | | | | the indicators related to Total deliveries |
| IR-2.4 | 3.1.6-6 Number of cases of child diarrhea treated in USG-assisted programs | Output | DHIS2 | Quarterly | 106,849 | 112,191 | 28,178 | 29113 | 103% | |
| IR-2.5 | 3.1.6-63 Number of children under five years of age with suspected pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs | Output | DHIS2 | Quarterly | 137,399 | 144,269 | 36,067 | 55,291 | 153% | Pneumonia among children under 5 is known to show a seasonal trend that is not evenly distributed across the quarters. It is expected that upcoming quarters will show a decline in the observed trend. |
| IR-2.6 | 3.1.6-Z23 Number of newborns receiving antibiotic treatment for infection through USG-assisted programs | Output | DHIS2 | Quarterly | 4,364 | 4,146 | 1,036 | 1,561 | 151% | The trend analysis has shown a slight increase in the newborn infection. Despite the great work by Ingobyi, some challenges to improve IPC measures have been identified during this last quarter and Ingobyi will continue to strengthen IPC measures together with advocating where those measures fall outside of its scope. |
| IR-2.7 | Proportion of low birth weight babies (less than | Outcome | DHIS2 | Quarterly | 70% | 80% | 78% | 82% | 106% | |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|--|--|----------------|-----------------|-----------|----------|-----------|-----------|------------|------------|--|
| | 200gr) admitted to facility-based KMC services | | | | | | | | | |
| IR-2.8 | Percentage of newborns put to the breast within 1 hour of birth | Outcome | DHIS2 | Quarterly | 92% | 95% | 94% | 94% | 100% | |
| Sub-IR 2.1 Improved provider skills in RMNCH/malaria (doctors, nurses, midwives and CHWs) | | | | | | | | | | |
| IR-2.1.1 | Total number of people trained using USG funds | Output | Ingobyi records | Quarterly | N/A | 2,413 | | 609 | 25% | The target includes refresher training of CHWs using eLearning module. During this last quarter, Ingobyi have worked with MoH to reconfigure the MoH e-learning platform to allow accommodation of the CHW module and produced a first draft of the ICCM content design. |
| IR-2.1.2 | 3.1.3.1-1 Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds | Output | Ingobyi records | Quarterly | N/A | 2,000 | | 34 | 2% | These are Child health and Malaria District based mentors oriented in June. The achievement against target is considering the quarterly data against the Annual target as there was no estimated quarterly targets. |
| IR-2.1.3 | Number of LDHF+ Mentors providing trainings | Output | Ingobyi records | Quarterly | N/A | 450 | 450 | 671 | 149% | This target did not include Mentors from |

| # | Indicators | Indicator type | Data source | Freq. | Baseline | Y1 target | Q3 target | Q3 results | % Achieved | Comments |
|--|--|----------------|-----------------|-----------|----------|-----------|-----------|------------|------------|---|
| | | | | | | | | | | professional associations. |
| IR-2.1.4 | Proportion health providers receiving mentorship by LDHF+ mentors | Output | Ingobyi records | Quarterly | N/A | 63% | 63% | 39% | 63% | Given staff shortages at health centers it difficult to keep a cohort of 6 mentees that was estimated during target setting. On average the mentors can only consistently mentor one mentee per technical area. |
| IR-2.1.5 | Number of CHWs completing refresher eLearning training module | Output | Ingobyi records | Quarterly | N/A | 1,450 | | 0 | 0% | This quarter Ingobyi worked with MoH to reconfigure the MoH e-learning platform to allow accommodation of the CHW module and produced a first draft of the ICCM content design. The platform will be initiated next quarter |
| Sub-IR 2.2 Institutionalized quality improvement approaches for RMNCH/malaria interventions | | | | | | | | | | |
| Sub-IR 3.2 Strengthened capacity of hospitals to achieve RMNCH/malaria related accreditation indicators | | | | | | | | | | |
| IR-3.2.2 | Proportion of women with eclampsia that received magnesium sulfate according to national EmOC protocols. | Outcome | DHIS2 | Quarterly | 90% | 95% | 94 | 84 | 90% | |

B. Environmental Monitoring and Mitigation

| Category of Activity | Specific Environmental Threat | Mitigation Measures | Outstanding Issues | Next Steps |
|---|-----------------------------------|---|---|---|
| Support mobile outreach | Generation of medical waste | Health workers involved in the Integrated RMNCAH outreach activity had been trained on waste management. The waste generated during the outreach activities was managed adequately per the waste management protocols. Materials utilized to gather the waste produced was brought from the health center (pedal bins, safety boxes, etc.). After the activity was completed, all waste generated at the outreach sites was returned to the health center for proper management and disposal. | None | Will continue monitoring of waste management during outreach activities and at facility level |
| Support district or national level trainings | Training generating medical waste | Immediately after training hazardous waste are disposed at the nearest health facility. | None | Ingobyi will continue to ensure that training hazardous waste are disposed at the nearest health facility. |
| Support supervision activities | Training generating medical waste | Ingobyi Activity staff conducted mentorship visits and supportive supervision in supported health facilities from 20 districts between April and June 2019. During each visit, Ingobyi Activity staff discussed waste disposal with the sites. In addition, Ingobyi conducted training of 56 on infection control and waste management integrated with the management of Ebola Virus Disease. | Community environmental health and sanitation officers (CEHO) in health facilities need to integrate waste disposal education sessions in IEC/BCC at health facilities. | Ingobyi Activity will continue to ensure that waste management and infection control is integrated in all training manuals. |
| | | During mentorship and supportive supervision, the mentors and supervisors check for waste management with proper colored bins. In addition, during outreach activities, Ingobyi Activity ensure that waste is segregation and disposal done using colored bins as per MoH guidelines. | CEHO in collaboration with head of health services need to monitor the bins and ensure safety at all times. | Ingobyi will continue monitoring of waste management during outreach activities and at facility level. |

C. Family Planning Compliance Updates

| Activities | Purpose | Targeted audience | Status | Next Steps |
|--|---|--|---|--|
| Preventive Activities | | | | |
| Orient Ingobyi staff on U.S. family planning and abortion legal and policy requirements (new staff in Ingobyi staff will undertake the online FP compliance course as part of their orientation during the first 90-days of employment, and subsequently take refresher training annually) | Ensure all Ingobyi staff are trained on compliance in person or through the online course | All Ingobyi staff | Course completed by all Ingobyi staff recruited during the period of April - June 2019. Certificates of completion are archived. | Orientation and training of any new staff recruited will continue and refresher training for existing staff will be conducted |
| Orient Ingobyi sub-grant staff on US abortion and FP requirements | Ensure FP compliance in the activities implemented by Ingobyi sub-grantee staff | Professional Associations and other sub-grantees | All sub grantees staff on board have completed the online course and their certificates are archived | Orientation will continue as a new staff come on board and refresher training will be done on annually basis |
| Organize quarterly meeting of Ingobyi/FP compliance committee | Ensure coordination of FP Compliance monitoring activities at all levels | Committee including Technical and administrative Ingobyi staff | The FP compliance committee is established. The FP compliance focal point at Ingobyi head office and in the four zones are available. The committee met this quarter to discuss FP activities implementation and FP compliance monitoring plan. | FP compliance committee meeting will continue to be conducted once a quarter as planned. Th FP compliance committee will organize field visit to conduct FP compliance monitoring |
| Organize quarterly meetings of FP compliance district focal points to share experience, discuss current | Ensure FP compliance through discussion on related issues in Ingobyi supported districts | FP compliance district focal points | This activity was combined with quarterly coordination meeting in Rutsiro District. All heads of HFs, M&E staff, data | The same activity is planned in other districts next quarter |

| | | | | |
|---|--|---|---|---|
| status and relevant risks, if any, which may compromise the FP compliance at service delivery level | | | managers, DH supervisors and district-based mentors attended the session | |
| Orient staff working in Ingobyi supported districts and health facilities on U.S abortion and FP requirements | Ensure that staff working in Ingobyi supported districts and health facilities are aware of US abortion and FP compliance requirements | Staff working in Ingobyi supported health facilities | 2,042 health care providers were oriented on FP compliance during mentorship, and Ingobyi used CHWs monthly meetings to provide the same orientation to 2,893 CHWs | Continue orientation in supported districts not covered this quarter and for new staff |
| Distribute printed posters, flip charts, leaflets on FP to Ingobyi supported health facilities for education of clients about FP methods. | Ensure that all health workers and clients have educational materials with comprehensive information on FP contraceptive methods | Ingobyi supported health facilities | These IEC materials are available in districts previously supported by MCSP | Advocate for provision of the communication materials in other districts |
| Monitoring Plan | | | | |
| Orient new Ingobyi staff on monitoring checklists and questionnaires to be used during routine field visits | Document due diligence in monitoring compliance with requirements. | All Ingobyi field staff | One Ingobyi staff in western zone, 4 staff for central zone and 8 staff for Eastern zone were oriented on FP compliance. | Orient newly recruited Ingobyi staff in all zones |
| Carry out facility FP compliance monitoring at supported health facilities and sub-grant organizations | Ensure that all Ingobyi partners follow US abortion and FP requirements | Ingobyi supported health facilities, Ingobyi sub-grantees | Monitoring is done on monthly basis by district-based mentors during mentorship and Ingobyi staff during routine field visit or routine supportive supervision. All 78 HFs offering FP services in western zone and 5 HFs in southern zone were visited this quarter. The FP compliance issue reported in western zone in April 2019 regarding stock out of Implanon NTX for 5 days was resolved. | This quarter more effort was put on staff orientation in all districts. For the coming quarter efforts will be placed on orientation and monitoring not only by the staff at zonal level, but also FP compliance committee. |

| | | | | |
|--|---|--|---|-----------------------------|
| Regular documentation and reporting on US abortion and FP requirements | Ensure documentation and reporting of all FP compliance efforts of Ingobyi Activity | All FP compliance activities documented and reported | Done on a regular basis. The report for staff oriented and FP monitored are archived in the zonal office. | This is an ongoing activity |
|--|---|--|---|-----------------------------|

D. Professional Association QI projects

RSOG QI Projects.

| QI statement | Baseline | Target | Progress to date (July 2019) |
|---|----------|--------------------------|------------------------------|
| 1.Byumba Reduce post C/S infections from January 2019 to September 2019 | 3 % | Zero cases by April 2019 | 2.5% |
| Reduce cases of birth asphyxia from January 2019 to September 2019 | 3.4% | 0.5% | 5% |
| Reduce number of PPH cases after C/S from Jan/019 to September 2019 | 2.5% | 0% | 2.5% |
| 2.Kibungo To reduce Post-op infections from January 2019 to August 2019 | 2% | <2% | 1.7% |
| To reduce neonatal birth asphyxia from Dec/2019 to August 2019 | 8% | 5% | 4.8% |
| To reduce the length of hospital, stay from Dec/2018 to Aug/2019 | 4days | < 2days | 2 days |
| 3.Kabgayi To reduce post-op infections from Dec/2018 to Sept/2019 | 5% | 0% | 4.8% |
| To reduce neonatal birth asphyxia from Dec/2018 to June 2019 | 5.5% | 0% | 2.8% |
| 4. Kaduha To reduce post-op infections from Jan/2019 to Sept/2019 | 5% | 2% | 10.6% |
| To reduce number of PPH cases from Jan/2019 to Sept/2019 | 2.5% | 1% | 3.1% |
| 5.Munini To reduce post-op infections from Jan/2019 to Sept/2019 | 5.2% | <2% | 4.4% |

| QI statement | Baseline | Target | Progress to date (July 2019) |
|--|--------------|---------------|------------------------------|
| To reduce number of PPH cases from Jan/2019 to Sept/2019 | 1.7% | 1% | 2.2% |
| Nyamata To reduce post-op infections from Jan/2019 to Sept/2019 | 1.2% | 0.75 | 4.2% |
| To reduce neonatal birth asphyxia from Jan 2019 to August 2019 | 2.9% | 1% | 3% |
| To reduce cases of post C/S peritonitis from Jan/2019 to Sept/2019 | 2.7% | 1.5% | 0% |
| 7.Kacyiru Reduce the rate of neonatal birth asphyxia from Jan/2019 to Sept/2019 | 2.1% | 1% | 2.3% |
| Reduction of the rate of post-partum infections from Jan/2019 to Sept/2019 | 4.5% | 1.1% | 2.7% |
| 8.Kabutare Reduction of the rate of post-partum infections from Jan/2019 to June/2019 | 7.5% | 2.5% | 3.8% |
| To reduce length of hospital stay for people with incomplete abortion and early pregnancy failure from Jan/2019 to June 2019 | 4 days | 1 day | 2 days |
| 9.Gisenyi Decrease surgical site infections from Jan/2019 to June 2019 | 2.3% | 1% | 2.5% |
| Reduce the rate of neonatal birth asphyxia from Jan/2019 to June/2019 | 3.4% | 1.8% | 3.1% |
| 10. Murunda Reduction of antibiotics in caesarian section from Jan/2019 to May 2019 | All patients | Less than 10% | |
| Reduce length of hospital stay post C/S from Jan/2019 to June 2019 | 5-7 days | 3 days | 4 days |
| 11.Kiziguro | 6% | 3% | (4.3 %) |

| QI statement | Baseline | Target | Progress to date (July 2019) |
|---|--|---|---|
| To reduce post-op infections from Jan/2019 to Sept/2019 | | | |
| Reduce length of hospital stay post C/S from Jan/2019 to September 2019 | Over 5 days | <2 days | Varies between 2-3 days |
| 12. Ruhango Reduce the use of misoprostol from Jan/2019 to Sept/2019 | 200 tablets | 100 tablets | 120 tablets |
| 13. Rwamagana Reducing waiting time for new admissions into dept from Jan/2019 to June 2019 | 2 Hours | 30 minutes | 1hour |
| Reduce the waiting time between decision to do C/S and time of incision from Jan/2019 to June 2019 | 3 hours | 30 minutes | 1hour |
| 14. Kigeme To reduce post-op infections from Jan/2019 to June/2019 | Over the Last 6 months of 2018 :Have a turnover of 5-6 Cases Monthly, 1.7% in Jan/2019 | 1 every 2-3 months | 4% |
| Reduction in birth asphyxia from Jan/2019 to Sept/2019 | 5% | 0% | 0.8% |
| 15. Kabaya To reduce birth asphyxia from Jan/2019 to Sept/2019 | 7.2% | 3% | 1.6% |
| To reduce PPH post C/S from Jan/2019 to Sept/2019 | 0.8% | 0.4% | 5% |
| 16. Ruhengeri Health providers prolong a labor for longer than is reasonable (Feb/2019 to Sept/2019). | Decision-to-delivery time interval (DDI) is 120'-180' | Decision-to-delivery time intervals to be 30'-60' | DDI now stands between 30'-60' and at times reaches 120' depending on circumstances |
| 17.Nyagatare Reduction of post-operative infection from Jan/2019 to September 2019 | 4.5% | 2.5% | 4.9% |

| QI statement | Baseline | Target | Progress to date (July 2019) |
|--|-----------------------|--------|------------------------------|
| Reduction of Birth asphyxia rate from Jan/2019 to Sept/2019 | 21.2% | 12% | 18.9% |
| 18.Gitwe Reduction of birth asphyxia from Jan/2019 to Sept/2019 | 5% | 0% | 2% |
| Decrease post-operative infections. from Jan/2019 to Sept/2019 | 2% | 0% | 2% |
| Decrease post-partum hemorrhage cases from Jan/2019 to Sept/2019 | 2% | 0% | 1% |
| 19.R-Rukoma Reduction of post op infection from Jan/2019 to June/2019 | 5.2% | 2.5% | 1.5% |
| reduction of neonatal asphyxia from Jan/2019 to June/2019 | 2.5% | 1.5% | 1.5% |
| 20. Shyira Reduction of neonatal birth asphyxia/HIE | 2.5% | 0% | 1.7% |
| 21.Masaka Zero Maternal Death by hemorrhage in Masaka Hospital from February 2019 to February 2020 | Still being worked on | 0% | No data yet |
| 22.Ngarama Decrease post-operative infection from Jan/2019 to Sept/ 2019 | 8% | 0% | 4% |
| Decrease post-partum hemorrhage cases from Jan/2019 to Sept/ 2019 | 5% | 0% | 1.5% |
| 23. Nyanza Decrease post-partum hemorrhage cases from Jan/2019 to June/ 2019 | 1.6% | 0.4% | 1.45% |
| 24. Muhororo Reduction of neonatal birth asphyxia from Jan/2019 to Sept/2019 | 9% | <5% | 13% |

| QI statement | Baseline | Target | Progress to date (July 2019) |
|--|----------|--------|------------------------------|
| 25. Kibagabaga Reduction of neonatal birth asphyxia from Jan/2019 to Sept/2019 | 4.7% | 0.5% | 3.9% |

RPA QI projects

| Hospital | QI statement | Baseline | Target | Status |
|---------------|--|----------|--------|--------|
| Rwamagana | To reduce hypothermia rate among babies born | 50% | 20% | 54% |
| | To perform all clinical death audits fully during the concerned month | 25% | 100% | 100% |
| Kabgayi | To reduce the number of hypothermia in Neo | 45% | 5% | 41.7% |
| | To improve fluids prescription in Emergency and pediatrics wards | 24% | 100% | 25% |
| Ruhengeri | To decrease by 50% newborn with HIE born | 60% | 50% | 50% |
| Masaka | To reduce the number of hypothermia in Neo | 33% | 10% | 33% |
| | To improve safety use of oxygen therapy in children | 49% | 10% | 43% |
| Munini | To reduce birth asphyxia rate | 19% | 10% | 6.25% |
| | To reduce prescription of inappropriate IV fluids (types and amount) | 52% | 26% | 30% |
| Nyamata | To reduce birth asphyxia rate | 27% | 15% | 4% |
| | To reduce hypothermia rate | 50% | 20% | 28% |
| Remera Rukoma | To improve a consistent monitoring and recording of vital signs for admitted neonates in Neonatology | 10% | 80% | 100% |
| Kaduha | To improve the fluid management practice by providing appropriate amount | 0% | 90% | |

| Hospital | QI statement | Baseline | Target | Status |
|-----------|---|----------|--------|-----------------|
| Kaduha | To improve feeding of small infants and sick infants in the Neonatology unit | 50% | 80% | 76% |
| | To improve management of bronchiolitis | 10% | 85% | 54% |
| Kiziguro | To improve infection control in the neonatology unit by availing alcohol spencer at each incubator from February to May 2019 | 0% | 100% | 0% ³ |
| | To improve IV fluids labeling in admitted newborns | 30% | 100% | 30% |
| Shyira | To reduce hypothermia among newborns | 37% | 0% | 40% |
| | To improve documentation in pediatrics | 30% | 100% | 91% |
| Gitwe | To decrease the prevalence of hypothermia | 50% | 20% | 59% |
| Kabutare | To equip and check the materials of the neonatology emergency trolley | 19% | 90% | 48% |
| | To reduce the cases of birth asphyxia by a third | 17% | 5% | 32% |
| Kacyiru | To decrease hypothermia rate | 36% | 18% | 14% |
| Kigeme | Kigeme H/ To improve infant feeding for infants fed with NGT from 60% to 90% from February to May 2019 | 60% | 90% | 77% |
| | To measure the MUAC (mid-upper arm circumference) for children aged from 1 year to 5 years and those aged over 6 months with height above 65 cm admitted in pediatric ward in order to do screening of acute malnutrition | 3% | 70% | 16% |
| Murunda | To improve infection control in Neonatology | 27% | 90% | 90% |
| | To avail an emergency trolley in the emergency room | 0 | 1 | 1 |
| Nyagatare | To improve taking and regular recording of vital signs (3 hourly as the neonatal protocol stated) in babies admitted in Neonatology | 0% | 90% | |

³ Due to insufficient infrastructure, the hospital worked on the reorganization of services to allocate more space for the neonatal unit, and the district mentor continues to work with the hospital staff to prioritize this action.

| Hospital | QI statement | Baseline | Target | Status |
|------------|--|----------|--------|--------|
| | To improve the triage system at ER by using of a triage form while assessing pediatric patients | 0% | 90% | 90% |
| Ruhango | To decrease hypothermia at admission in Neonatology | 61% | 30% | 78% |
| | To decrease long stay and quality of care of pediatric patients at Emergency department | 80% | 20% | 40% |
| Muhororo | To decrease the duration of stay of admitted premature babies | 75% | 20% | 75% |
| Kibungo | To improve feeding practices and IV fluids management in unstable neonates and neonates with HIE admitted | 43% | 90% | 50% |
| | To improve the use of oxygen in children admitted in pediatric | 55% | 90% | 100% |
| Gisenyi | To decrease birth asphyxia cases | 23% | 10% | 11% |
| | To improve triage of sick patients at emergency room | 40% | 70% | 70% |
| Kabaya | To reduce hypothermia | 86% | >2% | 60% |
| | To improve prescribing standards in pediatric ward | 40% | 90% | 40% |
| Ngarama | To reduce hypothermia | 36% | 15% | 17% |
| | To improve the use of triage form of sick children at ER | 66% | 95% | 72% |
| Byumba | To reduce the number of cases admitted and discharged in pediatrics for severe pneumonia without Chest X-ray | 72% | 2% | 39% |
| | To reduce hypothermia at admission | 30% | 5% | 59% |
| Kibagabaga | To reduce hypothermia | 52% | 5% | 52% |
| | To improve emergency management by a fully equipped emergency trolley | 0 | 1 | 1 |
| | To reduce hypoxia in newborn babies from labor ward and C-section | 40% | 5% | 40% |

E. Success Stories

USAID Ingobyi Activity Integrated Outreach Boosts Family Planning at Mukura Health Center

“We have never known such an increase before, women and men have positively received the messages disseminated through Ingobyi integrated outreach activities, where family planning messages were included as well as counseling and informed choice on FP and this had increased the demand of family planning methods among clients”



Perus Nyiransengimana, family planning focal point person, Mukura Health Center

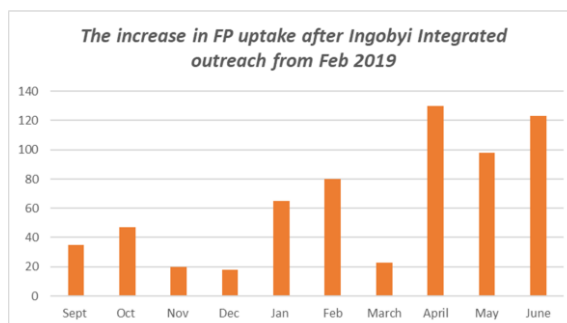
According to statistics from Mukura Health Centre that serves a catchment area of 39,091 people, the number of family planning users increased in five months from 19 percent in January 2019 to 24 percent in June 2019.

Perus Nyiransengimana, Focal person of Family planning at Mukura Health Center says the uptake was boosted by USAID-Ingobyi Activity Integrated Community Outreach sessions conducted at Mukura Health Centre in February and June, which saw a significant increase of people whom by own choice accepted to use FP methods at the selected sites and through referrals.

“Currently, we continue to receive an increased number of FP new clients compared to the figures we used to have before at our facility. We wish outreach activities would continue”, says Nyiransengimana.

“I am glad that community members have started to understand that FP uptake saves lives, not only for the mother but also for children and the whole family as parents get time to work for their family and invest for their future,” adds Nyiransengimana.

As per the figure below, the FP uptake has increased from February, during and after the integrated outreach activities. In March, the number was very low due to the stockout of FP methods while the demand was high. The situation improved in April as shown in below graph.



Nyirahabimana Ruth, 32, with four children, a resident from Mukura Sector, who also adopted FP methods during the integrated outreach activities, testified how messages and approach used helped her to have useful information to inform her choice and decision around FP.

“I and my husband attended the event, FP and available methods were communicated and we showed interest in FP and chose one of the methods after a counseling session with the nurse,” says Nyirahabimana.

Ingobyi Activity scoops awards in four districts during open days



Ingobyi staff (with microphone) explaining services provided at its exhibition stand to Nyaruguru District Mayor and other officials



Ingobyi staff (right) receiving an award from the in-charge of Economic Affairs in Nyanza District (left)

“We appreciate how clean, beautiful and private Ingobyi stand was. The quality and importance of services provided to Muhanga District population is also commended,” Iphigenie NYIRATUNGA, Muhanga District Joint Action Development Forum (JADF) Chairperson during the closing ceremony of Muhanga District development partners Open Day.

Between May and June 2019 Ingobyi Activity has participated and supported district open days; an activity that serves the purpose of bringing together all district development partners to exhibit, share and have open interactions with communities about their interventions for increased transparency, ownership and impact.

Ingobyi activity received four awards in Kamonyi, Muhanga, Nyanza and Nyaruguru districts for stand decoration and organisation, team punctuality, population’s interest in services offered at the stand and consistency of exhibitors. In Kamonyi District alone, Ingobyi Activity was awarded the second best amongst 85 exhibitors.

Ingobyi Activity provided services ranging from HIV counselling and testing, family planning counselling and methods provision, rapid pregnancy tests and under 5 growth monitoring and malnutrition screening. Over 100 people visited Ingobyi Activity stands daily.

“Let me add my appreciation to all teams for great performance. You continue to make us very proud. We very much appreciate your commitment and creativity,” said Samson Radeny, Ingobyi Activity Chief of Party.