

USAID Ingobyi Activity

FY22 Quarter 1 Progress Report

(October 1, 2021–December 31, 2021)

Report Submission Date:

January 30, 2022

Contact Information:

Name:

Samson Radeny, Ph.D.

Position:

Chief of Party

Phone number:

+250-727700021

Email address:

sradeny@intrahealth.org



USAID
FROM THE AMERICAN PEOPLE

IntraHealth
INTERNATIONAL
Because Health Workers Save Lives.



Table of Contents

1. Activity Description.....	4
2. Implementation Summary	7
3. Implementation Progress by Technical Area.....	13
I. Family Planning and Comprehensive Reproductive Health.....	13
II. Maternal Health.....	29
III. Newborn Health	45
IV. Child Health.....	57
V. Malaria Prevention and Treatment.....	66
VI. Cross-cutting Interventions.....	77
A. Strengthening Referral Systems.....	78
B. Social and Behavior Change Interventions.....	79
C. Gender Integration.....	80
D. Infection Prevention and Control	83
E. Disease Outbreak Preparedness and Prevention.....	89
F. Environmental Monitoring and Mitigation.....	90
G. Quality Improvement.....	90
H. Community Participation and Engagement	91
I. Data demand and use.....	92
J. Learning agenda.....	96
K. District-level support.....	98
4. Collaboration with USAID Implementing Partners and Other Stakeholders.....	100
5. Implementation Challenges.....	101
6. Lessons Learned.....	102
7. Short-Term Technical Assistance	102
8. Activities Planned for Quarter 2 of FY22.....	102
9. Management and Administration.....	107
10. Annexes.....	108
A. Indicator performance table	108
B. Environmental monitoring and mitigation.....	114
C. Family planning compliance updates.....	115
D. Success Stories.....	118
E. Summary of QI Projects currently Implemented in Health Facilities.....	124

Acronyms and Abbreviations

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CBMNH	Community-Based Maternal and Newborn Health
CBP-FP	Community-Based Program on Family Planning
CCD	Care for Child Development
CEHOs	Community Environmental Health Officer
CHWs	Community Health Workers
COVID-19	Coronavirus Disease 2019
CPAP	Continuous Positive Airway Pressure
CRH	Comprehensive Reproductive Health
CVA	Citizen Voice and Actions
DHIS	District Health Information Software
DHMT	District Health Management Team
DHU	District Health Unit
DMPA-SC	Depot Medroxyprogesterone Acetate Subcutaneous
DQA	Data Quality Audit
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
ETAT+	Emergency Triage, Assessment, and Treatment Plus Admission Care
FP	Family Planning
FY	Fiscal Year
GBV	Gender-Based Violence
GMCD	Guide for Monitoring of Child Development
GoR	Government of Rwanda
HBB	Helping Babies Breathe
HBM	Home-Based Management of Malaria
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICCM	Integrated Community Case Management
IEC	Individual Education and Counseling
IMCI	Integrated Management of Childhood Illness
IOSC	Isange One-Stop Center
IPC	Infection prevention and control
IR	Intermediate Result
IUD	Intrauterine Device
JADF	Joint Action Development Forum
KMC	Kangaroo Mother Care
LDHF	Low Dose High Frequency
LLIN	Long-Lasting Insecticidal Net

M&E	Monitoring and Evaluation
MCCH	Maternal, Child, and Community Health
MCH	Maternal and Child Health
MEL	Monitoring, Evaluation, and Learning
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MOPDD	Malaria and Other Parasitic Diseases Division
MPCDSR	Maternal, Perinatal, and Child Death Surveillance and Response
NBU	Newborn Unit
OPD	Outpatient Department
PDC	Pediatric Development Clinic
PHC	Primary Health Care
PNC	Postnatal Care
PPE	Personal Protective Equipment
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PVP-CVA	Patient Voice Program-Citizen Voice and Actions
QI	Quality Improvement
RAM	Rwanda Association of Midwives
RBC	Rwanda Biomedical Center
RDQA	Routine Data Quality Audit
RHAP	Rwanda Health Application Platform
RIHSA	Rwanda Integrated Health Systems Activity
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RPA	Rwanda Pediatric Association
RRT	Rapid Response Team
RSOG	Rwanda Society of Obstetricians and Gynecologists
SBC	Social and Behavior Change
SISCOM	<i>Système d'Information Sanitaire Communautaire</i>
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

1. Activity Description

Activity title	USAID Ingobyi Activity
Agreement number	72069618CA00005
Name of prime implementing partner	IntraHealth International
Names of sub-awardees	<ol style="list-style-type: none"> 1. Akros 2. Ingenuity Ltd. 3. Society for Family Health 4. Urunana Development Communication 5. World Vision Rwanda 6. Rwanda Association of Midwives 7. Rwanda Pediatric Association 8. Rwanda Society of Obstetricians and Gynecologists
Supported health facilities	<ul style="list-style-type: none"> • 2 referral hospitals • 2 provincial hospitals • 22 district hospitals • 325 health centers
Activity start date	July 27, 2018
Activity end date	July 26, 2023
Report period	October 1, 2021 to December 31, 2021
Total estimated budget amount	\$ 53,291,422
Total funds obligated to date	\$ 43,411,717
Actual expenditure to date (December 31, 2021)	\$ 33,022,108
• Family planning	\$ 13,517,003
• Maternal and child health	\$ 11,744,013
• Water	\$ 347,048
• Malaria	\$ 4,186,345
• Ebola	\$ 895,017
• COVID-19	\$ 2,332,682
Estimated remaining obligated funds	\$ 10,389,609

Activity Description, Objectives, and Expected Results

The United States Agency for International Development (USAID) Ingobyi Activity¹ 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

¹ USAID Ingobyi Activity is also referred to in this report as the Activity, Ingobyi Activity, or simply as Ingobyi.

mortality in Rwanda. The Activity builds upon the tremendous gains Rwanda has made in the health sector, as well as previous USAID investments.

Ingobyi Activity’s efforts aim to reduce infant and maternal mortality and the incidence of malaria in Rwanda by improving the availability, quality, and utilization of RMNCH and malaria services with resilience and toward 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 focuses on achieving a shared understanding of the patterns and systemic structures that underlie the health system and where and how to bring about measurable, sustainable improvements. Ingobyi Activity focuses on three intermediate results (IRs), as outlined in Table 1.

Table 1: USAID Ingobyi Activity results framework

Strategic Objective: To improve the utilization and quality of RMNCH and malaria services in a sustainable manner		
IR 1: Increased equitable access to RMNCH and malaria services in targeted districts	IR 2: Improved quality of high-impact RMNCH/malaria services along the continuum of care in targeted districts	IR 3: Strengthened performance of the health system at central and decentralized levels
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 community health workers)	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 (QI) 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 monitoring and evaluation frameworks

To deliver these IRs, Ingobyi Activity applies a strategic, results-oriented, and multipronged technical approach that addresses key bottlenecks and inspires the health system to respond to the RMNCH and malaria prevention and treatment needs of the Rwandan population. The Activity works with the GoR to 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 (FP), maternal health, neonatal health, child health, and malaria prevention and treatment. The strategy is built upon the understanding that Rwandan experience and leadership, supported by the Activity’s resources and knowledge, will strengthen the health system and the services it provides to contribute to a healthier population more effectively. Interventions delivered by Ingobyi Activity to achieve the expected results include the following, among others:

- Competency-based skill-building through clinical training and mentorship. This is a tailored approach aimed at developing a cadre of district-based mentors. Using an on-site “Low Dose High Frequency” (LDHF) training approach, Ingobyi staff and professional associations provide training and mentorship to health providers at district hospitals, who in turn conduct mentorship for health center (HC) providers.
- Health systems strengthening. This effort supports district health units (DHUs) in organizing regular district health management team (DHMT) meetings to discuss, prioritize, and respond to key health challenges. It also involves strengthening the referral system to improve case management; advocating for improved infrastructure, human resources, and equipment maintenance; contributing to the development of policies and guidelines; and integrating continuous quality improvement (QI) across all services.
- Training community health workers (CHWs) on community-level packages, including integrated community case management (ICCM), community-based maternal and newborn health (CBMNH), and the community-based program on family planning (CBP-FP).
- Infection prevention and control (IPC), including the prevention of nosocomial infections; preparedness; and the prevention of infectious diseases, such as Ebola virus disease and coronavirus disease 2019 (COVID-19), at facility and community levels to reduce preventable causes of morbidity and mortality. Efforts include experienced medical specialists delivering training and clinical mentorship to health providers.
- Promoting healthy behaviors and creating demand through radio broadcasts (drama series, talk shows, and mentions), community outreach regarding integrated RMNCH and malaria messaging and service delivery, and health communication for clients at the health facility level.

Ingobyi Activity promotes globally approved high-impact RMNCH and malaria interventions to increase access to high-quality services for mothers, newborns, children, and adolescents. In maternal health, Ingobyi promotes antenatal care (ANC); postnatal care (PNC); emergency obstetric and newborn care (EmONC); safe Caesarean sections; respectful maternity care; the management of pre/eclampsia; the prevention and management of postpartum hemorrhage (PPH); postpartum family planning (PPFP); and obstetric fistula screening and repair. For newborn health, the Activity promotes essential newborn care (ENC)—helping babies breathe (HBB), essential care for every baby, essential care for small and sick babies, and family-centered care. For child health, emergency triage, assessment, and treatment plus admission care (ETAT+); integrated management of childhood illness (IMCI); and ICCM are promoted, while in malaria, the Activity promotes improved diagnostic services, the management of malaria in pregnancy and of severe malaria, and home-based care interventions. Additionally, Ingobyi promotes comprehensive education and counseling that emphasizes voluntarism and choice in FP. Ingobyi Activity works with health providers to ensure that essential youth-friendly services are available and provided to young people (including at facility youth corners). These services include counseling; providing contraceptives, including emergency contraceptives; and managing sexual and gender-based violence (GBV), including providing post-exposure prophylaxis for HIV. The Activity also equips health centers with needed health communication materials and tools.

Geographic Coverage

USAID Ingobyi Activity is implemented in 20 districts that were selected by the Ministry of Health (MoH) based on key health indicators. The districts are grouped into zones to facilitate coordination and implementation (Figure 1). The RMNCH and malaria interventions are implemented in all 20 districts, while some other interventions are implemented at the national or central level only. Central-level interventions include participation in technical working groups (TWGs); policy development; and activities that respond to national maternal, newborn, and child health (MNCH); FP; and malaria priorities. District-level interventions include, but are not limited to, technical assistance and support to DHMTs, communities, facilities (hospitals, health centers, and health posts), and health providers.

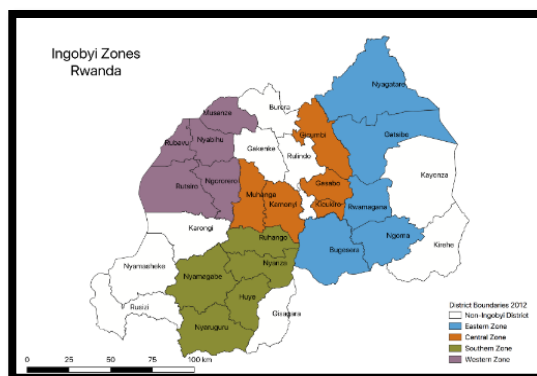


Figure 1: Map showing Ingobyi-supported districts by zone

2. Implementation Summary

This section of the report summarizes Ingobyi Activity’s achievements in quarter 1 of fiscal year (FY) 2022. The section is organized by technical area: FP, reproductive health services for youth, maternal health, newborn health, child health, and malaria prevention and treatment, as well as a variety of cross-cutting interventions. These achievements are further detailed in section 3 of the report and in the associated annexes.

Family planning

This quarter, USAID Ingobyi Activity continued to support the capacity-building of FP health providers through district-based mentorship in 20 supported districts. A total of 183 FP/adolescent sexual and reproductive health (ASRH) district-based mentors supported 542 mentees from 320 health facilities in 14 FP technical competencies. In addition, the Ingobyi technical team conducted routine supportive supervision visits to 179 health facilities, supported health centers to supervise 196 health posts, and provided FP technical assistance based on identified gaps and needs. Details on identified gaps, actions, and recommended next steps are presented in the next section of the report. Ingobyi Activity trained 129 trainers/mentors on hormonal intrauterine devices (IUDs), 21 health providers on depot medroxyprogesterone acetate subcutaneous (DMPA-SC), and 18 health providers on permanent FP methods through Ingobyi seconded staff to Rwanda Biomedical Center (RBC)/Maternal, Child, and Community Health (MCCH) Division. Other activities conducted during this quarter include hospital-to-health center outreach activities to increase access to permanent FP methods, orientation of health providers and sub-awardees on FP compliance requirements and participation in FP sub-TWG meetings, and workshops to share the Activity’s learning and experiences. Activities to create demand for FP were also conducted through the *Urunana* radio soap opera, radio sketches, and radio talk

shows with a focus on FP, as well as FP messaging and service provision during integrated RMNCH outreach in hard-to-reach communities.

Ingobyi FP interventions in quarter 1 contributed to improved immediate PFP uptake, from 60% to 64%, and maintained the level of new and active users despite a reported stockout of Implanon NXT.

Comprehensive reproductive health services for youth

USAID Ingobyi Activity continued to support the capacity-building of ASRH health providers through district-based mentorship in 20 supported districts, whereby 172 FP/ASRH district-based mentors supported a total of 405 health providers from 292 health centers in ASRH competencies. In addition, Ingobyi conducted routine supportive supervision visits to 129 health centers, 21 Isange one-stop centers (IOSCs), and ten youth centers and provided ASRH technical assistance based on identified gaps and needs. The identified gaps, actions, and recommended next steps are presented in the next section of the report. Other activities included the: training of 30 national trainers (17 males and 13 females) on the new national adolescent health training module, capacity-building of teachers on comprehensive reproductive health (CRH), and support to youth-led organizations to implement innovations for increasing ASRH service demand. Following an increased number of functional youth corners, Ingobyi supported health facilities to provide CRH services during weekends, which boosted adolescents and youth participation in the corners. As a result, the number of adolescents and young people who attended health education sessions increased from 96,543 in the last quarter of FY21 to 162,002 in the current reporting quarter—an estimated increase of more than 68%. Ingobyi Activity also participated in ASRH sub-TWG meetings and workshops to share the Activity’s learning and experiences.

Maternal health

During this quarter, USAID Ingobyi Activity continued to support the capacity-building of health providers through on-site training using the LDHF approach coupled with continuous mentorship and quarterly supportive supervision visits to 26 supported hospitals and two medicalized (upgraded) health centers in collaboration with two professional associations, Rwanda Society of Obstetricians and Gynecologists (RSOG) and Rwanda Association of Midwives (RAM). Through mentorship, RSOG reached 68 medical doctors from 17 hospitals and the two medicalized health centers, while RAM reached 90 midwives and nurses from 14 hospitals. Through supportive supervision, the two professional associations reached all 26 hospitals and both medicalized health centers. Ingobyi-supported district-based mentors reached 536 nurses and midwives from 325 health centers, who used the knowledge and skills they had acquired to improve quality of care and save mothers with obstetric complications. Additionally, USAID Ingobyi Activity supported 650 mentors from health centers to mentor 4,978 CHWs in CBMNH. The support aimed at building CHWs’ confidence and competence in providing effective and quality CBMNH services while conducting ANC and PNC home visits.

Ingobyi Activity’s technical staff conducted 144 supportive supervision visits to 24 hospitals, 88 health centers, and 12 health posts, including one rapid response visit. These visits aimed to improve health providers’ capacity to deliver quality care, improve problem-solving capabilities and the work environment, and promote the implementation of QI projects. Ingobyi Activity supported on-the-job EmONC training using the LDHF approach for 129 health providers (29 medical doctors, 50 nurses, 42 midwives, and eight anesthetists) from 13 hospitals and one upgraded health center to improve

clinical competencies. Compared to last quarter, Ingobyi maternal health interventions contributed to reduced maternal morbidities through improvements in service delivery. For instance, the provision of corticosteroids to women at risk of premature delivery increased by 27% percentage points compared to quarter 1 of FY21 and by 11% compared to the last quarter of FY21, while the proportions of women who received oxytocin to manage the third stage of labor and the percentage of women receiving a postnatal consultation within 24 hours of delivery were maintained at more than 95%.

Newborn health

This quarter, Ingobyi Activity implemented several interventions, including training, mentorship, and supportive supervision, to improve the quality of and access to newborn health services. Through clinical mentorship by Rwanda Pediatric Association (RPA), Ingobyi strengthened capacity of 32 medical doctors, while 31 hospital-level nurses working in neonatology services were mentored by specialized or experienced neonatal nurses on different newborn competencies. A total of 84 neonatal death audits conducted during mentorship visits revealed that prematurity and perinatal asphyxia accounted for 49% and 31% of the deaths, respectively. At the health center level, 176 neonatal district-based mentors conducted two-day monthly mentorship for 471 maternal and newborn health (MNH) mentees, 300 of whom were validated in at least one newborn health competency. Additionally, Ingobyi Activity conducted joint supportive supervision with the MoH and RPA in all supported facilities, during which neonatal data reviews were conducted to inform QI projects. To strengthen health providers' skills in neonatal care, on-site neonatal training was conducted for 54 staff (medical officers, midwives, and nurses) from five hospitals. These activities resulted in health providers' improved self-confidence in newborn resuscitation, as highlighted by a consistent increase in the proportion of successfully resuscitated live newborns who did not cry at birth, early initiation of breastfeeding, and postnatal consultation within 24 hours.

Child health

The provision of quality child health services is a key priority for the GoR. Ingobyi continued to apply various approaches, including training and mentorship for health providers, supportive supervision, and QI projects, among others, to improve the access to and quality of child health services in the 20 supported districts. During this quarter, a total of 128 IMCI district-based mentors conducted two-day monthly mentorship visits to 325 health centers and reached 593 mentees, of whom 315 were validated in at least one child health competency. In addition, 19 RPA mentors validated nine mentees, out of the 13 reached, in at least one child health competency. In collaboration with the MoH and RPA, Ingobyi conducted ETAT+ trainings for 52 health workers from 13 supported hospitals within the central and southern zones, involving at least four staff per hospital. Other activities included: conducting routine supportive supervision visits to 14 hospitals, 131 health centers, and 138 health posts; launching implementation of the pediatric development clinic (PDC) initiative at Murunda and Ruhengeri hospitals and follow-up clinics in 26 health centers within the two hospitals' catchment areas; participating in child health TWG meetings hosted and co-chaired by the MoH and RBC and contributing to national IMCI survey planning; supporting the final integration of care for child development (CCD) into IMCI and disseminating findings, which triggered key stakeholders to call for the scale-up of PDC in district hospitals and health centers. Ingobyi supported the printing of 2,300 IMCI registers, and neonatal and ETAT+ protocols and flip charts, which will be disseminated next quarter to all Ingobyi-supported hospitals and health centers. QI projects triggered improvements in most facilities, and Ingobyi will continue to mentor health providers to strengthen their problem-

solving capacity. Lastly, USAID Ingobyi contributed financially to and participated in Maternal and Child Health (MCH) week, during which 204,307 children under five were screened for malnutrition and 229,160 received vitamin A, 832,088 children aged one to 15 years were dewormed, and 2,146 women received FP methods.

Malaria prevention and treatment

Malaria presents a major public health problem in Rwanda and is a major cause of morbidity and mortality. USAID Ingobyi Activity continued to support malaria control programs through different interventions, including building the capacity of facility- and community-based care providers around malaria case management through training, supportive supervision, and death audits. During this quarter, USAID Ingobyi Activity trained 669 health providers from 14 hospitals and 185 health centers on national integrated malaria treatment guidelines. To increase the number of health personnel trained, 299 health providers, including 43 medical staff, 209 nurses and midwives, and 47 lab technicians received on-the-job training. Ingobyi Activity, in collaboration with RBC/the Malaria and Other Parasitic Diseases Division (MOPDD), updated the Quality Assurance and Quality Control manual to define standard operating procedures (SOPs) for malaria diagnosis; procured malaria commodities and pregnancy tests; ensured internal quality control; and performed other quality assurance activities. Ingobyi Activity conducted a long-lasting insecticidal nets (LLINs) needs assessment in all 325 health centers and supported the redistribution of LLINs from 49 health centers to others that had reported stockout or risk of stockout. In addition, 2,235 health providers at the health center level, 668 clinicians at the hospital level, and more than 10,000 CHWs were supported through supportive supervision and mentorship during the quarter.

Social and behavior change (SBC) interventions

Ingobyi Activity continued to implement various activities aimed at improving health-seeking behaviors for RMNCH and malaria services. Activities this quarter included: the weekly production and broadcast of *Urunana* radio soap opera episodes, with messages that focused on RMNCH and preventing COVID-19 and malaria (26 episodes broadcasted on Radio Rwanda and Radio10; the production of eight *Umuhoza* radio magazine programs broadcast on Radio10; the airing of 13 radio sketches on nine community radio stations; and the airing of 13 radio mentions on KISS FM. Ingobyi supported messaging on the prevention of and vaccination against COVID-19 by integrating key messages into the *Urunana* soap opera and eight radio talk shows. Ingobyi conducted one audience survey activity in Nyamagabe district, Kitabi sector. The survey aimed at pre-testing messages to be integrated into the *Urunana* soap opera; post-testing messages that had already been aired; and exploring myths, misconceptions, and attitudes toward health issues that would be addressed through SBC radio interventions. During the reporting period, over 10,477 listeners provided feedback on *Urunana* productions that focused on RMNCH, malaria, and COVID-19 messages.

Additionally, Ingobyi Activity organized and conducted community outreach events in hard-to-reach areas to increase the awareness of, and access to, RMNCH and malaria information and services. During these events, a total of 6,465 individuals (2,977 males and 3,488 females) were reached with integrated messages and 726 received FP methods of their choice. In addition, to improve teachers' knowledge and skills in comprehensive reproductive health (CRH), 253 teachers (127 males and 126 females) and 35 CRH focal points (14 males and 21 females) from 16 and 19 health centers in Musanze and Gatsibo districts, respectively, were trained. Lastly, 40 parents and 20 adolescents aged 14–24

participated in parent-youth communication sessions organized in Musanze and Gatsibo districts to improve communication on SRH issues.

Gender integration

Ingobyi Activity continued to support hospitals to ensure gender integration in their routine RMNCH and malaria services and to address gender-related barriers and capacity-building of health providers. During this quarter, 30 ASRH national trainers were trained on gender integration. In addition, 96 staff from 25 supported hospitals, including GBV officers, psychologists, investigators, and medical doctors, and 256 health center providers, including GBV focal points and those in charge of mental health, were trained in GBV management. Additionally, 136 women, including 58 teenage mothers who are members of savings groups were trained on how to cope and deal with stigma, family conflicts, and GBV. Ingobyi supported IOSCs to conduct home visits for 167 GBV victims and 37 group therapy sessions attended by 304 GBV victims. Ingobyi integrated gender and GBV messages into *Urunana* radio soap opera episodes and radio sketches to educate community members, particularly men, to make informed SRH decisions that protect the health and well-being of their partners and families. Lastly, Ingobyi organized and participated in events to commemorate the 16 days of activism against GBV in four supported districts.

Quality improvement

To ensure that QI is integrated across all interventions, Ingobyi continued to build the capacity of health providers in continuous QI. In this reporting period, 202 HC staff (81 females and 121 males) from six districts were trained on primary health care (PHC) standards. The content of the training included QI approaches; PHC standards, roles, and responsibilities; and composition of QI and IPC committees. Ingobyi also conducted a mentorship training on QI methodology and developing QI projects for heads of departments, service unit managers, hospital senior leaders, and the managers of four hospitals (Ngarama and Nyanza district hospitals and Rwamagana and Ruhango provincial hospitals). In total, 105 (54 females and 51 males) hospital staff attended the training and initiated QI projects to reduce post-Caesarean section infections, birth asphyxia, and neonatal hypothermia.

Citizen participation and engagement

Ingobyi Activity applies the Patient Voice Program-Citizen Voice and Actions (PVP-CVA) approach to enhance citizen participation and engagement in RMNCH and malaria services. The approach facilitates dialogue between communities and government authorities to improve services that impact daily lives and enables joint action planning to address structural, policy, and service delivery gaps. In quarter 1, Ingobyi Activity supported the formation and training of 22 PVP-CVA working groups with 436 members (256 males and 180 females) and facilitated 58 community-level scorecard meetings with 1,811 members (661 males and 1,150 females) to discuss barriers to health care access. Out of 810 issues identified across 73 facilities, 562 (69.4%) were resolved, and the groups are working to address the remaining issues according to the action plans developed during the scorecard meetings.

Savings groups for vulnerable families

The savings group approach aims to improve the economic capacity of vulnerable households to pay for immediate health needs, such as health insurance premiums. Ingobyi supported 79 savings groups with 1,531 members (1,190 females and 341 males), including 376 teenage mothers, 252 persons living with disability or representing disabled family members, and 114 mothers of children with

malnutrition-related problems; the groups were formed in FY21 and Ingobyi's continued support has ensured they continued to thrive. Ingobyi Activity is promoting the uptake and renewal of community-based health insurance among savings group members to ensure their access to health services, as well as their investments in microenterprise activities to enhance the financial stability of their households.

Infection prevention and control

Infections are a major cause of maternal, newborn, and child morbidity and mortality in Rwanda. As such, IPC is a critical area of focus for Ingobyi Activity. Ingobyi prioritizes low-cost, bundled interventions using QI systems approaches for improved infection control. In quarter 1, Ingobyi conducted supportive supervision in 22% (72/325) of supported health centers and 85% (22/26) of hospitals to reinforce IPC measures during service delivery. During the supervision visits, 25 QI projects were reviewed and discussed with providers. Analyses conducted by Ingobyi Activity showed that 67% (14/21) of the hospitals had reduced Caesarean section infections, leading to a consistent reduction in post-Caesarean section and newborn infection rates in these health facilities.

Disease outbreak, preparedness, and prevention

The COVID-19 pandemic has brought unprecedented social and economic disruptions globally. To support the GoR's response to the COVID-19 outbreak, Ingobyi Activity supported the RBC to conduct supportive supervision at 135 vaccination sites to ensure vaccines were distributed according to the national protocol. Ingobyi continued to support the RBC with 30 data managers to strengthen data entry at 27 vaccination sites in Gasabo and Kicukiro districts, through November 30, 2021. During this campaign, 306,020 individuals received their first dose of COVID-19 vaccine, 137,634 received their second/full dose, while received 6,955 booster shots.

Health systems strengthening

Ingobyi Activity works together with the MoH to strengthen the health system to improve the delivery of health services. Ingobyi support includes improving the Health Management Information System (HMIS) and data quality, as well as strengthening the referral system to improve patient transfers and care. In quarter 1, the MoH requested Ingobyi to provide technical support in revising the existing outpatient and inpatient registers such that it captured information on malaria, referrals, and the systematic screening of key conditions and age groups to enable the MoH to report on global indicators. Following the revisions, Ingobyi supported the printing and distribution of 20,700 registers. Ingobyi continued supporting the MoH to improve the functionality of the referral system and referral linkages between and across RMNCH and malaria services by training 205 health providers on the use of new transfer forms and referral guidelines. In this reporting period, Ingobyi conducted routine data quality audits (RDQAs) in 118 facilities, routine supportive supervision on data quality and use in 171 health facilities, and supported hospitals to conduct data management coaching for 98 HC data managers. Furthermore, Ingobyi collaborated with Rwanda Integrated Health Systems Activity (RIHSA) to design the data dashboard in the Rwanda Health Application Platform (RHAP) and participated in planning for the rollout of the platform at the district level. The aim of the RHAP is to facilitate data-driven decision-making at decentralized levels.

District support

USAID Ingobyi Activity provided technical and financial support for various health-related activities in the 20 supported districts, including health facilities mentorship meetings, district health coordination meetings, DHMT meetings (including functionality verification meetings), health facility supervision visits, and joint action development forum (JADF) meetings, among others. In total, Ingobyi Activity supported 48 district meetings (12 health facility mentorship, nine district health coordination, nine DHMT functionality verification, nine quarterly DHMT, three planning, and six JADF health commission meetings).

3. Implementation Progress by Technical Area

This section elaborates USAID Ingobyi Activity's accomplishments and results during the reporting period. Further results can be found in Annex A.

I. Family Planning and Comprehensive Reproductive Health

Family Planning

The improved availability of FP commodities and services is a priority in Rwanda's framework for development. Besides timing and limiting the number of children birthed in the country, the government views FP as a vehicle for better health through decreased maternal, infant, and child mortality. Rwanda has made significant progress in making FP accessible over the years. The unmet need for FP in currently married women decreased from 18.9% in 2015 to 13.6% in 2020. However, the unmet need for FP in sexually active unmarried women was 37.3% in 2020.² A rapid assessment of the availability and quality of FP services, conducted in FY21 at 122 USAID Ingobyi Activity-supported health facilities, revealed that both short- and long-acting reversible FP methods and services were available and were integrated into 99% of maternity and 97% of HIV services in assessed facilities. The assessment reported improvements in provider skills in the provision of FP counseling and consent-seeking, in addition to improved respect for the clients' choice of FP methods. However, permanent methods were only available in 28% of the assessed facilities, mostly in hospitals. There were missed opportunities to integrate FP into other key services, such as outpatient department (OPD), nutrition, and immunization. Twenty percent of the facilities experienced stockout in some FP commodities, as well as a lack of equipment, such as gynecologic tables and lamps, which was observed in 3% of the facilities.

In quarter 1 of FY22, USAID Ingobyi Activity continued to work alongside the MoH, RBC, and the supported health facilities to address gaps and issues identified in the assessment to improve the quality of FP services. These services should be made accessible to clients through various approaches, including advocacy to make FP commodities and supplies available, active participation in the development of guidelines and standards, capacity-building of health providers through LDHF trainings, clinical mentorship and classic trainings, and supportive supervision in the 20 supported districts. Key FP accomplishments are summarized below.

² National Institute of Statistics of Rwanda, 2020. Rwanda Demographic and Health Survey 2019-20: Key Indicators Report

Support at the national level to plan and manage FP services

Participation in TWGs

USAID Ingobyi Activity contributed to the national FP sub-TWG quarterly meetings, which provided opportunities for Ingobyi to showcase its work and learn from the experiences of other implementers. Below are key USAID Ingobyi contributions through the TWG.

FP2030 commitments: During the FP TWG conducted this quarter, Ingobyi participated in reviewing the country's FP2030 commitments and integrating comments from the FP2030 secretariat; the document was submitted for endorsement by the Minister of Health. FP2030 is a global partnership aimed at bringing together the widest possible range of partners across disciplines and sectors, while situating FP at the center of global health, development, and gender equality agendas. Governments and other stakeholders are invited to join FP2030 by making a formal commitment. USAID Ingobyi Activity is part of the core team developing national FP2030 commitments. Draft commitments were shared with the FP2030 secretariat, who provided comments and input to improve the document.

Updates on the new FP commodities supply plan: USAID Ingobyi Actively participated in meetings to discuss the supply chain for FP commodities and used these opportunities to share the challenges of Implanon NXT and other FP commodity stockouts. In response, Rwanda Medical Supply and the USAID Procurement and Supply Management (PSM) Project promised to speed up procurement processes. By the end of this quarter, most FP community stockout issues had been resolved, except for Implanon.

Discussions on Demographic Health Survey 2020 secondary data analysis by Track 20 project: This was a quick analysis to identify potential areas for interventions that could guide FP2030 commitments. It was noted that women in the postpartum period, between six and 24 months after delivery, have the most unmet need for FP. Any intervention targeting these women would likely reduce the current need.

World Contraception Day celebration: USAID Ingobyi Activity joined the MoH/RBC and other partners to celebrate World Contraception Day on September 30 and during subsequent events in October 2021. Key speakers called for concerted efforts to reach those left behind and to ensure that everyone exercises their right to choose whether to become pregnant, when to become pregnant, and how often. USAID Ingobyi Activity participated in and supported radio campaigns organized by the MoH/RBC on Radio Rwanda, and Huye and Nyagatare community radio stations, to raise awareness about the advantages of contraception and how to access quality FP services to enable individuals and couples, including young people, to make informed choices about their SRH. Ingobyi Activity participated in four radio talk shows, during which listeners asked many questions related to FP service delivery, side effects, and reproductive health, among others.

Improving FP provider skills

FP district-based mentorship

Mentorship is an approach that involves on-the-job practical training, as well as consultation that fosters ongoing professional development of learners/mentees to deliver sustainable high-quality clinical care. USAID Ingobyi Activity, through district-based mentors, continued to build the capacity of health providers in delivering quality FP services to their clients. Each FP mentor conducted two-



Photo 1: FP/ASRH mentor coaching a mentee on postpartum IUD insertion at Kinunu HC, Rutsiro District

day visits every month at each of their two assigned health centers. At the hospital level, mentorship was conducted by a trained FP focal point (local mentorship) to ensure the integration of FP in all services. This quarter, 183 Ingobyi-supported, district-based mentors conducted continuous mentorship activities in their assigned health facilities to improve mentees' knowledge and skills in the 14 FP competencies. Mentors reviewed FP data to identify potential service delivery gaps; reviewed FP tools, registers, and client files for completeness; and conducted refresher trainings on US abortion and FP compliance requirements. In total, 183 FP district-based mentors reached 542 mentees from 320 health facilities across the 20 Ingobyi-supported districts, and 409 of them were validated in at least one FP competency.

Validating mentees on postpartum IUD insertion remains a challenge due to the limited number of clients available during mentorship visits. Thus, mentees validated on postpartum IUD insertion using anatomic models were considered validated. District-based mentors put in place a plan to maintain their mentees' skills by conducting quarterly practical sessions on postpartum IUD insertion and removal using anatomic models until they can be observed on real clients. During this quarter, 18 additional district-based FP mentors were identified, trained, and deployed to replace those who had transitioned out for various reasons, including transfers and resignations. The process of identifying, training, and orienting potential candidates to become new mentors is conducted jointly by Ingobyi staff and hospital supervisors, followed by intensive support through supportive supervision.

As part of the ongoing study to pilot the feasibility of clinical mentorship at the health post level, USAID Ingobyi Activity continued to support the mentorship of health providers at health posts in Nyanza District, where 14 champions (validated mentees serving as mentors) reached 22 mentees across 21 health posts. This quarter, three mentees were validated on all FP competencies required at the health post level.

Training health providers on DMPA-SC

DMPA-SC, also known as Sayana Press, was introduced in Rwanda to improve method mix and give FP clients a wider range of method choices. Since last year, USAID Ingobyi Activity has continued to support the MoH/RBC to equip providers with the competencies required to provide DMPA-SC, as well as the skills to teach clients to self-inject at home. During this quarter, Ingobyi FP staff seconded to the RBC/MCCH Division provided technical assistance to implement DMPA-SC in the Ingobyi non-supported district of Nyarugenge, which was the last district to be trained on this method, as other

districts were trained in FY21. Twenty-one health providers (20 females and one male) were trained. Following the training, health facilities in this district began providing DMPA-SC to clients. Ingobyi Activity will continue to support subsequent plans to roll out DMPA-SC at the community level.

Training of trainers in hormonal intrauterine devices

According to the draft national FP2030 commitments, the GoR intends to increase modern contraceptive prevalence rate among married women from 48% to 60% by 2024. To achieve this target, MoH continues to extend its modern methods mix to provide clients with more choices. During this quarter, a hormonal IUD (Mirena) was introduced and is being integrated into the national training manual, monitoring and evaluation tools, and supply chain systems. In preparation for the Mirena roll-out, the MoH/RBC in collaboration with Ingobyi Activity and other partners, including the Clinton Health Access Initiative and United Nations Population Fund, organized a training of trainers expected to lead the introduction of hormonal IUD into the existing range of FP methods in Rwanda. The purpose of this training was to equip existing FP trainers with knowledge and skills in the hormonal IUD method and to refresh them on clinical training skills to increase their capacity to train site trainers, who will in turn train their peers. In total, 129 FP trainers/mentors (96 females and 33 males) were trained. Twenty-seven trainers, including four Ingobyi staff, were trained as master trainers, while 102 were trained as national trainers. Eighty-one participants were from Ingobyi-supported districts. In subsequent quarters, Ingobyi will train FP providers from all supported health facilities through on-site LDHF trainings.

Increasing access to permanent FP methods

USAID Ingobyi Activity supported doctors from 26 hospitals to conduct outreach events for the provision of permanent FP methods at selected health centers. As a result, 223 beneficiaries received permanent FP methods (168 tubal ligations and 55 no-scalpel vasectomies); two previously trained medical doctors were validated on the provision of no-scalpel vasectomy. In addition to outreach events, Ingobyi's seconded staff to the RBC/MCCH Division provided technical assistance to conduct a ten-day permanent method training session for 18 health providers (17 males and one female), including 16 medical doctors and two midwives. Six of the trainees were from Ingobyi-supported hospitals, and 12 were from non-Ingobyi-supported hospitals. During the practical sessions, trainees performed 61 tubal ligations and 26 no-scalpel vasectomies under close supervision by the trainers. Five medical doctors were validated to perform both procedures, eight were validated on tubal ligation, and three were validated on no-scalpel vasectomy. The non-validated trainees will be supported through coaching during routine service provision and outreach activities.

Meeting FP demand through integrated FP outreach activities

In collaboration with local authorities, including district health offices, district hospitals, health centers, and CHWs, Ingobyi Activity organized and conducted community outreach events in hard-to-reach areas to increase the awareness of, and access to, RMNCH and malaria information and services. Outreach sites were identified based on existing FP data, focusing on faith-based organizations' catchment areas. The events included community mobilization, counseling, and service provision to increase the availability

During the outreach events conducted in this quarter, 726 users adopted FP methods: 46% (331) selected injectables, 27% (196) selected pills, 24% (171) selected implants, and 4% (28) selected condoms.

of quality FP services in hard-to-reach areas. FP services were provided at the community level within locally available venues. Clients who selected a method that could not be provided at the outreach event site were referred to a nearby health center and linked with CHWs to facilitate referral linkage. Outreach activities were conducted in compliance with Ingobyi Activity’s Environmental Monitoring and Mitigation Plan (EMMP), and measures taken to assure proper waste management (Annex B).

Routine supportive supervision

USAID Ingobyi Activity conducted routine quarterly supportive supervision visits to 179 (51%) facilities to work with providers, mentors, and facility leaders in improving the quality of FP services. The visits focused on the quality of

Supportive supervision visits include the oversight and implementation of clinical and nonclinical tasks and activities that affect the organization, management, and delivery of FP services.

mentorship provided by the district-based mentors, the quality of FP service provision, compliance with US abortion and FP requirements, addressing gaps that could be immediately addressed, and the implementation of QI projects designed to sustainably improve FP service quality. At the end of each supervision session, supervisors conducted a debrief meeting with the heads of the visited health facilities, hospital supervisor, district-based mentors, mentees, and other relevant health facility team members, such as data managers and community environmental health officers (CEHOs), to discuss identified strengths, areas for improvement, and strategies to improve coordination and the quality of mentorship and FP service delivery. In addition, Ingobyi Activity supported health centers to extend the FP supportive supervision to health posts located within their catchment areas. A total of 196 health posts were supervised. As a result, there is improved collaboration between health posts and health centers, especially Catholic faith-based health centers that began referring clients in need of modern FP methods to the nearest health posts, as they have increased confidence that health posts can provide quality FP services. Table 2 summarizes the key findings and actions taken during the supportive supervision visits.

Table 2: Summary of findings from FP supportive supervision at the hospital, health center, and health post level

	Hospital	Health center	Health post
Strengths	Trained staff are available to provide long-acting reversible contraceptives, including hormonal IUDs, short-acting reversible contraceptives, and permanent methods in all hospitals; individual PPFPP counseling is systematically conducted and documented in maternity registers; provided FP methods are well documented in client files and FP registers; the handover of clients who initiate FP methods at the hospital has improved; basic equipment, materials, and consumables are available; there are good IPC	FP services are available seven days a week; updated FP data reporting tools (registers, consultation files and daily consumption register) are available and used; short- and long-acting reversible contraceptives are offered at all health facilities; FP services are integrated into HIV, ANC, immunization, maternity, and nutrition services, among others; FP rooms have the basic equipment and materials needed to deliver FP methods and offer privacy to clients; health providers can manage the side effects related to FP methods; individual education and counseling materials for FP are available; counseling for FP clients	FP services, including health education, counseling, the provision of short-acting reversible contraceptives, and side effect management are offered at 100% of visited health posts; updated tools (registers, client files, and individual cards) are used for regular and accurate reporting; there is improved collaboration between health posts and health centers.

	measures at FP service delivery points; and new staff are oriented on US abortion and FP requirements.	has improved; and new staff are oriented on US abortion and FP compliance requirements.	
Gaps	There was an insufficient number of trained medical doctors to provide permanent FP methods at some hospitals; there was a stockout of FP commodities, including Implanon NXT, in all hospitals and Jadelle in some hospitals; a stockout of local anesthesia (lidocaine) was also observed in some hospitals; there were too few kits for permanent FP methods in some hospitals.	The use of referral forms for clients from facility to community remains a gap in some health facilities; stockouts of some FP commodities, such as Implanon NXT and Jadelle, were observed at some health facilities; collected data were incomplete at some health centers, where FP registers and client files were not updated; data discrepancies were found during the DQA done by Ingobyi staff.	Follow-up of clients is not yet done correctly at many health posts; client files are not updated at many health posts; FP services are mixed with other services, especially in the OPD; most FP providers at health posts are not trained on the provision of FP methods; at some health posts, there are insufficient materials for IPC; the medical eligibility criteria wheel was missing from two visited health posts.
Actions	For stockout of FP products, Ingobyi staff analyzed the root cause and found that there was a national stockout of Implanon NXT, which led to high consumption of Jadelle, which subsequently led to its stockout at some hospitals. Ingobyi continues to work with health facility managers and district pharmacies to improve the supply chain. Additionally, the issue was reported to the FP TWG. The RBC, under the technical assistance of Ingobyi-seconded staff, conducted a training of providers, including medical doctors, nurses, and anesthetists, on permanent FP methods.	Ingobyi worked with: heads of health centers and hospitals to avail referral forms and guided health providers on how to use them for community referral; district-based mentors in charge of FP to reorganize client files by village and by appointment; facility managers and FP focal persons, drug store managers, and Rwanda Medical Supply branch managers to minimize the issue of FP commodity stockouts.	The supervisors from health centers coached providers at health posts to provide FP counseling and referral for all methods (including those not provided at their level) through supportive supervision. The supervisors shared the FP reporting template with the health posts to start reporting to the health centers and provided other tools found to be missing, like FP consents forms and the medical eligibility criteria wheel.

Family planning and adolescent sexual and reproductive health quality improvement projects

USAID Ingobyi Activity used a QI approach as a structured methodology to review FP/ASRH data, analyze the gaps, prioritize key interventions, and continue a focused monitoring of achievements. A participatory, multidisciplinary approach bringing together relevant stakeholders—including FP/ASRH care providers and mentors, hospital committees (on IPC and QI, plus rapid response teams [RRTs]), data managers, hospital leadership, and the Ingobyi team—was prioritized to enable a multidimensional analysis of the gaps. Detailed action plans were developed to allow smooth implementation and monitoring, and a review of implementation progress was conducted as part of mentorship and supportive supervision. Up to 78 FP/ASRH QI projects were implemented in this quarter, including 51 initiated in the last fiscal year. Seventeen projects were related to PFP, 14 to improving the classification and filing of clients files by appointment and village, 19 to increasing the awareness and use of ASRH services, five to increasing individual education and counseling sessions on PFP during ANC service provision to increase pregnant women’s awareness women, nine to raising awareness via reproductive health outreach, 12 to seeking to reduce the incidence of teen

pregnancies, and two to improving general FP services. Around 99% of the projects were implemented at the health center level, while only 1% were at the hospital level. Up to 12.8% of continuing QI project targets were completed this quarter, with 10.3% of them achieved by the set timeline; 82% were still in progress, while 7.7% of the projects did not reach the targets by the end of reporting period (see Annex E for details).

Community-based program on FP

Ingobyi Activity supports the RBC/MCCH Division, health facilities, and CHWs to implement CBP-FP. The aim is to strengthen the skills and knowledge required for CHWs to: provide refills of FP methods initiated by health center to clients, monitor adherence to short-term FP methods, report on CBP-FP activities, improve referral linkage to health centers, follow-up with dropouts, and manage waste generated from CBP-FP activities. Details of the support provided this quarter are outlined below.

Community-based program on family planning mentorship

During this quarter, Ingobyi Activity, in collaboration with district hospitals, supported 650 mentors from 20 districts to conduct mentorship of 8,142 CHWs in CBP-FP. Through mentorship visits, mentors oriented CHWs on the provision of FP methods (injectables and pills), condom use, the use of cycle beads, appropriate counseling of FP clients, the completion of CBP-FP registers, as well as CBP-FP waste management. A large



Photo 2: Ingobyi staff (joint visit) supporting CHWs from Gihara HC to provide injectable

number of CHWs were not trained in CBP-FP, and some of those trained lacked confidence in providing CBP-FP services. Through mentorship sessions, mentors built the capacity of these CHWs, and 84 of them from four districts were able to start providing CBP-FP methods during this quarter. Moreover, Ingobyi Activity plans to support districts to train polyvalent CHWs in the next quarter to increase the number of CHWs who can provide CBP-FP services. During this quarter, Ingobyi-seconded FP staff co-facilitated a training of 44 trainers from Nyamasheke District, during which the content of this new package was tested. Currently, the trainers are cascading the training to CHWs in this district.

Routine supportive supervision in CBP-FP

During this quarter, USAID Ingobyi supported 325 CEHOs to conduct supportive supervision of 9,236 CHWs. CEHOs assessed CHWs' knowledge and skills in FP client follow-up and checked the availability and use of updated national FP standard tools, the completeness of FP registers, and the availability and use of personal protective equipment (PPE) to ensure safe service provision during the COVID-19 pandemic. They also checked waste management, compliance with IPC measures, documentation, and reporting. At the health center level, Ingobyi Activity staff, in collaboration with hospital community health supervisors, conducted a joint supportive supervision of 114 health center staff to ensure they provided effective and coordinated support to CHWs who deliver FP services at the community level. The aim was to build the capacity of health center FP teams to improve the referral system, manage FP products, fill out FP client cards correctly, use data to orient community-based FP

interventions, and follow up with lost FP clients. With this support, challenges were identified and actions taken, including improving communication and linkage between FP nurses and CHWs using health center-to-community referral forms.

CBP-FP mentorship coordination meeting

During this quarter, USAID Ingobyi Activity supported 15 districts to conduct CBP-FP mentorship coordination meetings. The purpose of the CBP-FP mentorship coordination meetings was to discuss mentorship implementation progress, performance on CBP-FP indicators, key challenges/gaps, and possible solutions and to share best practices and lessons learned. A total of 514 CBP-FP mentors, together with health center heads and hospital and DHU directors, attended the meetings. The community health mentorship coordination meetings provided platforms for CBP-FP mentors to update themselves on specific technical competencies, discuss harmonization of mentorship tools, and receive updates on their use. During these meetings, hospital leaders facilitated different sessions to discuss community mentorship-related challenges and ways to overcome them. Health facility leaders committed to providing more support in terms of planning and monitoring community mentorship activities. Recommendations from the meeting were further presented in district and facility leaders' coordination meetings to orient leadership-related actions to improve community mentorship.

Demand creation for FP services

USAID Ingobyi Activity disseminated key messages on FP through the *Urunana* radio soap opera broadcast twice a week on Radio Rwanda and Radio10, focusing on the benefits of all methods, including PFP. In addition, one radio sketch on FP was aired on nine community radio stations and KISS FM, focusing on how to deal with the side effects of FP methods. The sketch on FP was aired on KISS FM for one week in November. In addition, SBC interventions that promote FP uptake were conducted through integrated RMNCH outreach in hard-to-reach communities. During the outreach events, a total of 6,465 individuals (2,977 males and 3,488 females) were reached with integrated messages, and 726 of them received FP methods of their choice.

US abortion and FP compliance requirements

The principles of voluntarism and informed choice guide Ingobyi Activity's FP interventions. Ingobyi is committed to ensuring that women and couples have access to voluntary FP services and that comprehensive information is provided to clients to enable them to make informed decisions about their reproductive lives. The guiding principles are articulated in program guidelines and several legislative and policy requirements that govern the use of US FP assistance. USAID Ingobyi Activity ensured that every staff member, mentor, and trainer supporting the facilities had completed an online course on US abortion and FP compliance requirements (2021 version). The orientation on these requirements was included in the agenda of various Ingobyi-supported trainings and meetings, including, but not limited to, a training of trainers on the new adolescent health module, the mentorship program, LDHF trainings, CHW coordination meetings, district coordination meetings, DHMT meetings, and CVA group trainings, among others. In total, 1,395 individuals (493 males and 902 females), including Ingobyi staff and health providers, were trained. Moreover, 2,353 CHWs (1,440 females and 913 males); 73 members of CVA (44 females and 29 males); and 107 health facility heads,

data managers, and CEHOs (63 males and 44 females) were oriented during quarterly district coordination meetings.

In addition, USAID Ingobyi Activity conducted quarterly FP compliance visits to health facilities to audit their compliance with US abortion and FP requirements. Up to 162 health facilities were visited, with no observed violations (Annex C). However, a few challenges were observed in some community-level health facilities, including stockout of FP methods, especially Implanon NXT, microgynon, Jadelle, and Depo-Provera. To address these gaps, the Ingobyi team advocated to health facility managers, the RBC, and Rwanda Medical Supply for an improved supply of FP methods.

Observed trends in selected FP outcomes

FP users

The new user’s indicator³ measures the availability and utilization of FP methods at health facilities, the effectiveness of SBC efforts to increase FP uptake, and the health facilities’ efforts to recover clients who have stopped FP methods and/or who have been lost to follow-up. Interventions conducted by Ingobyi Activity to increase the number of new FP users include: LDHF trainings on FP, training of health providers on a new method (DMPA-SC) and on permanent FP methods, integrated community outreach campaigns, hospital-to-health center outreach events to provide permanent FP methods, clinical mentorship, supportive supervision, and support for QI project implementation.

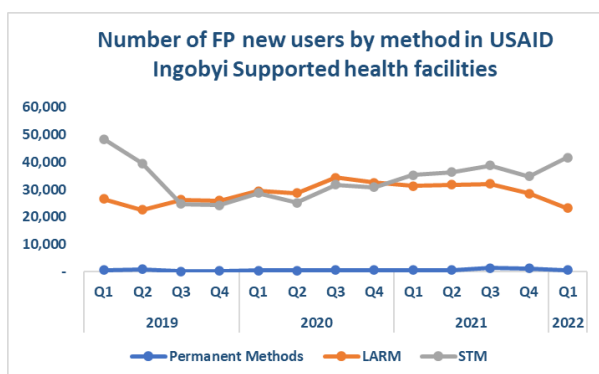


Figure 2: Number of new users of FP by methods in Ingobyi supported facilities

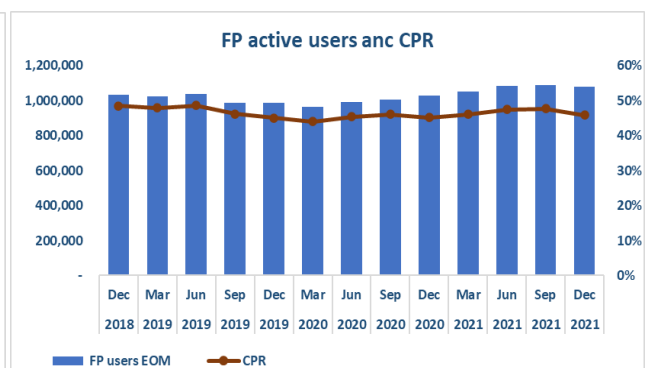


Figure 2: Number of active users of FP methods and contraceptive rate in Ingobyi supported facilities

During this quarter, there was a decrease in the number of long-acting reversible contraceptive users and a corresponding increase in short-term method users (Figure 2). The reason for this change was the reported stockout in Implanon NXT, which led to increased use of Jadelle (an implant). The issue was reported through different for a, and medical supply institutions are working hard to speed up procurement. There was also a decrease in the number of new EOM users of permanent methods due to fewer outreach events conducted during the quarter, a reported stockout of local anesthesia (lidocaine), and insufficient kits for permanent FP methods in some hospitals. Overall, the number of active users of FP at the end of reporting period increased, and there was an observed 2% decrease in the overall contraceptive prevalence rate from the last quarter of FY21 to this quarter (Figure 3). Ingobyi will continue to advocate and collaborate with the MoH and supply chain partners to ensure

³ New FP users include new FP acceptors, active FP users changing a method, and previously stopped users (for any reason) resuming FP method.

the consistent availability of FP methods. In addition, through mentorship and supportive supervision, Ingobyi will continue to support facilities to make early forecasts and timely requests for FP products to minimize recurrent stockouts.

Postpartum family planning

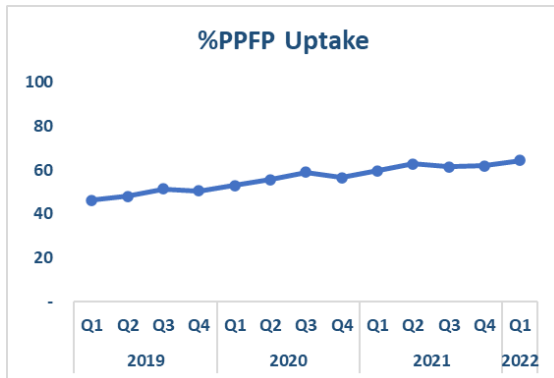


Figure 4: PPFP uptake in Ingobyi-supported facilities

The PPFP uptake indicator captures the availability and utilization of PPFP services. Strengthened PPFP is a key priority of the MoH, as it can accelerate progress in RMNCH outcomes. The relatively high ANC attendance and facility-based deliveries present opportunities for Ingobyi and the MoH to address the unmet need for PPFP by offering contraceptive counseling during ANC and prior to postpartum discharge from the health facility. Ingobyi Activity’s support toward improving PPFP this quarter included strengthening provider capacity in counseling and

PPFP provision and SBC interventions through the *Urunana* radio soap opera, *Umuhoza* magazine, and radio talk shows. As a result, there was a continuous increase in PPFP uptake. Compared to the same quarter in FY21, PPFP uptake increased from 60% to 64% in this quarter (Figure 4).

Comprehensive reproductive health services

The issue of adolescent fertility is important on both health and social grounds. Children born to young mothers are at increased risk of sickness and death, and teenage mothers are more likely to experience adverse pregnancy outcomes. The latest Rwanda Demographic Health Survey (2019–2020) reported that 5% of females aged 15–19 had begun childbearing.⁴ Adolescents in Rwanda still face challenges when seeking or trying to access CRH services, including the limited availability of specialized trained health providers capable of catering to adolescents’ health needs, cultural mores and myths, religious beliefs, and peer pressure. Health providers should be able to respond to the needs of young people, alleviate their fears, respect their concerns, ensure confidentiality, and provide services within an environment that caters to their preferences. Ingobyi Activity continued to support health facilities in offering high-quality CRH services, including providing health information, education, and counseling; a range of safe and affordable contraceptive methods; quality obstetric and ANC for all pregnant teenagers; testing (for pregnancy and HIV); information on the prevention and management of sexually transmitted infections; health promotion activities; and opportunities for youth to participate in various interventions that aim to break down the barriers that prevent young people from accessing services. Key activities implemented to support delivery of CRH services are summarized below.

⁴ National Institute of Statistics of Rwanda, 2020. Rwanda Demographic and Health Survey 2019-20: Key Indicators Report

Participation in ASRH sub-TWG meetings

Ingobyi Activity participated in ASRH sub-TWG meetings to support the MoH and RBC to develop, review, and validate national ASRH documents. Ingobyi Activity participated in, and supported a number of TWG activities during the reporting period. Ingobyi contributed to the review and validation of a new comprehensive adolescent health training module developed by the RBC, in collaboration with the World Health Organization (WHO), and UNICEF, to include all aspects of adolescent health, including reproductive and mental health, nutrition, noncommunicable diseases, and bioethics, among others. The new training module includes all aspects of adolescent health, not only SRH. The review workshop was attended by other contributing partners, including Partners in Health, the Health Development Initiative, Enabel, Imbuto Foundation, AIDS Healthcare Foundation, and select ASRH national trainers and youth-led organizations (AFRO-ARK and the FP2030 youth representative). The final module validated by the ASRH sub-TWG is expected to be reviewed and validated by the larger RMNCH TWG next quarter.

The FP2030 secretariat recommended the inclusion of activities that are led by different youth organizations contributing to the FP2030 commitments. The ASRH and FP sub-TWGs worked together to integrate activities into the FP2030 commitments to be implemented by youth-led organizations. Youth organizations are expected to contribute to commitment number one, which is *“to expand strategies for FP awareness-raising to address gaps in knowledge, attitude and behaviors on FP and to increase the total demand for FP among community members including men, women and young people in Rwanda.”*

Improving provider skills in adolescent CRH

Progress toward universal health coverage for adolescents will require renewed attention to the education of health providers. Ingobyi Activity has invested heavily in efforts to strengthen the capacity of health providers to deliver quality SRH services to adolescents and youth through training, mentorship, and supportive supervision.

Training of trainers on the new comprehensive adolescent health training module

The MoH has recently developed a new comprehensive adolescent health training manual for health providers based on the WHO program orientation on adolescent health for health providers. To update existing ASRH national trainers on this new module, a five-day training of trainers was organized, reaching a total of 30 participants (17 males and 13 females). National trainers updated on this new module will train health providers from health centers and hospitals, who in turn will provide comprehensive adolescent health services in their respective workplaces.

District-based mentorship

District-based mentors continued to support the capacity-building of health providers in health centers through on-site training using the LDHF approach, coupled with continuous mentorship and capacity-building to deliver youth-friendly and responsive services. During this quarter, Ingobyi supported 172 CRH mentors to conduct mentorship for 405 mentees from 292 health centers, and 276 of them were validated in at least one CRH competency (Figure 5). The mentorship included capacity-building in four CRH competencies, namely: how to conduct quality health education sessions, how to conduct quality individual counseling sessions, the provision of emergency contraception, and demonstration of effective condom use for youth. The mentorship also focused on

data review, documentation, and reporting tools; ongoing CRH activities during weekends; and the provision of quality CRH services to youth while complying with COVID-19 prevention measures.

Capacity-building of teachers on comprehensive reproductive health

Rwanda is implementing a compulsory 12-year basic education program, which means the majority of adolescents are expected to be in school. Considering the settings in which to address the reproductive health needs and problems of adolescents, schools stand out as one of the most important and utilized settings to reach almost all adolescents. Teachers can play an important role in this respect. In a survey conducted by Ingobyi in FY21, 34.2% of adolescents reported that teachers were their source of information on CRH. Teachers need to be



Photo 3: Executive secretary of Rwaza sector in his remarks during the orientation of teachers at Rwaza health center

skilled and confident to effectively play this role. Last FY, USAID Ingobyi Activity trained 226 teachers (121 males and 115 females) from Rubavu and Gicumbi districts on CRH services. The two districts were prioritized for this intervention based on their incidence of teen pregnancies and their low service demand by young people in youth corners. This quarter, USAID Ingobyi Activity trained 253 teachers (127 males and 126 females) and 35 CRH focal points (14 males and 21 females) from 16 schools and 19 health centers in Musanze and Gatsibo districts, respectively. The training focused on CRH concepts in school settings, how to facilitate school clubs, and how to strengthen linkages to facility SRH services (youth corners). Apart from the creation of school clubs, teachers also started to refer students to youth corners, especially during weekend days.

Routine supportive supervision

Ingobyi Activity conducted quarterly supportive supervision in the 20 supported districts, where 129 health centers, ten youth centers, and 21 IOSCs located in hospitals were supported to strengthen the capacity of health facilities to provide youth-friendly services. During the visits, Ingobyi staff supported 118 CRH mentors to improve their mentorship and support to health facilities in the implementation of school and community-based youth activities. In addition, Ingobyi supported the facilities to improve the organization of youth corners to ensure the availability and delivery of adolescent and reproductive health services during convenient times for youth, including weekend days; provided coaching on the completion of reporting tools and the CRH register; and used data to reveal potential service delivery gaps that needed special focus. The data review session was an opportunity to support district-based mentors and CRH focal persons to track implementation progress of the CRH QI projects developed in FY21 and to discuss needed adaptations to remain on track. Most of the developed QI projects aimed to increase the number of adolescents and youth who attend CRH group education sessions and individual counseling in youth corners.

At the end of each visit, feedback sessions were conducted, bringing together Ingobyi staff, mentors, facility managers, and mentees to discuss identified strengths and areas for improvement and to propose strategies to improve the coordination and quality of mentorship and youth-friendly services. Gaps that could not be solved immediately were escalated to higher levels through district coordination and DHMT meetings. An example of the result of this advocacy during this quarter is the recruitment of a permanent CRH service provider for Nyaruguru youth center in Nyaruguru District.

Ingobyi Activity will continue to provide technical support to the newly recruited staff as needed to strengthen capacity in the provision of CRH services. Table 3 below summarizes findings from the supportive supervision.

Table 3: Summary findings of adolescent and youth CRH routine supportive supervision

	Hospital	Health center	Youth centers
Strengths	Updated GBV tools, such as GBV registers, SOPs, and the GBV case management protocol are available; preventive medications and commodities, such as post-exposure prophylaxis, emergency contraception, pregnancy tests, HIV tests, and tetanus vaccine are available in all visited IOSCs.	Adequate youth corner rooms were identified and equipped as recommended during the previous visits to some health centers; HCs with TV screens display CRH messages to youth during IEC sessions and to all HC clients; updated CRH registers are available; the majority of visited HCs established quarterly plans to conduct adolescent and youth education sessions in the community and in schools in their catchment areas; health communication materials are available in all visited health centers, and some centers have audiovisual materials in youth corners; HCs have started to provide CRH services during weekends.	All visited youth centers are functional, with basic equipment and a trained health provider.
Gaps	CRH services are not integrated into routine activities; hospital supervisors do not include CRH services in the supervision schedule; CRH data are not included in routine monthly/quarterly data analyses; GBV register at IOSCs are incomplete; there is misunderstanding on payment costs associated with GBV cases, including teen mothers identified, in some hospitals.	In some health centers, youth corners are used as COVID-19 vaccination areas due to insufficient infrastructure, thus, limiting CRH service provision during the immunization period; there were discrepancies in ASRH data when comparing register and monthly reports.	There is still low service demand for visited youth centers; the CRH service package is incomplete, with staff shortages and a lack of materials and consumables, as there is no link between the youth center and the district pharmacy; appropriate IPC materials are lacking; health communication materials are lacking; and there is no close collaboration between some youth centers, health centers, and/or hospitals.
Actions	In collaboration with hospital directors general, the ASRH focal point will closely follow CRH activities in the hospital catchment area, and CRH data will be integrated into the routine data analyses. IOSC staff, including the identified ASRH focal point, were trained on the holistic approach and oriented on youth-friendly services. After a refresher	Ingobyi staff worked with health center managers to identify another adequate immunization area to ensure the continuity of CRH service provision. In collaboration with the health center data manager, observed data quality issues were	Ingobyi continues to work with health centers, hospitals, and districts to strengthen the functionality of youth centers and revitalize youth-friendly services; providing staff training and strengthening linkage and referrals between youth centers and health centers and hospitals are emphasized; Ingobyi advocated to district health leaders and

training, CRH services for adolescents and youth will be provided in IOSCs. Emergency contraceptives are provided as needed and a multidisciplinary approach is used to manage GBV cases in adolescents and youth. All hospitals are now following MoH instructions regarding the cost of GBV services after discussing the issue in district coordination and DHMT meetings.

immediately corrected. Ingobyi supported the ASRH focal persons and health center data manager to analyze and display CRH data in youth corners.

hospitals to include the youth centers in their schedule during supportive supervision visits; the RBC was encourage to make available some tools and materials, like registers, IEC materials, IUDs, and implant kits; health centers will continue to offer nurses to provide adolescent and youth CRH in youth centers at least once a week; Nyaruguru District recruited a new staff person to provide CRH services in the Nyaruguru youth center.

Provision of CRH services to adolescent and youth during weekend days

As of the end of FY21, Ingobyi had supported more than 77% of youth corners to become functional (meaning they had SRH services available and a health provider assigned to attend to youth). However, in an SBC study conducted by Ingobyi in the same fiscal year, only 15.8% of the adolescents reported receiving CRH information from health providers. By analyzing this gap, it became obvious that youth corner services were only open during working days, when the majority of youth are in school.

To increase youth access to CRH services, especially for those in school, USAID Ingobyi Activity supported all health centers to initiate the provision of youth and adolescent reproductive health services during weekend days. At least twice a month, each health center provides CRH services during weekend days. Strategies to sensitize youth about this opportunity were put in place, including collaboration between schools and health centers and messaging through CHWs, peer educators, and health providers during routine health education sessions. Provided services included group health education on several reproductive health-related topics, individual counseling based on specific needs, FP method provision, HIV testing, pregnancy testing, ANC to pregnant teens, and referral services, among others.

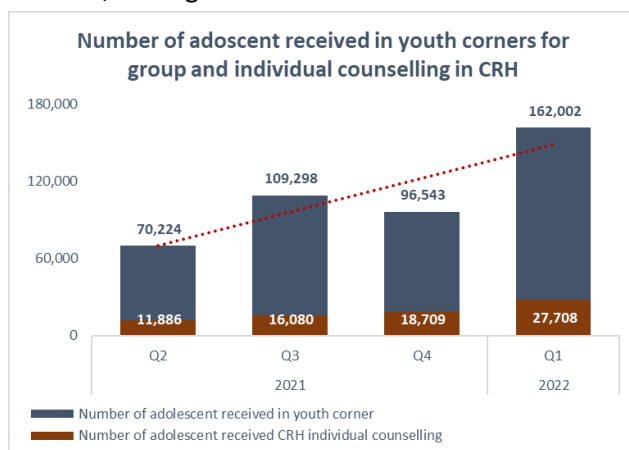


Figure 5: Number of young people who received services in quarter 1 (FY22)

As a result of making the services available over the weekend, there was a massive increase in adolescent attendance at the youth corners: the number of adolescents and young people who attended IEC sessions increased from 96,543 in the last quarter of FY21, to 162,002 in the reporting quarter (Figure 5), an estimated increase of more than 40%. The number of adolescents and young people who received individual counseling also increased by 32.5%.

District-based mentors also use this opportunity to support their mentees, and this is expected to accelerate learning and validation on CRH competencies since there is an increased service demand, thus real clients available for practice. CRH service provision during weekend days was also an opportunity to provide COVID-19 prevention messages, including immunization, to youth.

Strengthening parent-adolescent communication in the community

The SBC study conducted in FY21 reported that 65.3% of parents discussed SRH with their children, while the remaining 34.7% did not. Half of the study participants (50.7%) reported lack of knowledge as a hindrance to parent-adolescent communication. To address this gap, USAID Ingobyi Activity supported health centers and local leaders to conduct one-day parent-adolescent communication sessions in two districts, Musanze and Gatsibo. Forty parents having at least one adolescent in their household and 20 youth aged 14–24 years participated in these sessions. This activity aimed to break the silence on CRH, as well as to improve parental knowledge and skills in CRH and adolescent communication. The “*Tuganire Mwana Wanjye*” (“Let’s Talk My Child”) booklet, produced by the Imbutu Foundation and approved by the MoH, was used in these sessions.



Photo 4: Parent- youth communication session in Gatsibo District

Youth-centered innovations

In FY22, Ingobyi Activity will continue to work with two youth-led organizations—Rwanda We Want and Community Health Boosters—to implement innovative youth SBC activities. These activities were designed by and for youth to meet their needs for CRH information and services and to address their health concerns, such as their reluctance to visit health facilities for CRH services for fear of judgment by health providers.

Rwanda We Want: production and dissemination of adolescent and youth CRH educational videos through social media

During this quarter, Ingobyi Activity, through Rwanda We Want, supported the use of social media and online platforms to create awareness of ASRH information and services among youth and adolescents across the country. The youth-led organization produced and posted CRH educational videos on their social media platforms (Facebook, Instagram, and Twitter) to increase young people’s awareness and knowledge of SRH issues and to empower them to make informed decisions about their health and future. These videos were also distributed to all supported health facilities and are being used during adolescent and youth education sessions, especially during weekend sessions. During this quarter, 21,396 youth accessed messages posted on the Rwanda We Want Facebook and Instagram accounts (Figure 6).

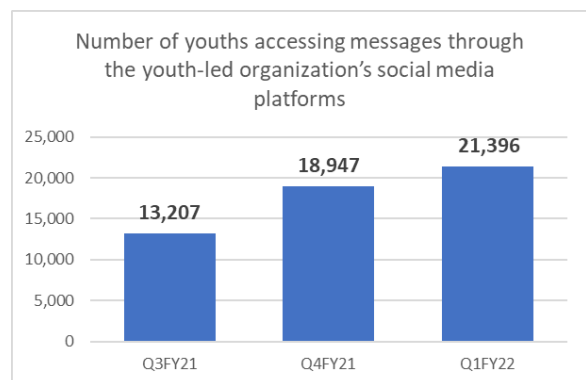


Figure 6: Number of youths accessing messages through the youth-led organization's social media platforms

Tubivugeho campaign

The Tubivugeho campaign aims to create safe spaces for boys and girls to talk about adolescent and youth reproductive health matters, including the physical, physiological, and psychological changes that happen during puberty and adolescence; teenage pregnancy; FP; sexually transmitted infections and HIV; and GBV. In addition to Gatsibo District, Ingobyi Activity planned to extend the Tubivugeho

boys', girls', and mixed-group discussion sessions (also referred to as "spaces") in two other districts, Ngoma and Nyanza. The Tubivugeho implementation cycle involves conducting separate youth spaces (meetings) for girls, boys, and teen mothers, followed by combined group spaces, and concluding with adolescent-parent spaces. During this quarter, Tubivugeho sessions were conducted in Ngoma District and brought together 36 adolescents and youth (20 boys and 16 girls), 26 teen mothers, and six parents. During the sessions, youth received counseling and education to increase their knowledge on reproductive health and CRH services, including FP to prevent unwanted pregnancies and to facilitate teen mothers' social reintegration into their families and communities through parent-adolescent communication sessions. Health providers from the nearest health centers used this opportunity to offer appointments at youth corners to teen mothers, so they could receive more information and services. At the end of each Tubivugeho cycle, a competition was conducted to evaluate the knowledge of adolescents. Youth who participated in the spaces, and those who understood the messages and demonstrated their intent to adopt positive behaviors, received awards to recognize their efforts. In addition, the USAID Ingobyi in collaboration with Rwanda We Want continued to support peer educators trained in FY21 in Gatsibo District to continue disseminating reproductive health information to peer youth from their respective sectors. Peer educators provided reproductive health information to 234 youth (144 males and 90 females) through existing platforms, including youth clubs and other community gatherings.

Community Health Boosters: Rengerubuzima software development

Ingobyi Activity, in collaboration with Community Health Boosters, has designed and developed user-centered Rengerubuzima software made of an online-offline mobile application (Android and iOS) and a web application named YAhealth that will deliver reproductive health information and services via a menstruation cycle tracking system, a GBV reporting system, a geo-tracking system, and chat services, and will connect youth users to associated services and support systems across the country. Adolescent and youth reproductive health educational messages were loaded, and the software was presented to the ASRH sub-TWG for comments and tested to assess its user-friendliness. During this quarter, the software content was presented to the Rwanda Health Communication Center TWG for approval. Some messages in the software were validated and can be displayed to the public, while others will need another validation session by the health promotion TWG. The launch of this CRH educational tool is planned for the next quarter. Ingobyi will continue to work with Community Health Boosters to raise awareness of its availability and promote its use by young people.

Other SBC interventions for adolescents and youth

USAID Ingobyi continued to use the *Urunana* soap opera, *Umuhoza* magazine, and radio sketches to disseminate CRH messages. During this quarter, the focus was on the benefits of the pre-nuptial checkup, consequences of early and unprotected sex, and complications of teenage pregnancy. At least two radio sketches on CRH were produced and aired on nine community radio stations and KISS FM. The sketches highlighted the consequences of early pregnancy, menstrual hygiene, and the benefits of youth corners, as well as the CRH service package available to adolescents and youth.

II. Maternal Health

Over the years, Rwanda has registered impressive gains in maternal health. The maternal mortality ratio decreased from 1,071 per 100,000 live births in 2000 to 203 per 100,000 live births in 2020.⁵ Those deaths are a result of preventable complications during pregnancy, childbirth, and the immediate postpartum period. Common causes of maternal death include severe bleeding, obstetric complications, infections, and hypertensive disorders in pregnancy. Deaths are mostly attributed to poor case management, delays in referring patients to a higher level of care, insufficient staff and diagnostic capacity, delays in recognizing complications, inadequate monitoring of labor, and poor follow-up in the immediate postpartum period. The provision of quality care and services delivered by appropriately prepared health care personnel is critical to reducing this high burden.⁶ USAID Ingobyi Activity therefore builds on providers' capacity to deliver quality EmONC services and allows equitable access to maternal health quality services. In this quarter, USAID Ingobyi Activity continued to build on providers' capacity to deliver quality EmONC services and supported equitable access to maternal health quality services through the following activities:

Support at the national level to plan and manage maternal health services

Participation in TWGs

During the quarter, USAID Ingobyi Activity hosted and co-chaired two Safe Motherhood sub-TWG meetings. Discussions focused on maternal health data for the previous quarters. Following the data review, Ingobyi highlighted the lack of a "Pregnancy wheel–Rwanda version," a tool that helps health providers calculate gestational age and plan for subsequent ANC visits, thus potentially increasing to four ANC standard visits. A core team led by Ingobyi Activity under coordination of the RBC/MCCH Division was appointed to identify key landmarks for the tool, considering the new national ANC guidelines. In the next quarter, Ingobyi will support the design and production of an adapted Rwanda pregnancy wheel version. Other discussion topics from the TWGs included the implementation plan for the ANC guidelines and WHO's Labor Care Guide: User's Manual (version 2020). Some key recommendations from the meetings included adapting a new generic WHO partograph to a national version and close collaboration among all partners in implementing the plan for the new ANC guidelines.

Supporting the MoH to develop and review maternal health protocols and guidelines

As part of the contribution to the implementation of the new ANC guidelines, during this quarter, USAID Ingobyi supported the MoH to finalize national ANC training materials and tools that will be used for cascade training. Final versions of the participant manual, facilitator guide, updated ANC register, ANC file, and the national MCH handbook are available for editing and printing.

Improving maternal health provider skills

LDHF training in EmONC

⁵ National Institute of Statistics of Rwanda, 2020. Rwanda Demographic and Health Survey 2019-20: Key Indicators Report

⁶ Schwerdtle P, Morphet J, Hall H. A scoping review of mentorship of health personnel to improve the quality of health care in low and middle-income countries. *Glob Health*. 2017;13(1):77

To facilitate the uptake of clinical mentorship competencies, USAID Ingobyi continued to increase the number of trained staff on maternal health competencies from supported districts by facilitating an intense on-site training in hospitals. In the last quarter of FY21, Ingobyi conducted training of health providers from 15 hospitals and one upgraded health center.



Photo 8: Basic EmONC LDHF training in Ngarama and Byumba hospitals

During this quarter, Ingobyi continued LDHF on-the-job training of the remaining targeted providers from 13 hospitals and one upgraded health center. The LDHF training was conducted in 12 sessions over four weeks to allow time to merge theory with practice using a blend of different methodologies, including presentations, demonstrations and practice using anatomic models, ward rounds, file review, and real case management (when available). Every topic was concluded by discussion to identify service delivery gaps, suggest solutions, and commit to actions for improvement.

The main training topics included: interpersonal communication; respectful maternity care; gender integration; IPC; rapid initial assessment; care during labor and childbirth; the management of vicious presentations, such as breech presentation and shoulder dystocia; hypertensive disorders in pregnancy; PPH; post-abortion care; preterm premature rupture of membranes; obstetric infections; helping babies survive; and PNC. A total of 129 health providers (72 females and 57 males), including 29 medical doctors, 50 nurses, 42 midwives, and eight anesthetists were trained. The evaluation conducted at the end of the training showed an increase in knowledge, from 65% on the theoretical pre-test to 89.5% on the post-test, which included practice. All participants received continuous professional development points. Ingobyi will continue to sharpen and reinforce knowledge retention through clinical mentorship.

Clinical mentorship in maternal health

Clinical mentorship is an approach that involves practical training and consultation, fostering the ongoing professional development of learners/mentees to deliver sustainable, high-quality clinical care. Research shows that the retention of health providers' skills declines as soon as three months after classic training. Most health workers do not get the experience they need to maintain skills beyond infrequent training intervals. In addition, loss of time on the job for training results in reduced quality of patient care. Skilled health providers with the ability to prevent, detect, manage, and/or refer major obstetric complications are crucial to reducing maternal and neonatal mortality. Ingobyi Activity worked in collaboration with RSOG and RAM to improve the capacity of health providers at 26 supported hospitals and two upgraded health centers. District-based mentors also supported 325 health centers and 20 health posts through clinical mentorship.

Clinical mentorship by RSOG and RAM

During this quarter, Ingobyi Activity-RSOG mentors conducted three-day monthly mentorship for general practitioners in 17 supported hospitals and two upgraded HCs that have one or no permanent gynecologist. All facilities benefited from one-day quarterly supportive supervision conducted by senior obstetricians and midwives from the two associations. This quarter, Ingobyi Activity continued to collaborate with RSOG and RAM to improve the capacity of health providers in 20 districts. In

previous years, mentorship support to the hospitals was not differentiated, and all hospitals were receiving the same level of support. Over time, key strengths and achievements at different health facilities were documented, including increases in the number of obstetricians and gynecologists—the MoH has appointed more obstetricians and gynecologists to different hospitals, with some hospitals having at least two obstetricians/gynecologists in place; more master mentors from hospitals; the noted acceptable positive trends in key MNH indicators; the increase in leadership skills among those in charge of maternity services; and strong teamwork among maternity services staff, among others. However, HMIS data show that some hospitals need more support than others because they have only one or no obstetrician/gynecologist and heavy workloads. Starting from this quarter, mentorship support was targeted and differentiated at each hospital depending on needed support.

Mentorship and supportive supervision by RSOG

During this quarter, Ingobyi Activity-RSOG mentors conducted clinical mentorship in 17 hospitals and two upgraded HCs that have one or no permanent gynecologist. The mentorship was conducted over three consecutive days on a monthly basis to allow time to identify facility knowledge and practice gaps and conduct customized mentorship based on facility needs. The mentorship focused on the provision of lifesaving skills through clinical presentation during morning staff meetings, bedside teaching during ward rounds, case scenarios to improve decision-making during obstetric and neonatal emergencies, practical Caesarean section sessions, and sessions on the use of ultrasound. Topics covered in LDHF learning sessions included: partograph interpretation; obstetric emergencies, including pelvic anatomy; Caesarean section principles (indications of Caesarean sections, informed consent, use of preoperative antibiotic prophylaxis, and regular use of surgical checklists); PPH management; management of preeclampsia with severe features as an obstetric emergency; malaria in pregnancy; preterm premature rupture of membranes and premature rupture of membranes management; and post-abortion care. Mentors promoted the culture of clinical data review to identify critical service delivery gaps, reviewed the recommendations and learning opportunities from maternal and perinatal deaths audits, and worked with supported health providers to develop a focused action and implementation plan to close service delivery gaps. As a result, 68 medical doctors were mentored on four live-saving interventions (safe Caesarean section, PPH management, delivery by vacuum extraction, and preeclampsia management). During the mentorship visits, RSOG mentors and their mentees successfully managed seven life-threatening obstetric complications. Those complications were due to PPH, uterine rupture, ectopic pregnancy, and complicated Caesarean section. Mentees were encouraged to learn not only from the mistakes but from the successes, which increases health provider morale .

Nine hospitals that did not benefit from the RSOG clinical mentorship because they had two or more obstetricians/gynecologists received a one-day supportive supervision from senior obstetricians/gynecologists, preferably located in the same catchment areas. The aim of the supportive supervision visit was to facilitate a smooth transition from mentorship to building self-efficacy and local expertise. The supervision was dedicated to maternal health wards for the following activities: assessing the availability of protocols, guidelines, equipment, and materials, among others; organizing services; assessing compliance with IPC standards; reviewing analyzed quarterly hospital data; reviewing death audit reports and recommendations; reviewing progress toward implementing recommendations from previous mentorship or supportive supervision visits, and providing both verbal and written feedback to maternal health staff and hospital leadership. It was also an

opportunity to discuss difficult cases and solicit expert recommendations to improve the quality of maternal health services.

Mentorship and supportive supervision by RAM

Ingobyi Activity continued to collaborate with RAM to improve the competence of staff working from 14 hospitals and two upgraded health centers. RAM conducted three-day monthly mentorship visits to 14 hospitals and two upgraded health centers that had been identified as having persistent gaps, staff shortages, and insufficient service leadership. Mentorship interventions included LDHF sessions delivered through lecturers, bedside teaching, case scenarios/discussions, simulations with anatomical models, and demonstration on real cases. This quarter, 90 midwives and maternity nurses (58 females and 32 males) were mentored by RAM mentors. Mentorship topics included: effective labor monitoring and use of the partograph, birth preparedness, active management of the third stage of labor, newborn resuscitation, essential care for every baby, essential care for small and for sick babies, helping mothers survive (focusing on PPH prevention and management), management of preeclampsia and eclampsia, PNC for mothers and their babies, the promotion of respectful maternity care, IPC, the management of other obstetric emergencies like breech delivery, and vacuum extraction and comprehensive post-abortion care.

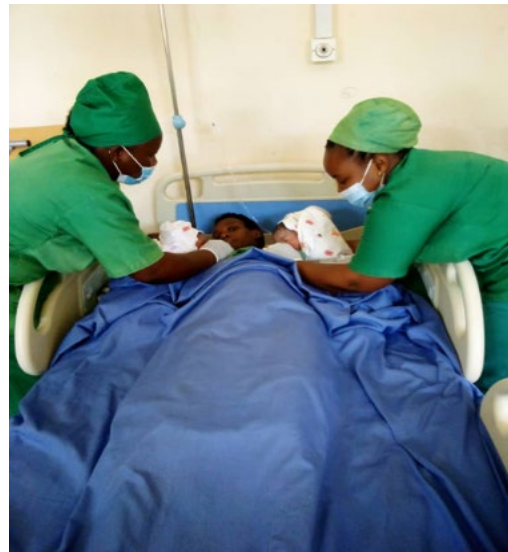


Photo 5: RAM mentor and mentee in early initiation of breastfeeding after a C/Section at Rutare HC, an upgraded HC

The mentorship was implemented continuously to encourage validated mentees to keep supporting peer providers in the absence of mentors. Other areas of mentorship included a review of clinical maternal health data to identify critical gaps in service delivery, follow-up on the implementation of interventions and actions from death audits, supporting the development and implementation of QI projects, and working with hospital management to improve the work environment.

As a result of mentorship visits, RAM mentors supported hospitals to manage 12 obstetric and neonatal complications, including four cases of PPH, two cases of severe preeclampsia, one case of post-abortion complications, three cases of birth asphyxia, and two cases of neonatal hypothermia.

In addition to the RAM mentorship, seven senior midwives were deployed by RAM to conduct supportive supervision to all 26 hospitals and two upgraded health centers, including 12 hospitals (Byumba, Masaka, Kacyiru, Kibagabaga, Ruhengeri, Gisenyi, Kibungo, Kabgayi, Nyamata, Nyanza, Ruhango, and Remera Rukoma hospitals) that did not benefit from clinical mentorship because they had strong mentors, few critical gaps, and strong maternity services leadership, all of which had been achieved from past mentorship sessions. The supportive supervision visit focused on: supporting

mentors to deliver high-quality mentorship; supporting maternity services to ensure the availability and use of the most recent protocols and guidelines, as well as lifesaving equipment/materials; organizing maternity services; improving compliance with IPC standards; reviewing death audit reports and recommendations to support services to translate those into actions; reviewing progress toward implementation of recommendations from previous mentorship supportive supervision visits, including reviewing data to analyze progress toward QI projects and making necessary adaptations; and providing both verbal and written feedback to mentors, maternal health staff, and hospital leadership.

Key achievements from supportive supervision included: availability of emergency kits/trolleys to manage maternal-related emergencies without delay; increased capacity of nurses and midwives to manage childbirth-related complications, like newborn resuscitation, severe preeclampsia/eclampsia, PPH, and post-abortion care; continuous availability of emergency medications, including antibiotics, MgSO₄, tocolytics, and oxytocin, in hospital maternities; improved use of partographs for labor monitoring; improved service organization focusing on IPC measures, increased number of handwashing facilities within maternity units; and increased data use for QI.

Mentorship by maternal and newborn health district-based mentors

During this quarter, Ingobyi supported 175 MNH district-based mentors (137 females and 38 males) to conduct two-day monthly clinical mentorship to 536 midwives and nurses (380 females and 156 males) from 325 supported health centers. Up to 369 mentees (128 females and 58 males) were validated in at least one MNH competency, including 53 validated in all MNH competencies on anatomical models, except vacuum extraction and post-abortion care.

This quarter, mentors started to focus on the most lifesaving competences, like PPH prevention during normal delivery, management of PPH, and management of severe preeclampsia/eclampsia, which increased the percentage of validated mentees in most lifesaving competences from 46% to 73%. Mentors continued to work with mentees and other service providers to review MNH data and tools and to facilitate improvement in the facility work environment and service delivery.



Photo 6: A district-based mentor coaching mentees on MVA technic

As a result of the mentorship, during this quarter, mentees recognized and treated/stabilized different obstetric and neonatal complications at the health center level, including 34 cases of PPH due to uterine atony; 12 cases of PPH due to retained placenta, using manual removal of placenta; 25 cases of severe preeclampsia, by the correct pretransfer loading dose of indicated medications including MgSO₄; seven cases of breech deliveries, successfully conducted; 159 successful resuscitations of neonates; and five cases of cervical tears, diagnosed and stabilized before transfer.

Key achievements this quarter include: improved follow-up of women for ANC by actively tracking those missing their ANC appointment; continuous availability of emergency medications (including

antibiotics, MgSO₄, tocolytics, and oxytocin) in emergency kits to manage maternal-related emergencies without delay; improved use of partograph for labor monitoring; and increased capacity to manage pregnancy-, childbirth-, and postpartum-related issues, such as newborn resuscitation, severe preeclampsia/eclampsia, PPH, and post-abortion care.

MNH mentorship in health posts in Nyanza District

Mentorship in Nyanza District health posts

Ingobyi supported clinical mentorship activities in 15 health posts in Nyanza District, 14 of which are first-generation health posts and one a second-generation health post (with a maternity unit). A total of 15 mentees were reached by mentors from various health centers who had received training by district-based mentors and Ingobyi staff using the LDHF training approach. Each health post is supported by at least one mentor from a nearby health center. For the first-generation health posts, the training content included: health education during ANC, focusing on identifying danger signs; documentation of referral and postnatal visits; newborn physical examinations; and education on PFP, exclusive breastfeeding, and the importance of the first 1,000 days of a child's life. For the second-generation health posts, the content of the training included ENC, HBB, the use of referral guidelines, ENC documentation, and PNC. In addition, during this quarter, in collaboration with Nyanza Hospital and Nyanza District leaders, Ingobyi Activity staff visited 11 health posts—to follow implementation of recommendations from previous visits and support QI. Ingobyi staff observed that iron and folic acid, dexamethasone, vitamin K and G24, catheters, and mosquito nets were available and usable; IPC measures had improved; and the fourth PNC visit was made on the same day as the second dose on the infant's immunization schedule. Nonetheless, in all health posts, there were noted persistent challenges, such as insufficient refrigerator capacity to store anti-tetanus vaccine; no electricity in some health posts; only one nurse covering an entire health post, making validation impossible for that person; and some essential ANC laboratory tests being not covered by community-based health insurance. Since October 2021, the second-generation health post closed maternity services due to insufficient staff, as currently the entire health post is run by only one nurse; the district health management team was alerted to this situation. Ingobyi supported improvements in service organization to deal with understaffing challenges.

Routine monitoring and supportive supervision of maternal health services

USAID Ingobyi Activity conducted supportive supervision visits to 142 health facilities (including 88 health centers, 24 hospitals, and 30 health posts) for maternal health service delivery. The frequency and nature of the supervision were informed by routine data reviews and maternal and neonatal death notifications.

The purpose of the supportive supervision was to work with mentors, health providers, and hospital leadership to review facility health system gaps and challenges that might compromise the provision of quality maternal health care and to support advocacy with districts, the MoH, and other stakeholders to address outstanding bottlenecks. During the supportive supervision, USAID Ingobyi Activity followed the implementation of recommendations made through prior supervision visits, death audits, and accreditation assessment. USAID Ingobyi advised health facilities on further interventions to close gaps; followed and checked measures in place to limit/control the spread of COVID-19 in maternity areas; ensured the availability of maternal health services and lifesaving

equipment, as well as the organization of services; and advised on space management, data management, the referral system, and the commodity and supply chain.

Table 4 below summarizes key findings and achievements from the supportive supervision.

Table 4: Summary of findings from routine MNH supportive supervision at the hospital, health center, and health post levels

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment	Data use for decision-making
Hospitals	Strengths	All hospitals provide the entire maternal health package, including comprehensive EmONC; the new national EmONC protocols are available and used; observed improvement is the use of severe pre and Eclampsia guideline in the majority of hospitals; emergency calls from health centers/health posts are managed by midwives in the majority of hospitals, which improved communication between health centers/health posts and the hospital team in referral process; the pre-referral management of obstetric complications has improved; interpersonal communication and teamwork following actions taken during previous on-site training and mentorship sessions have improved; all hospitals use the Situation-Background-Assessment-Recommendation approach for written handovers.	Improved birth preparedness and readiness to manage birth complications through availability of emergency and essential medicines and supplies, helper approach is practiced in the majority of hospitals; IPC measures, including routine general cleaning and disinfection has improved in all hospitals; the completeness and use of documentation tools following the discussion and services tours done during on-site training sessions have improved.	An emergency trolley, with essential medications for maternal emergency cases, including uterotonics, MgSO ₄ , and resuscitation supplies, is available in the labor and operating theater.	Admission, labor, and delivery rooms are organized and equipped; the majority of hospitals have a cardiotocography machine for labor monitoring; delivery rooms have acceptable delivery kits and resuscitation equipment.	Most hospitals conduct joint maternity-neonatology weekly meetings dedicated to discussing the delivery of quality services and reviewing any poor maternal or neonatal outcome that happened in the maternity; all hospitals conduct surveillance of surgical site infections.
	Gaps	A significant proportion of providers are not trained on the new EmONC protocols, leading to inadequate and delayed care; severe preeclampsia/eclampsia and preterm labor are poorly managed; preterm premature ruptured membranes and premature ruptured membranes remain issues; labor is poorly monitored, leading to poor maternal and newborn outcomes; there is a lack of standard Caesarean section registers in all hospitals and a lack of updated partographs.	Privacy in labor and postpartum rooms is insufficient, limiting the companion of choice during labor; there are shortages of patient linens, including bedsheets, blankets, and towels.	Inappropriate concentrations of MgSO ₄ are found in some hospitals; pregnancy wheels are not available in most of hospitals.	There is a lack of appropriate sterilization machine at Shyira, Nyanza, and Kabgayi district hospitals; the anesthesia machine in Nyamata District Hospital is nonfunctional; handwashing stations in postpartum wards are insufficient.	There is poor documentation in medical records, leading to lack of data and inadequate reporting; maternal and perinatal death audits are not done well; key elements of the partograph are missing in the maternity electronic medical record.

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment	Data use for decision-making
	Actions	At least ten providers are trained in each hospital, and an additional 12 providers are planned to be trained next quarter; facilities are supported to address critical gaps that could be immediately addressed; mentors are advised to actively check in with services to ensure onboarding orientation so knowledge gaps in clinical protocols can be filled; USAID Ingobyi advocated for updating the partograph and introducing a national Caesarean section register, as well as including the partograph in the electronic medical record.	Ingobyi advised facilities to increase patient linens procurement started in the majority of hospitals. Also, Ingobyi advised hospitals administration to find budget for simple modification of existing spaces to maximize the mothers' privacy for improving respectful maternity care.	Ingobyi advocated to Rwanda Medical Supply to procure appropriate doses of MgSO4 of 50% to comply with national guidelines.	Ingobyi advocated for sterilization machines, resulting in the provision of a new sterilization machine from the RBC to Kabgayi District Hospital; Ingobyi will support maintenance of the rest of the sterilization machines depending on the availability of broken spare parts.	Effective completion of patient files and registers discussed with providers focusing on missing elements; maternal HMIS indicator explained to providers for better reporting; continuous support of death audit committees
	Remaining gaps	Staff shortages remain, manual vacuum aspiration kits and aspirator machines for post-abortion care are missing in some hospitals; there is a lack of standardized anesthesia monitoring registers. Ingobyi will discuss these issues with the MoH to seek their intervention.	The majority of hospitals do not have reserved space for critical patients (Red/Orange rooms), and immediate postpartum rooms are likewise lacking. Ingobyi will continue to advocate for infrastructure improvements at district and central levels.		There is a shortage of patient monitor and a lack of cardiotocography machines at eight hospitals; infrastructure is inadequate, hindering respectful maternity care and appropriate IPC measures; there is a lack of appropriate delivery tables at five hospitals.	Key elements are missing from the electronic medical record. Support will be provided next quarter during supportive supervision to address this issue.
Health centers	Strengths	ANC and maternity health services are available in all HCs; linkage between OPD and ANC services has improved in most HCs; HBM/HBS guidelines and action plans in maternity are available; the pre-referral management of obstetric complications has improved; new transfer forms are in use in all HCs.	Privacy is ensured in labor rooms; all maternity rooms are cleaned daily; delivery kits are well organized and ready to be used in many HCs; interpersonal communication in most of the supported HCs has improved, following recommendations from last quarter supportive supervision; most HCs have an admission form for every admitted mother; patient handover has improved.	All emergency and essential drugs and consumables are available in most HCs.	Some health centers have a good maternity building for the delivery of quality maternity care.	Interventions from ANC indicators are discussed at each health center to improve ANC coverage; documentation has improved; all tools are being used properly.

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment	Data use for decision-making
	Gaps	Labor is monitored poorly in all HCs due to a shortage of staff (one staff is allocated to more than two services); medical tools are incomplete; monitoring systems for emergencies and essential drugs within services are lacking; there is a lack of pregnancy wheels; the protocol for managing obstetric complications is not being adhered to, especially in HCs with a significant number of staff not trained on current basic EmONC guidelines; there is insufficient use of the partograph.	Privacy in labor and postpartum rooms is insufficient, hindering having a companion of choice during labor; there is a lack of an immediate link between hospital and ANC clients identified with high risks; active follow-up of high-risk pregnant women in ANC is lacking in most of HCs; there is insufficient follow-up for ANC appointments.	There are frequent stockouts for some ANC testing and laboratory reagents.	Inadequate infrastructure does not allow the delivery of quality care in many HCs; some equipment and materials, mainly vacuum extractors and manual vacuum aspiration kits, are missing in many HCs; delivery tables are very old and damaged; sterilization equipment is inadequate.	Providers do not regularly review MNH data; new staff in charge of the maternity do not understand MNH data elements.
	Actions	Elaboration of a sheet to monitor emergent and essential drugs has been shared with those in charge of maternity services; active follow-up strategies were discussed and put in place; registers to document all pregnant women at high risk have been introduced to support focused follow-up and timely linkage to hospitals; use of the partograph was discussed and mentors were advised to reinforce the actions.	Mothers' privacy continues to be prioritized in all advocacy with health facility leaders; privacy and role of companion of choice in labor and birth is included in respectful maternity care discussions in all mentorship activities.	The issue of stockout is discussed in all meetings (including coordination meetings, DHMT meetings, and TWGs).	Advocacy for new equipment continues to be aimed at different stakeholders, including the MoH/RBC and districts.	Staff and facility leaders were advised to plan a monthly meeting to review and discuss all critical cases and trends; new staff in charge of the maternity has been oriented on the definition of key data elements.
	Remaining gaps	Staff shortages remain; vacuum extraction and manual vacuum aspiration, the two basic EmONC functions, are still not available in all HCs; medical files are lacking in the maternity of all HCs. Ingobyi will support advocacy at district and central levels to seek support in resolving these issues.	There is a lack of immediate postpartum spaces in all HCs. Ingobyi will discuss with facility leaders the allocation of appropriate spaces.	Some essential drugs and supplies mentioned in the new basic EmONC guidelines are not covered by community-based health insurance. Ingobyi will follow up with the MoH so that these drugs may be considered.	Inadequate infrastructure does not allow the delivery of quality care in many HCs. Ingobyi will continue supporting advocacy at the district level.	
Health posts	Strengths	IANC skills have improved; maternal complications are detected early and transfer is timely; ANC services are available in all visited	In response to last quarter's visit recommendations, maternity services are well-organized; staff	Some emergency and essential drugs are available in delivery rooms (oxytocin,	Delivery rooms are available, and equipped with at least one delivery kit.	

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment	Data use for decision-making
		health posts; maternity services are available in most secondary health posts; IPC measures have improved compared to last quarter due to the availability of disinfectant and cleaning soap.	trained in basic EmONC are now available at the majority of health posts, following recommendations given to the HCs.	intravenous fluids, antibiotics, etc.)		
	Gaps	The delivery register and partograph are poorly completed in all health posts; there is poor follow-up of pregnant women in ANC; ANC visits are not well scheduled in just a few health posts; there are shortages of essential materials and equipment, like pregnancy wheels, blood pressure machines, and thermometers to diagnose and manage some complications.	There is inadequate birth preparedness and complication readiness due to the unavailability of some materials (Ambu bags and masks); IPC measures are inadequate (no water for handwashing and no decontamination solution).	Some drugs (MgSO ₄ , corticosteroids, and antihypertensive drugs) are not available in some health posts; HIV tests are not done at health posts; laboratory services are not open every day.	The infrastructure for most health posts is inadequate and inappropriate; sterilization equipment is inappropriate in most health posts (e.g., use of a hot air oven).	Data are neither reviewed nor used in all health posts.
	Actions	Staff have been oriented on the use of the partograph and how to plan ANC visits for each pregnant woman; advised HCs to share some of the materials with health posts.	Ingobyi staff and champions supported local care providers to organize services for better service delivery, including proper cleaning of rooms.	Gaps in drug and test availability were discussed with the heads of HCs ; HIV samples from pregnant women were sent to HCs for testing; advocacy continues for HIV testing at health posts.	During a coordination meeting, the issue was raised, and district leaders agreed to follow up and find further solutions.	Data managers from HCs were advised to provide support to all staff working at the health post in reporting data on a monthly basis.
	Remaining gaps	Staff shortages remain, and there is still a lack of pregnancy wheels. Ingobyi will continue to advocate with the MoH for increased staffing, and Ingobyi plans to develop and distribute pregnancy wheels to all health facilities.	There is insufficient space for maternity services. Ingobyi will continue to advocate for improvements in infrastructure at the district and central level.	There is a lack of a refrigerator to store reagents and anti-tetanus vaccines at all health posts. Facility managers were advised to prioritize this issue in their next FY budgets.	Infrastructure for most health posts is inadequate and inappropriate; there is inappropriate sterilization equipment at most health posts; some health posts do not have a source of electrical power.	

Intervention by Rapid Response Team

Bigogwe HC faces an increase in the number of clients, with no change in infrastructure or staffing. Data show that the number of deliveries and Caesarean sections in Bigogwe HC is higher than Shyira District Hospital, which hinders service quality. The issue had been noted in different mentors' reports, showing persistent staff shortages and poor maternal outcomes from this health facility. In response, a team of members from RBC, Ingobyi Activity, professional associations, Nyabihu District, and Shyira Hospital visited Bigogwe HC to review and discuss the root causes of maternal, newborn, and child deaths and morbidity and to recommend feasible actions to resolve the problems. Table 5 summarizes the findings, discussions, and proposed actions.

Table 5: Findings of the rapid response team at Bigogwe upgraded health center

Findings	Discussion	Action/recommendation	Timeline
Shortage of staff	Bigogwe HC has 16 nurses, who need to be distributed over 12 different services, two midwives, two general practitioners, and two Anesthetists under contract. Meanwhile, Shyira District Hospital, which has fewer clients, has more than 20 general practitioners.	The MoH to allow Shyira District Hospital to share the needed staff with Bigogwe HC; continue to advocate at MoH to have at least two additional doctors, two midwives, anesthetists, and nurses.	January 2022
Increased workloads	Increased workloads lead to poor quality of service and thus a high number of stillbirths, maternal and neonatal mortality, and birth asphyxia. At this point, there is almost no monitoring or follow-up with mothers in the postpartum wards.	The MoH to increase staff. An RBC representative will support follow up with MOH.	Continuous
No functional ambulance at this HC	The ambulance based at Bigogwe HC is currently not in use following a crash. To transfer a client from the HC to a hospital, an ambulance from another HC currently serving many other HCs must be called, delaying treatment.	Shyira District Hospital to avail another ambulance to support this HC while it waits for its own ambulance to be repaired.	In one week following visit
Shortages of space and equipment	Spaces are small and equipment is insufficient, including a lack of an anesthesia machine.	Ingobyi to avail some essential equipment whenever possible, and keep advocating for more from different partners; Shyira District Hospital was assigned to resolve the issue of the lack of an anesthesia machine, as this was seen as being possible.	Next quarter
Inadequate IPC measures	Inadequate IPC measures were noted, including lack of an incinerator (medical waste is treated at Shyira District Hospital, with increased cost).	Medical waste must be treated at other nearby hospitals .	Immediately

Community-based maternal and neonatal health interventions

Mentorship in CBMNH

USAID Ingobyi Activity supported 650 mentors from 20 districts to conduct mentorship of 4,978 CHWs in CBMNH. The support aimed at building the confidence and competence of CHWs in the provision of effective and quality CBMNH services. Through the mentorship sessions, CBMNH mentors oriented CHWs on: the proper identification of danger signs in pregnant women, mothers and



Photo 7: CHW from Muko HC in Gicumbi District during a mentorship session, counseling pregnant women on danger signs

newborns; the effective counseling and education of pregnant and postpartum women; the appropriate use of tools (thermometer, balance, timer, mid-upper arm circumference tool, and urinary pregnant tests); the proper interpretation of pregnancy test results; s of breastfeeding and care for low birth weight babies; education on the prevention and/or management of PPH; and the completion of CBMNH registers. Mentorship activities were supervised by Ingobyi and hospitals. A total of 184 CBMNH mentors (65 males and 119 females), including midwives, nurses, and CEHOs from 13 districts, were supported to plan, conduct, and report on CBMNH mentorship sessions. Key observed gaps included the inconsistent availability of mentors due to COVID-19 vaccination activities and the turnover of trained nurses. To address these challenges, USAID Ingobyi Activity worked with hospitals and districts to provide on-site orientation of 12 newly appointed nurses from six districts (Musanze, Nyabihu, Rutsiro, Ngororero, Huye, and Ruhango) on the community health mentorship approach, as well as the use of mentorship tools. The newly oriented staff started to conduct mentorship sessions this quarter. Moreover, health facility managers were advised to integrate mentorship activities into other facility plans.

Supportive supervision of CBMNH interventions

In addition to mentorship, Ingobyi Activity continued to provide routine supportive supervision to strengthen the capacity of CHWs and the health center maternal health team on: the planning, conducting, and reporting of community-level maternal health activities; the referral process and use of referral tools; and ensuring the availability and completeness of community health registers. During this quarter, Ingobyi Activity and hospital staff conducted supportive supervision of 161 HC staff, including midwives, nurses, and CEHOs, at their HCs. Ingobyi Activity extended this support and facilitated 325 CEHOs from 20 districts to conduct supportive supervision of 4,995 CHWs at the cell and village level to improve the quality of CBMNH services. CEHOs assessed the availability and use of updated national CBMNH standard tools, completeness of registers, management of CBMNH commodities/drugs (urinary pregnant tests and misoprostol), reporting, the use of PPE to ensure the safe provision of services during the COVID-19 pandemic, waste management, compliance with IPC measures, documentation, data quality, and reporting. Observed gaps were immediately discussed with CHWs and corrective measures were proposed and implemented.

CHW coordination meetings for CBMNH interventions

To improve the coordination and harmonization of mentorship activities in the supported districts, USAID Ingobyi Activity supported one-day CBMNH mentorship coordination meetings in 15 supported districts. A total of 665 participants, including mentors and hospital team and district leaders, attended the meetings. The purpose of the CBMNH mentorship coordination meetings was to discuss mentorship implementation progress; discuss performance against CBMNH indicators; share best practices and lessons learned; and discuss key challenges and possible solutions. This meeting provided the opportunity for district health leaders to gain more insight into the community health mentorship approach and its role in improving community-level service delivery. Leaders committed to provide more support for the effective implementation of community mentorship. Key challenges highlighted included the turnover of trained CHWs; the frequent stockout of community commodities and drugs (urinary pregnant tests and misoprostol); and the lack of some equipment, like boots, torches, and boxes. Training CHWs on the comprehensive package started in this quarter. In quarter 2 of FY22, Ingobyi Activity is planning to procure some tools for CHWs in the supported districts.

Maternal health demand creation and community engagement

USAID Ingobyi Activity continues to support the GoR to implement maternal health demand interventions and strategies aiming to increase appropriate care-seeking behavior (including ANC and institutional delivery) and appropriate home-based care practices for mothers and newborns. According to the Rwanda Media Barometer 2021, Rwanda has 40 radio stations and 20 television stations. The findings highlight that 94.3% of Rwandans get information through radio stations, whereas 50.5% get information through television. The Rwanda Media Barometer is a biannual publication established by the Rwanda Governance Board, which sets up a comprehensive framework to regularly monitor and assess the state of media in Rwanda. Among the 40 radio stations, USAID Ingobyi Activity contracted ten, which helps the project reach almost the whole country with key RMNCH, malaria, and COVID-19 messages.

During this quarter, USAID Ingobyi Activity continued to disseminate key maternal health messages through the *Urunana* radio soap opera broadcast, Radio Rwanda, and Radio10. The key maternal health messages included: the benefits of completing four ANC visits, birth preparedness, the role of a companion of choice, danger signs during pregnancy, benefits of delivery at the health facility, benefits of community-based health insurance, early care-seeking, hygiene (critical times for handwashing), consequences of home delivery, danger signs for women after delivery, causes and signs of obstetric fistula, and the benefits of a balanced diet for pregnant and lactating mothers. Following issues raised by *Urunana* listeners at the end of each episode, two *Umuhoza* radio programs were produced and aired to highlight the importance of a balanced diet for a pregnant/lactating women and the role of CHWs in MNCH service delivery. Additionally, two five-minute radio sketches, with messages on avoiding harmful traditional practices toward pregnancy and the benefits of having a companion of choice during labor and delivery, were aired almost once every day on nine community radio stations. Ingobyi also broadcast one radio spot on the benefits of companion of choice on Radio KISS FM.

Institutionalization of QI, including maternal, perinatal, and child death surveillance and response

USAID Ingobyi Activity continued to support facilities to implement proven, high-impact interventions, such as QI projects, including maternal, perinatal, and child death surveillance and response (MPCDSR)

and confidential inquiry into maternal deaths, to improve service quality.

Maternal, perinatal, and child death surveillance and response

Ingobyi Activity supported the MoH/RBC to conduct the biannual national MPCDSR committee meeting. The national MPCDSR committee is an independent technical and advisory organ that supports the MoH to further improve the tracking of maternal, perinatal, and child deaths; identify modifiable causes of deaths; and deploy effective strategies to address preventable deaths. The meeting was attended by 17 participants representing health facilities, schools of medicine and midwifery, professional associations, and MCH development partners. The objectives of the meeting were to discuss findings from the joint supportive supervision conducted in quarter 4 of FY21; develop an MPCDSR supportive supervision tool (checklist); discuss findings from maternal, perinatal, and child death audit reports, including documentation of the gaps; and formulate final recommendations for submission to MoH/RBC high-level decision-makers to support prevention measures against similar avoidable maternal deaths in the future. The following recommendations were formulated:

- Request hospital directors general to be more accountable for the MPCDSR committee's functionality, and a letter to remind them to raise awareness of the hospital leadership on the causes and contributing factors of maternal and perinatal mortality was drafted and submitted to MoH;
- Strengthen mentorship (quality and quantity): involve hospital leadership in the implementation of mentorship recommendations (including having consistent mentees in maternity, neonatology, and pediatrics departments);
- Request the MoH to recognize and validate experienced and skilled general practitioners to perform lifesaving obstetric interventions;
- Mobilize resources to equip hospitals according to need, prioritizing hospitals with a high caseload and with special geographical challenges in maternity and neonatology services; and
- Strengthen specialized care in the provincial and referral hospitals to ensure permanent specialist coverage (e.g., at least three specialists per provincial I referral hospital).

Maternal health QI projects

During this quarter, USAID Ingobyi Activity used a QI approach as a structured methodology to review maternal health data, analyze the gaps, prioritize key interventions, and continue a focused monitoring of achievements. A participatory, multidisciplinary approach, bringing together relevant stakeholders, including ANC and maternity health providers, maternal health mentors, hospital committees (IPC, QI, and death audits, as well as RRTs), data managers, hospital leadership, and the Ingobyi team, was prioritized to allow multidimensional analysis of the gaps. Detailed action plans were developed to allow smooth implementation, and the monitoring and review of implementation progress was conducted as part of mentorship and supportive supervision. Forty-seven maternal health projects were implemented, including 37 that were still open at the end of FY21. Seventeen projects were related to increasing ANC coverage; 24 to reducing post-Caesarean infections, three to improving PNC services, two to improving PPH management practices, and one to managing preeclampsia. About 58.7% of the projects were implemented at the hospital level, while 41.3% were at the health center level. Up to 34% were completed this quarter, 55.3% were still in progress at the

end of the quarter, and 10.7% did not reach the targets and were overdue as of the end of the reporting period.

Observed trends in selected maternal health outcomes

ANC standard visit attendance

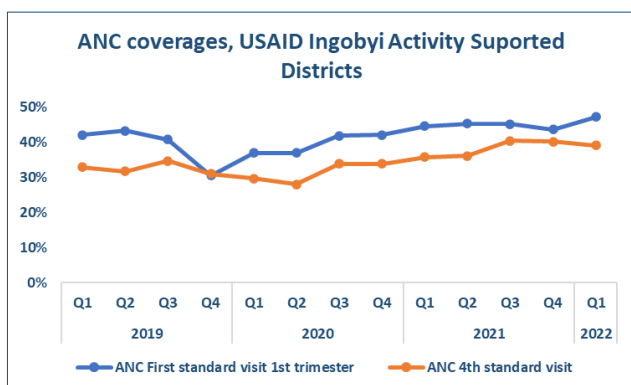


Figure 7: ANC 1 (at least one ANC visit during the first trimester) and ANC 4 (at least four ANC visits)

ANC is important, as it helps mothers prepare for safe childbirth. The MoH recommends at least four standard ANC visits, starting before the 12th week of amenorrhea or as early as the woman suspects she is pregnant. While attendance at least one ANC visit at any time during pregnancy is high in Rwanda, attendance of the fourth standard visit is still low because women do not attend their first standard ANC visit before the 12th week of pregnancy, as shown in Figure . To address this problem, Ingobyi Activity continued to:

implement SBC activities that promote the uptake of ANC services; strengthen community health services to increase early identification and referral; improve the identification of pregnant women attending OPD and link them to ANC, and actively follow up to increase retention of ANC services. As a result, uptake of the first and fourth standard ANC visits continued to increase. Compared to the same quarter of FY21, the first and fourth standard ANC visits increased by 5.7% and 8.5%, respectively, in this quarter (Figure 8 and 9).

Labor, delivery, and maternal postnatal consultation

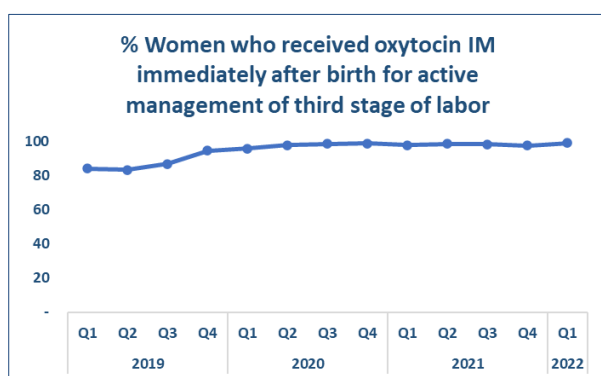


Figure 8: Use of oxytocin for the third stage of labor

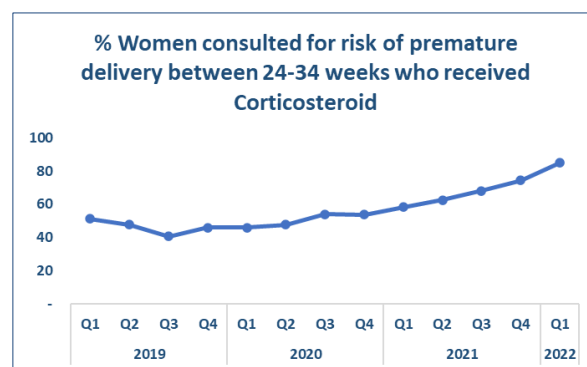


Figure 9: Women 24-34 who received corticosteroids

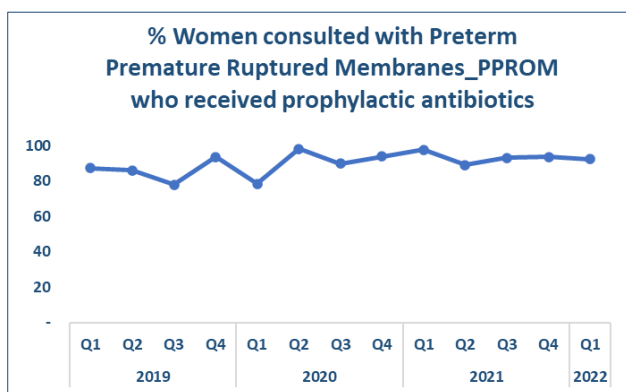


Figure 10: Women with preterm premature rupture of membranes (PPROM) who received antibiotics

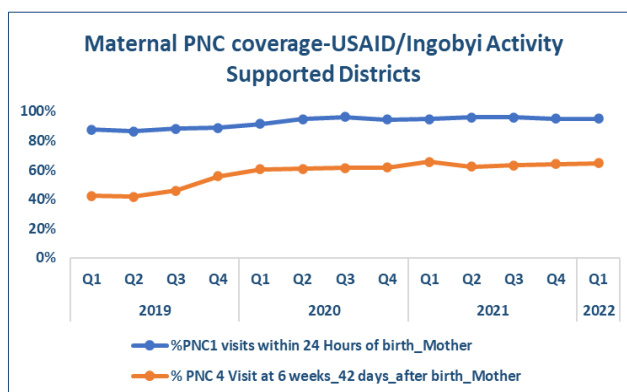


Figure 11: Maternal PNC 1 and PNC 4 coverage

As part of its efforts to manage PPH, the leading cause of maternal death in Rwanda, USAID Ingobyi Activity continued to mentor health providers to improve their knowledge of and skills to manage PPH, starting with active management of the third stage of labor. The availability and use of uterotonics was checked regularly during mentorship and supportive supervision visits to ensure a continuous high rate of oxytocin use (Figure 9). The provision of corticosteroids to women at risk of premature delivery continued to show a consistent increase of 27% percentage points, as compared to the same quarter of FY21, including an 11% gain observed from the last quarter of FY21 to this quarter. The provision of prophylactic antibiotics to women with preterm premature rupture of membranes (Figure 10) remained high at >90%. The positive results are due to ongoing LDHF and mentorship activities. In addition, supportive supervision is based on identified gaps in data management (better definition of indicators and data analysis).

USAID Ingobyi Activity continued to promote postnatal consultation for mothers to maximize the monitoring and management of post-delivery complications. The first PNC visit, conducted within 24 hours of delivery, continued to remain high (95%). The proportion of women attending the fourth PNC visit, conducted at six weeks post-delivery, also continue to increase compared to baseline in FY19 (Figure 11), but not to as high a percentage as was expected. This is possibly due to staff shortages, as the fourth PNC visit is done on the immunization day. USAID Ingobyi Activity will continue to work with health facilities and districts to increase attendance at the fourth PNC visit.

III. Newborn Health

Over the past decade, Rwanda has registered impressive achievements in maternal health, but these have not been reflected in child and neonatal health, especially in the past five years. The infant mortality rate was 33 per 1,000 live births in 2020, up from 32 per 1,000 live births in 2015, while the reported neonatal mortality rate was 19 per 1,000 live births in 2020 and 20 per 1,000 live births in 2015. The slight increase in the infant mortality rate was attributed to neonatal mortality and post-neonatal mortality, which remained at almost the same level.⁷ During quarter 1 of FY22, Ingobyi Activity continued work with the RPA to improve newborn care in supported health facilities.

Supporting the national level to plan and manage neonatal health services

Ingobyi Activity joined other partners in a newborn health TWG meeting to review newborn health indicators from the last quarter of FY21 and to discuss the progress of newborn interventions

⁷ National Institute of Statistics of Rwanda, 2020. Rwanda Demographic and Health Survey 2019-20: Key Indicators Report

implemented by different partners. The meeting was hosted and co-chaired by Partners in Health in November 2021. The TWG was an opportunity to discuss challenges faced by providers and facilitate collaboration and learning from each other. Participants were from Ingobyi Activity, Partners in Health, RPA, and the Royal College of Pediatrics and Child Health. Participants from the meeting discussed plans for the celebration of World Prematurity Day, which was shifted from November 17 to December 14, 2021 during the 5th RPA conference, as it coincided with the national Maternal and Child Health Week.

Celebration of World Prematurity Day

USAID Ingobyi Activity in collaboration with other partners supported the MoH to celebrate World Prematurity Day. The objectives of the event were: to raise awareness about prematurity in the community, including the risks of prematurity and the needs of preterm babies; to disseminate the message that preterm babies can survive and thrive; and to celebrate the work of neonatology teams who care for preterm babies. This year’s World Prematurity Day event was celebrated during the 5th RPA annual scientific conference, which offered a good opportunity to review different work and publications around newborn health. Table 6 summarizes the presentations and recommendations from the event.

Table 6. Topics and recommendations presented to mark World Prematurity Day

Topics	Recommendations
Rapid assessment on causes of lower utilization of Kangaroo Mother Care in four Rwandan districts within the Ingobyi Activity catchment area	Review the current policy to allow health centers to provide Kangaroo Mother Care services in the context of task shifting for stabilized neonates
Human resources need to improve sick and small newborn care (the role of pre-service and in-service institutions)	Deploy competent medical personnel for sick and small newborns in an appropriate number. Prioritize the right investments in pre- and in-service human resources for health for sick and small newborns.
Perspectives of caregivers on home transition of premature infants assessed by a post-discharge telephone call in two Rwandan teaching hospitals	Educate caregivers about home-based PNC using SBC messages sent to their mobile phones. Identify specific nurses in charge of the follow-up and creation of a free hotline.
PDC—Survive and Thrive: Outcomes of children enrolled in a follow-up clinic for small and sick newborns in rural Rwanda	Scale up and create guidelines for health providers and at the community level (pediatric developmental clinic).
Testimony: Miracle baby. Case of extremely preterm twins (one weighing 500 g at birth) who survived at King Faisal Hospital.	Provide holistic care, including educational, psychological, and financial support, to mothers of preterm babies. Provide financial support to mothers/caregivers of preterm babies whenever possible. Create a website where testimonies and videos can be posted as educational tools for parents who are caring for these babies. Prolong the maternity leave for mothers of preterm babies.

The event attracted a few media outlets, including the Rwanda Broadcasting Agency, The New Times, and Pressbox, which conducted a live session and home visit to the mother of the miracle baby.



Photo 8: Ingobyi staff, a mother with a miracle baby, and other partners celebrate World Prematurity Day during the 5th annual RPA conference

The second day of the RPA conference was marked by dissemination of the RPA Strategic Plan 2021–2025. After the presentation by Prof. Lisine Tuyisenge, eminent speakers, including Robin Martz, director of the USAID Rwanda Health Office, gave their remarks. She expressed her sincere thanks, profound respect to all pediatricians in Rwanda, and praised the continuous collaboration with RPA over the last five years, whose efforts resulted into achieving previous MDG number 4. Nonetheless, she noted that there is still more work to be done, given the latest Rwanda Demographic Health Survey 2019–2020 results on neonatal and infant mortality rates, to attain SDG number 3 by 2030.



Photo 9: RPA legal representative on the right hands over a certificate of appreciation to the USAID Rwanda Health Office Director, Robin Martz

Improving newborn health provider skills

Training on the neonatal protocol 3rd edition

To support the quick uptake of the new national neonatal protocol 3rd edition—which included new sections on quality of care, newborn referrals, congenital abnormalities, family-centered care, and palliative care for newborns—USAID Ingobyi Activity conducted an on-site neonatal LDHF training for 54 staff (medical officers, midwives, and nurses) working from five hospitals: Kabgayi, Gisenyi, Muhororo, Ruhango, and Rwamagana. Knowledge, as measured by pre-test and post-test scores, increased from 68% to 92%. Trainees and hospital management appreciated the on-site training approach, citing reasons like the ability to train many participants, understanding local problems, and addressing them collectively on-site. Challenges included participants’ inability to attend all sessions due to night shift schedules and exhaustion associated with afternoon sessions. Next quarter, Ingobyi plans to train the remaining staff from six high-volume hospitals to ensure that all neonatal health workers are trained on the national neonatal protocol 3rd edition.



Photo 10: Sample of photos demonstrating various on-site neonatal training sessions from different hospitals

Neonatal clinical mentorship and supportive supervision by the RPA

During this quarter, USAID Ingobyi Activity collaborated with the RPA to conduct three-day monthly clinical mentorship sessions in 17 hospitals and two medicalized health centers. The mentorship used the LDHF model blended with cases observations, contact meetings, clinical simulations, and bedside coaching to build the capacity of medical doctors and neonatal nurses in select topics, customized to address specific gaps identified for each mentored facility. The RPA mentors reached 32 mentees on 19 topics from the national neonatal protocols. By end of this quarter, 18 mentees had been validated in at least one neonatal health competency. The mentorship aimed at improving the key newborn indicators highlighted in Table 7.

Table 7: RPA progress on mentorship indicators for 17 supported hospitals and two medicalized HCs

No.	Indicators	Baseline October 2021	Target (%) September 2022	Current progress December 2021	Status of progress
1.	Proportion of low birth weight babies admitted to facility-based Kangaroo Mother Care clinic/services	29%	36%	28%	Stagnant
2.	Proportion of newborns admitted to neonatal unit with hypothermia (<36.5°C) during a period of six months	61%	45%	51%	On track
3.	Neonatal mortality for 12 months	9.5%	7%	8.2%	On track
4.	Birth asphyxia case fatality rate	20%	15%	27%	Not on track
5.	Neonatal infection case fatality rate	12%	9%	12%	Stagnant
6.	Prematurity case fatality rate	19%	15%	12%	On track
7.	Proportion of sick and small newborns in neonatal unit for whom feeding/fluid volume were prescribed in accordance with the national protocol	81%	90%	83%	On track
8.	Proportion of children dying 24 hours after admission to pediatric units during 12 months	50%	37%	48%	On track

There was a notable low admission of low birth weight babies in Kangaroo Mother Care (KMC) due to contraindications and infections.

Contraindication to KMC: Some babies are born with an emergency condition such as birth asphyxia, convulsions, or hypoglycemia, which requires urgent assistance in the neonatology department. In these situations, hospital team members prefer to transport the baby themselves rather than involving the family member.

Newborn with neonatal infection: For some hospitals with small neonatology units (e.g., Gatunda and Ngarama), babies at risk of neonatal infections are treated in the postpartum room near their mothers, which reduces the number of babies referred to KMC. For babies coming from the theater due to postdelivery weakness and pain, hospital staff prefer to transport newborn themselves instead of involving family member.

There has been little progress in improving the birth asphyxia fatality rate, yet with the current rate above baseline, strategies for this indicator should be revised. Ingobyi will reinforce measures to prevent birth asphyxia at the community to hospital level. At the community level, Ingobyi will reinforce SBC messages to improve health-seeking behaviors for pregnant women, and a scale-up of eLearning on CBMNH is planned. At the health center level, LDHF and mentorship will continue, at the hospital level, professional association will continue LDHF and mentorship plus QI on birth asphyxia prevention; Will continue to engage district leaders through DHMT to address identified gaps

Despite the low admission rate, champions reported that babies are kept skin-to-skin as much as possible. To improve this indicator, Ingobyi will continue to reinforce education on the importance of KMC for parents, caretakers, and staff in maternity departments and to ensure that the hospital team understands the indication and contraindications of KMC. Effective February 2022, each hospital will conduct a root cause analysis and initiate QI projects on KMC, specifically targeting and involving hospital administration (the director general, director of nursing, and clinical director) in this QI project.

Despite these achievements, the following challenges are still hindering mentorship in neonatal health: staff issues (shortages and mentee absenteeism); equipment issues (frequent breakdowns, insufficient maintenance, and a high amount of non-working equipment); administrative issues (inadequate ownership of mentorship activities); and infrastructure issues (old/cold buildings that make it difficult to practice KMC and prevent hypothermia).

To ensure the quality of RPA mentorship and support advocacy surrounding filling the outstanding gaps that were not resolved through mentor intervention, senior pediatricians from the RPA conducted one-day supervision visits to the 26 Ingobyi-supported hospitals and two medicalized HCs, including those that did not benefit from the mentorship because they had two or more pediatricians. During their visits, RPA supervisors participated in data analysis, development, and follow-up of QI projects and advocated for filling gaps in lifesaving equipment, staff, and infrastructure. Eighty-four neonatal death audits were conducted by RPA mentors, and prematurity accounted for most deaths (n=41: 49%), followed by perinatal asphyxia (n=26: 31%). Unfortunately, more than 50% of cases were found avoidable. Therefore, emphasis will be put on neonatal protocol training and use, regular death audits and follow-up on the implementation of recommendations as strategies to prevent future deaths. Three neonatal near-misses were reported this quarter. First, the mentorship team diagnosed a neonate with Klebsiella species at Remera-Rukoma District Hospital; proper treatment and strict

isolation was immediately initiated to limit the outbreak. Second, a neonate from Byumba District Hospital was diagnosed with complications of disseminated intravascular coagulation due to post-severe sepsis and was referred to the *Centre Hospitalier Universitaire de Kigali*; after 48 hours, the neonate was reported as clinically stable. Lastly, a three-week-old neonate was admitted to at Kabaya District Hospital with features of neonatal pneumonia, put on continuous positive airway pressure (CPAP) plus antibiotics, and by end of the third day, had restarted breastfeeding with no respiratory distress.

District-based mentorship

Ingobyi Activity continued to build the capacity of health providers in 325 supported health centers through mentorship implemented by 176 district-based mentors. The goal was to build the capacity of mentees to improve ENC practices, including preparation for birth, IPC, skin-to-skin care for at least one hour after birth to prevent hypothermia, early breastfeeding, delayed cord clamping, and administration of vitamin K and tetracycline ointment to prevent diseases, as well as improving HBB skills. Up to 471 MNH mentees were mentored, and 300 of them (219 females and 81 males) were validated in at least one MNH competency.



Photo 11: District based mentor conducting group coaching

Integration of neonatal nurses into clinical mentorship

The current mentorship program has focused less on vital neonatal nursing practices, which are paramount for neonatal survival. Such practices include newborn nursing procedures, the organization of neonatal units, the use of equipment in neonatal units, IPC measures, implementation of nurturing care, and family-centered care, among others. To address these gaps, in the last quarter of FY21, Ingobyi Activity identified 27 specialized or experienced neonatal nurses who were oriented on neonatal nurse-driven clinical mentorship to complement neonatal clinical mentorship conducted by the RPA in 26 supported hospitals and two medicalized health centers. In this quarter, ten neonatal nurse mentors conducted three-day monthly mentorship visits to nine hospitals and one medicalized health center, reaching 31 mentees, of whom 25 were validated in at least one newborn competency.



Photo 12: Sample photos of neonatal nurse mentors conducting their routine activities with mentees at various duty stations

During the mentorship, neonatal nurse mentors managed to support their mentees with five near-misses, as detailed in Table 8.

Table 8: Example of neonatal near-miss cases averted by neonatal nurse mentorship activities

Hospitals/ Health Center	Description of the near-miss	Intervention/actions taken to avert case	Outcome of the near-miss
Byumba	Infant admitted with prematurity and extremely low birth weight (1.1 kg)	Parents and providers were counseled to enhance IPC measures and prevent hypothermia to improve outcomes.	Early family-centered care ensured intermittent KMC and IPC compliance, resulting in a reduced hospital stay; the baby was discharged at 1.75 kg.
Nyamata	Infant admitted with prematurity, extremely low birth weight (900 g), and severe hypothermia	The nurse on duty realized the incubator where the baby was kept did not have a skin probe; the nurse immediately consulted a neonatal mentor and was advised on what to do.	The nurse on duty placed the baby into a functional incubator, and body temperature was normalized.
Kiziguro	Infant admitted with prematurity and extremely low birth weight (1 kg), with features of severe respiratory distress syndrome	The baby was put on a CPAP machine, as per neonatal protocol. Importantly, nurses are comfortable using CPAP.	The baby was stabilized, and intermittent KMC was possible, at full feeds via NGT + breast feeding, and currently weighs 1.3 kg.
Bigogwe Health Center	A full-term baby born with an Apgar score of 3	The baby was resuscitated and received pre-referral medication—phenobarbitone, intravenous fluids, and antibiotics—before being referred to Ruhengeri Hospital for further management.	The baby is currently under care at Ruhengeri Hospital.

The neonatal nurse mentors made good progress on all performance indicators, as shown in Table 8. Indicators related to preventing health facility-acquired infections through provider handwashing and newborn equipment cleaning were achieved. Other indicators related to newborn feeding, hypothermia prevention, and newborn resuscitation are on track (Table 8).

Table 1: Progress of performance indicators for neonatal nurse mentorship

Mentorship performance indicator	Hospital	Baseline August 2021	September 2021	December 2021	Target February 2022	Comment
Proportion of neonatal nurses who perform handwashing correctly	Nyagatare	(2/10; 20%)	(4/10; 40%)	(8/10; 80%)	80%	Achieved
Proportion of neonatal nurses who appropriately clean equipment		(1/10; 10%)	(6/10; 60%)	(8/9; 89%)	80%	Achieved
Proportion of neonatal nurses who perform handwashing correctly	Kiziguro	(1/6; 17%)	(3/6; 50%)	(6/6; 100%)	80%	Achieved
Proportion of neonatal nurses who appropriately clean the neonatal unit	Kiziguro	(1/10; 17%)	(4/6; 67%)	(5/6; 83%)	80%	Achieved

Mentorship performance indicator	Hospital	Baseline August 2021	September 2021	December 2021	Target February 2022	Comment
Proportion of neonatal nurses who appropriately use equipment (syringe pump, CPAP machine, etc.)	Murunda	(0/7; 0%)	(5/7; 71%)	(6/7; 86%)	80%	Achieved
Proportion of neonatal nurses who appropriately prescribe nutrition and hydration		(1/7; 14%)	(5/7; 71%)	(5/7; 71%)	80%	In progress
Proportion of neonatal nurses who appropriately clean equipment		(3/7; 14%)	(4/7; 57%)	(4/7; 57%)	80%	In progress
Proportion of neonatal nurses who appropriately clean equipment	Ngarama	(4/8; 50%)	(6/7; 85%)	(7/8; 87%)	80%	Achieved
Proportion of neonatal nurses who successfully resuscitate a newborn	Bigogwe HC	(2/18; 11%)	(4/18; 22%)	(3/18; 17%)	25%	In progress
Proportion of neonatal nurses who appropriately use a syringe pump	Byumba	(4/12; 33%)	(8/12; 67%)	(8/12; 67%)	80%	In progress
Proportion of neonatal nurses who appropriately prescribe nutrition and hydration	Muhororo	(1/7; 14%)	(2/6; 33%)	(3/6; 50%)	80%	In progress
Proportion of neonatal nurses who appropriately use equipment (syringe pump, CPAP machine, etc.)		(1/7; 14%)	(2/6; 33%)	(3/6; 50%)	80%	In progress
Proportion of neonatal nurses who appropriately clean equipment	Kabutare	(1/4; 25%)	(2/4; 50%)	(2/3; 67%)	80%	In progress
Proportion of babies admitted with hypothermia		(1/4; 25%)	(2/4; 50%)	(2/3; 67%)	80%	In progress
Proportion of neonatal nurses who appropriately do handover as required		(1/4; 25%)	(2/4; 50%)	(2/3; 67%)	80%	In progress
Proportion of neonatal nurses who appropriately use a syringe pump	Kabaya	(3/7; 43%)	(4/7; 42%)	(5/7; 71%)	80%	In progress

Routine monitoring and supportive supervision of neonatal health services

Ingobyi Activity, together with senior pediatricians from the RPA and RBC, conducted routine supportive supervisions to support the implementation of newborn health services. These supervisions are aimed to support the quality of clinical mentorship and assess the availability of newborn drugs and medical equipment for ENC and sick newborn care. The frequency and timing of supportive supervision are usually determined by RRT triggers, data reviews, and death audits. During this quarter, 26 supported hospitals and 121 health centers benefited from at least one visit. Table 9 summarizes the key findings and actions from the supportive supervision.

Table 2: Findings and actions from newborn supportive supervision

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment
Hospital	Strengths	National neonatal protocol/flip charts are available in most newborn units (NBUs) for quick reference; calorie fortification practice has been implemented in some hospitals, improving newborn outcomes, thus hospital pharmacies are ensuring their regular supplies; 54 staff (medical officers, nurses, and midwives) working in NBUs at Kabgayi, Gisenyi, Muhororo, Ruhango, and Rwamagana hospitals were trained on the latest national neonatal protocol, as well as using/manipulating on-site equipment; intravenous fluid administration using syringe pumps and infusion pumps for preterm babies has improved with support from neonatal nurses; feeding practices have improved with the introduction of the maternal feeding chart and enhanced family-centered care for preterm babies fed using a Naso/orogastric tube.	Most NBU IPC measures have improved, and services are clean and organized; regular maternity and neonatology team meetings are conducted to discuss pressing issues affecting the quality of MNH services; Gisenyi Hospital rehabilitated the room to admit neonates born outside the hospital.	Resuscitation materials were available in both maternity and neonatology services.	Syringe pumps that had been stored are used being for planned purposes; a resuscitation area is available in the neonatology room; essential neonatal drugs are available in all hospitals.
	Gaps	There is a high number of birth asphyxia and hypothermia cases in western and central zone facilities.	NBUs are overcrowded, especially at Masaka, Remera-Rukoma, and Ruhengeri district hospitals; there is low compliance with IPC measures, including those limited by infrastructure.	Facilities in the eastern and southern zones have radiant warmers with no sensors; essential equipment and staff are insufficient for the management of newborns at Bigogwe health center.	Some nurses working in some NBUs, like at Masaka District Hospital, are reluctant to use manufactured equipment (CPAP machines, syringes, infusion pumps); there is no isolation system for septic-identified babies at Muhororo, Kabaya, Remera-Rukoma, Kibagabaga, and Shyira hospitals.
	Actions and recommendations	An emphasis on neonatal resuscitation during basic EmONC training and on-site neonatal trainings conducted for neonatal staff by Ingobyi, as well as quality improvement projects, have decreased the number of birth asphyxia cases; on-site neonatal training has	Reinforced the practice of family-centered care; and application of the rule of 20/80 nursing care.	Making available and using syringe pumps is advocated for, as well as the procurement of radiant warmer sensors.	Ingobyi advocated for one at least one high-volume facility per zone to be supported with lifesaving neonatal equipment.

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment
		boosted health workers' confidence in the manipulation and appropriate cleaning of neonatal equipment; continue mentorship by neonatal nurse mentors should be continued in all Ingobyi-supported hospitals.			
Health center	Strengths	The pre-referral management of newborns at risk of infections has improved; hypothermia prevention for newborns has improved by implementing skin-to-skin practices within one hour of delivery and referrals to Kangaroo Mother Care; neonatal referral forms are available in all visited health centers and are used when referring newborns; PNC 1 from most health centers has improved tremendously.	The practice of breastfeeding within one hour of delivery has improved.		Newborn medications, including vitamin K1 dexamethasone, and nifedipine for the management of preterm labor, are available; neonatal resuscitation kits are available at most health centers.
	Gaps	There are gaps in the pre-referral management of sick newborns and the use of referral forms.	There are still gaps in the prevention of hypothermia.	There are frequent stockouts of corticosteroids, and intravenous phenobarbitone in district pharmacies.	Infant warmers have nonfunctional sensors; insufficient sterilization compromises IPC practices.
	Actions taken	Ingobyi teams provided technical support to district-based mentors has continued, focusing mainly on HBB at every mentorship visit; emphasized pre-referral management of all cases; there is a plan formally train health center staff on basic EmONC, helping babies survive and HBB, essential newborn care, and the pre-referral treatment of newborns; the pediatric development clinics at selected health centers of Musanze and Rutsiro districts have been continuously supported.	The practice of skin-to-skin contact for one hour after birth has been reinforced; breastfeeding within one hour of birth was been encouraged.	Conducted RRT to Bigogwe health center to explore the repetitive issues and action/recommendation submitted to RBC/MCCH Division for further guidance	Ingobyi teams advocated for the procurement of lifesaving equipment and additional staff for Bigogwe health center; there has been continuous advocacy to the Rwanda Social Security Board to harmonize billing at health centers.

Newborn health social and behavior change interventions

Urunana radio soap opera episodes had key messages on the benefits of early breastfeeding within the first hour after birth, the importance of child registration, the benefits of immunizing newborns, the benefits of exclusive breastfeeding, and danger signs for newborns. Two radio sketches with messages on the benefits of hygiene for the newborn and the importance of avoiding harmful traditional practices toward newborns were produced and aired on nine community radio stations. Three radio mentions⁸ broadcast on KISS FM focused on danger signs for the newborn, the benefits of early care-seeking when the newborn is sick, and the importance of hygiene for the newborn.

Newborn health quality improvement projects

USAID Ingobyi Activity continues to support and promote QI approaches as a structured methodology to analyze and review data; identify gaps; prioritize, plan, and implement key interventions; and continue a focused monitoring of achievements as part of mentorship and supportive supervision. Up to 40 QI for newborn health projects were implemented this quarter: 17 were related to birth asphyxia, 12 to reducing deaths related to neonatal hypothermia, four to reducing neonatal infections, two to resuscitating newborns, one to improving skin-to-skin practices, two to feeding practices, one to reducing prematurity complications, and one to improving weight gain monitoring for admitted neonates. Around 92% of the projects were implemented at the hospital level. Up to 90% were initiated in this quarter and are still in progress; 5% of QI project targets were achieved by the set timeline, while another 5% did not reach the targets and were overdue as of the end of reporting period (see Annex E for details).

Key newborn health indicators

Breastfeeding

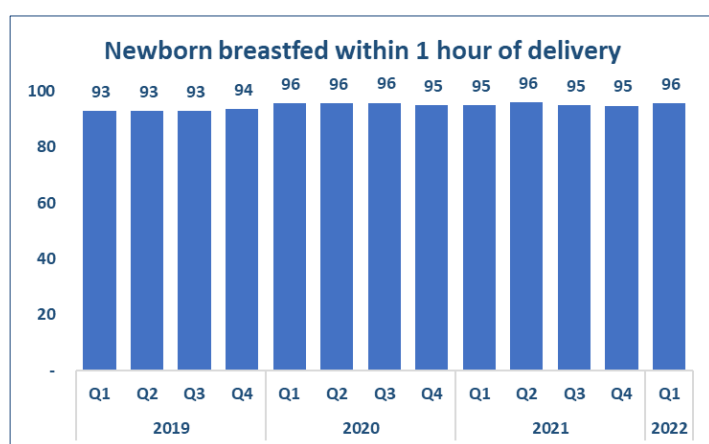


Figure 12: Proportion of newborns breastfed within 1 hour

USAID Ingobyi Activity continued to promote the immediate initiation of breastfeeding, within the first hour of delivery, as recommended by the infant and young child feeding guideline. Maternity providers were mentored on the timing of putting the newborn to the breast; on checking on newborn feeding; and on continued counseling of the mother about exclusive breastfeeding during the postnatal consultation. As a result, the proportion of live newborns breastfed within the

first hour of delivery continued to remain high (>95%) in this quarter (12).

⁸ A radio mention is a public announcement or advertisement made by a popular radio presenter to draw attention to an important message.

Neonatal resuscitation

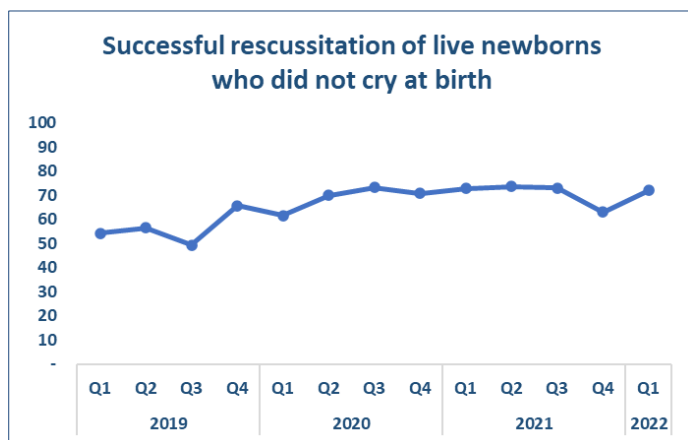


Figure 13: Proportion of successful resuscitation of live newborns who did not cry at birth

The number of newborns successfully resuscitated indicates the outcome of labor monitoring and newborn resuscitation. Ingobyi Activity continued to provide LDHF training on EmONC and ENC, which includes HBB, during mentorship and supportive supervision, conducted in collaboration with RAM members at district hospitals and district-based mentors in health centers. Mentors focused on HBB simulations using mannequins, explained how to interpret the partograph and Apgar

score, encouraged documentation in registers and files, supported clinical birth asphyxia audits, and addressed the causes of asphyxia by implementing QI projects. These activities have resulted in health providers' improved self-confidence regarding newborn resuscitation and improved neonatal outcomes. In addition, in FY21, USAID Ingobyi Activity procured lifesaving neonatal equipment, including Penguin suction devices, Ambu bags, oxygen concentrators, and CPAP machines, among others, for the neediest facilities. This has resulted in an 18% increase (from 54% to 72%) in successful live newborn resuscitations since baseline (Figure 13).

Postnatal consultation within 24 hours of birth

The first PNC visit for newborns, within 24 hours of birth, is critical for newborn survival, as it helps identify any danger signs before mothers and babies are discharged. Ingobyi Activity provided LDHF training to health providers on ENC, including PNC, to ensure they have sufficient capacity to care for newborns. During mentorship and supportive supervision, mentors and Ingobyi staff encouraged providers to conduct quality PNC, which includes a full clinical

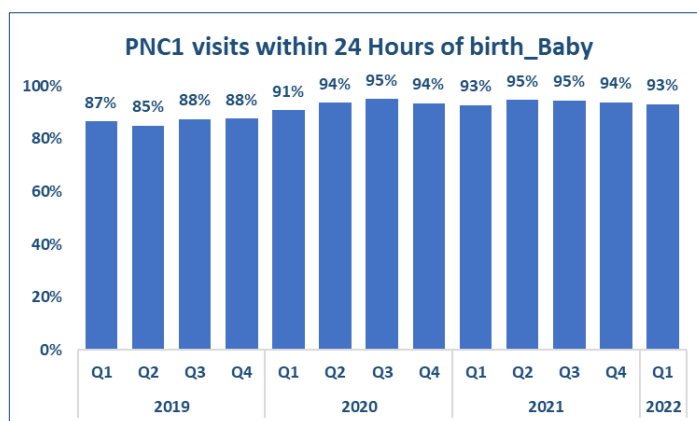


Figure 14: PNC1 for babies

examination of the newborn, comprehensive counseling on danger signs, and information on the following PNC visit done in the community. They also encouraged the proper documentation of findings in PNC files and registers. As a result, there is improvement in first PNC visit coverage from the baseline, which has continued to remain high, as shown Figure 14.

IV. Child Health

The provision of quality child health services is a key priority for the GoR. The recent Rwanda Demographic Health Survey showed a decline in under-five mortality, from 50 deaths per 1,000 live births in 2014–2015 to 45 deaths per 1,000 live births in FY2019/2020. This decrease has been attributed to minimal changes in newborn and infant mortality, which account for 73% of all under-five deaths and which occur before a child's first birthday; moreover, 42% of deaths occur in the first month of life. Ingobyi continued to apply various approaches, including training and mentorship for health providers, supportive supervision, and QI projects, among others, to improve the access to and quality of child health services in the 20 supported districts.

Supporting the national level to plan and manage child health services

During quarter 1 of FY22, USAID Ingobyi Activity continued to work with the MoH and other partners to review and adapt national policies and clinical protocols based on global and local evidence in child health to improve the management of child health services.

Participation in the child health TWG

USAID Ingobyi supported the MoH to plan and host a virtual child health TWG meeting in October 2021 attended by participants from the RBC, WHO, UNICEF, and MCH development partners. In addition to reviewing key child health indicators, partners presented progress from child health interventions they are implementing. Ingobyi presented a concept note for the MCCH Division-commissioned IMCI survey. This is expected to follow the first survey conducted by WHO in 2015. A team from Ingobyi, WHO, UNICEF, and Partners in Health were identified to lead the preparation and conducting of the survey and cost share the budget. Ingobyi also presented updates on the implementation of the PDC to follow-up with high-risk infants in Musanze and Rutsiro districts, with technical support from Partners in Health. The recommendation was that PDC can be implemented nationwide, and the proposal will be shared with the MCCH Division director. Partners in Health was assigned to lead the development of national PDC guideline to inform nationwide scalability.

Support integration of care for child development into IMCI

CCD is an evidence-based intervention developed to help caregivers promote the healthy growth and holistic development of children and to help prepare persons who work with families on how to counsel caregivers on responsive care and child psychosocial stimulation. Following the child health TWG recommendations, Ingobyi Activity in collaboration with the RBC/MCCH Division supported a workshop aimed to integrate CCD components into existing IMCI tools. During this workshop, participants updated the IMCI Rwanda protocol to integrate CCD and conducted practical sessions to test tools on children of different age groups at Mayange Health Center. Participants reported that integration of CCD into IMCI services was feasible, but that it took too long (*about 30–40 minutes*) to do a complete assessment for one child. Further recommendations included filling the need for nutritionists to be trained on IMCI, involving national early childhood agencies/partners in CCD implementation, orientating district-based mentors on CCD, and integrating CCD into the Integrated Management of Childhood Illness Computerized Adaptation and Training Tool.

Participation in Maternal and Child Health Week

USAID Ingobyi supported and participated in Maternal and Child Health Week in collaboration with other government agencies. MCH Week is organized twice a year to deliver an integrated package of cost-effective preventative services to improve MCH. The key interventions during the campaign were Vitamin A supplementation to children aged six to 59 months, deworming for children aged one to 15 and for adults, malnutrition screening for children aged six to 59 months, and the provision of FP methods. Besides those interventions, there was sensitization on malaria prevention, FP, and the promotion of hygiene and sanitation. During MCH Week events, Ingobyi participated in the preparation and implementation of, and provided full financial support to, this event in four districts (Gasabo, Kamonyi, Kicukiro, and Ngoma). Ingobyi staff were involved in supervising MCH Week activities and providing some services. In addition, Ingobyi supported the national launch of this campaign in Gasabo District. During this campaign in the four Ingobyi-supported districts, 204,307 children aged six to 59 months were screened for malnutrition using the mid-upper arm circumference tool and 229,160 received vitamin A; 832,088 children aged one to 15 years were dewormed; and 2,146 women received FP methods.

Improving provider skills

ETAT+ Training



Photo 13: ETAT+ instructor evaluates a trainee on newborn resuscitation

In collaboration with the MoH and RPA, Ingobyi Activity supported a training on the latest ETAT+ protocol. ETAT+ is a basic pediatric protocol that contains guidelines on the classification of illness severity, criteria for triage and admission, and inpatient management of the major causes of childhood mortality, such as pneumonia, diarrhea, malaria, severe malnutrition, meningitis, and HIV. This quarter, two ETAT+ trainings each lasting five days were conducted for providers from 13 hospitals from the eastern and central zones. The trainings focused on the following topics: clinical definitions; management of the airway; breathing and circulation in a collapsed infant/child; newborn resuscitation; management of hypoglycemia; management of convulsions; interosseous access; neonatal sepsis management; management of jaundice; management of premature and low birth weight babies, including their feeding; management of altered consciousness level and severe malaria; management of respiratory distress, diarrhea/dehydration and severe malnutrition; and practical sessions related to covered courses. A total of 52 health workers attended the training. The average pre-test score for the two trainings was 24%, and the average post-test score was 74%. Next quarter, two similar ETAT+ trainings will be conducted for health providers from hospitals located within the western and eastern zones. The trainings will improve health providers' knowledge and skills in managing pediatric emergencies, which should contribute to reducing child mortality within 24 hours of admission.

District-based mentorship in IMCI

Ingobyi Activity supported IMCI clinical mentorship in 325 health centers from all 20 supported districts through skilled district-based mentors. The main objective of the district-based mentorship is to support mentees to improve the quality of IMCI services, focusing on the management of sick

newborns, infants, and children. To achieve this objective, mentors supported the orientation of health providers on IMCI tools; the completion of IMCI registers; and the use of IMCI booklets on dehydration, pneumonia, and fever/malaria management, as well as nutrition assessment. They also supported facilities to improve the organization of IMCI services, ensure the availability of IMCI materials and drugs, and encourage data for decision-making. A total of 128 IMCI district-based mentors conducted two-day monthly mentorship visits and reached 593 mentees, including 315 validated in at least one child health competency.

Most district-based mentor achievements relate to increased uptake of IMCI services, the systematic checkup of nutritional status and danger signs, and the correct management and use of antibiotics/antimalarials/oral rehydration salts. More effort should be geared toward implementing IPC measures, equipping oral rehydration therapy corners, and educating parents on when to return to the health center for their children to be reviewed. Persistent challenges include: incorrect or incomplete data recording into the HMIS, health workers overwhelmed with COVID-19 vaccinations, lack of mentor refresher trainings, amoxicillin stockout, poor documentation in IMCI registers, and long distances for mentors to travel.

Clinical mentorship by Rwanda Pediatric Association

USAID Ingobyi Activity collaborated with the RPA to conduct clinical mentorship for general practitioners at 26 supported hospitals and two upgraded health centers. The main objective of the mentorship visits is to build the capacity of health providers through bed-side teaching and coaching. The topics covered during mentorship included: treatment of convulsions, severe malaria, pneumonia, asthma, and meningitis; triage of a sick child; child basic life support; pediatric emergency drug dosages; and initial intravenous fluids; among others. The topics were identified based on knowledge and skill gaps observed during coaching of mentees. The mentors conducted ward rounds with their mentees to manage complicated cases, reviewed data for QI, supported routine child death audits, facilitated learning and adaptation from death audit results, and worked with hospital management to improve the work environment. Thirteen general practitioners benefited from the mentorship, and nine were validated in at least one child health competency.

Routine supportive supervision in child health

In quarter 1 of FY22, Ingobyi conducted supportive supervision in child health with the objective of strengthening the capacity of health providers to offer quality services and improve performance. During supportive supervision, Ingobyi worked with mentors to ensure the delivery of high-quality clinical mentorship, apply acquired knowledge and skills, and identify and address gaps. The supportive supervision teams provided feedback on performance, gave technical updates or guidelines, conducted on-site orientation of mentors' on-the-job training, worked with health workers to identify opportunities for improvement through observation and data review, and jointly proposed action plans for improvement. Out of 297 child health supportive supervision visits conducted, 28 were conducted by the RPA at 26 hospitals and two medicalized health centers, 131 were conducted by Ingobyi staff at health centers, and 138 were conducted by identified champions from validated mentees at health posts. Findings, gaps, and actions identified during supportive supervision visits are summarized in Table 10.

Table 3: Findings and key actions from child health supportive supervision

Facility level	Assessed items	Availability of services	Service organization	Commodities and supply	Infrastructure and equipment	Data use for decision-making
Hospital	Strengths	ETAT+ training was conducted for four staff per hospital from all hospitals within the central and south Ingobyi catchment area; pediatric ward staff were provided with soft/hard copies of the ETAT+ protocols, as well as ETAT+ flipbooks for use; the triage system is functional.	Most hospitals have more than one pediatrician, and general practitioners are assigned to provide care to very sick children during all shifts; hospitals use the Situation-Background-Assessment-Recommendation approach for safe handover between shifts; the emergency trolley checklist is regularly used .	Most hospitals have pediatric emergency drugs.	Most lifesaving equipment is available.	
	Gaps	Community malpractices and seeking care from traditional healers has increased, predominately in Rubavu District; some pediatric cases are not managed according to ETAT+ protocols.	There is frequent rotation of general practitioners assigned to pediatrics.	There are no intra-osseous needles available for use in cases of pediatric emergency.	There is a lack of equipment like resuscitation tables, CPAP machines, and pulse oximeters, and equipment is insufficiently maintained; although most hospitals have radiant warmers, many are nonfunctional due to the lack of sensors, especially at south and eastern zone hospitals.	There are data quality issues.
	Actions taken	Two ETAT+ trainings were completed in all hospitals in the south and central zones, and the remaining two will be held next quarter; on-site trainings were supported on topics associated with the prevalent causes	Ingobyi child health specialists were supported with a reorganization of services and the triage system.	Emergency trolley/drug checkup checklists were put in place.	Ingobyi teams advocated with hospital leadership for the provision of a functional suction machine; and provincial and referral hospitals' were advised to plan	A data review was conducted and ways of improving were discussed.

		of childhood morbidities and mortalities; RPA mentors to enhance mentorship on pediatric nursing care; CHWs have continued to be mobilized to disseminate SBC messages aimed at reducing harmful child practices in Rubavu District.			for their own HDUs as most child deaths were reported to be attributed to lack of beds at CHUs.	
Health center	Strengths	All visited health centers provide IMCI services; health workers have improved their skills in assessing danger signs and referring complicated cases.	Each health center has an IMCI health provider to deliver IMCI services.	Most IMCI materials, including registers, booklets, and drugs, as well as oral rehydration salts are available; the management of IMCI medicines and use of protocols have improved in different health centers.	IMCI spaces are available in most health centers.	Most district-based mentors explained how IMCI data are linked with the protocol; district-based mentors continuously monitor the quality of data with data managers and in-charges of health centers.
	Gaps	Health issues are inadequately classified, especially fever, ear problems, HIV, and tuberculosis, as well as the treatment of sick children under five; some health providers still do not provide proper counseling to mothers; some health centers still admit severe cases instead referring them.	There is a lack of refresher IMCI training to mentors; there are gaps in IPC practices; IMCI registers are incomplete.	There is irrational use of antibiotics; expiration dates for drugs, especially malaria drugs, are not regularly verified; there is a lack of regular verification of stockout of some essential drugs, such as amoxicillin and nystatin.	Oral rehydration therapy corners are not equipped as required.	The District Health Information Software 2 (DHIS2) tool is not installed for mentors to use directly on their mobile phones; identified gaps include discrepancies in HMIS data.

	Actions taken	Ingobyi supported health workers to understand the content of the IMCI register and booklet during mentorship and supervision visits; Ingobyi will support ten on-site hospital IMCI trainings next quarter.	Ingobyi supported the final integration of CCD into the IMCI booklet.	Ingobyi supported the printing of 2,300 IMCI registers to be distributed next quarter; Ingobyi advocated for the consistent supply of essential IMCI drugs during coordination and DHMT meetings.	Dustbins, hand sanitizers, and handwashing stations were made available.	Ingobyi advised data managers to conduct DQA regularly; Ingobyi will organize a one-day orientation workshop for mentors on QI.
Health post	Gaps	The majority of health posts do not use the IMCI protocol; the majority of visited facilities did not have a trained IMCI provider.	IMCI registers are not available in most health posts; IPC measures generally need improvement.	Antibiotic use is inappropriate.	There is a lack of essential equipment (height rods, timers, scales); no room for IMCI services was observed.	
	Actions taken	Next quarter, Ingobyi plans to conduct ten on-site hospital IMCI trainings to IMCI providers working in health centers; Ingobyi to advocate for hospital districts to provide their supportive supervision.	Every health post within the Ingobyi catchment area will be provided with two IMCI registers at the beginning of next quarter.	Ingobyi will advocate that the Rwanda Social Security Board reimburses essential medicines within the service care package at health health post level.	Ingobyi will advocate for district pharmacies to offer health posts a continuous supply of essential medicines.	Health post IMCI data will be integrated into the HMIS.

Implementation of the Pediatric Development Clinic (PDC)



Photo 14: Infants brought back to Murunda PDC during a group counseling session prior medical consultation provided by a PDC mentor

Advancements in technology and resuscitation capacity increase the survival of preterm, low birth weight, and other high-risk infants in the early neonatal period. However, when discharged from the neonatal units, they have little support in the community for their health, nutrition, and development, compromising their chances of survival in the first month of life. To address this concern, Ingobyi Activity initiated a PDC in selected health facilities of Musanze and Rutsiro districts. During this reporting quarter, the PDC continued to be implemented at Ruhengeri and Murunda hospitals, as well select health centers within their catchment area. So far at both PDCs, 103 infants including infants born prematurely and with low birth weight (82), and perinatal asphyxia (21) have been enrolled in follow-up care. At the children's appointments, mothers/caregivers benefit from services such as group and individualized counseling, and children receive medical consultation, play, and stimulation. The hospital PDC admitted and treated two infants diagnosed with severe malnutrition; an additional 27 cases with moderate malnutrition were treated at health center PDCs, and their mothers were counseled on breastfeeding and breast milk fortification. As of the end of the reporting period, all of the infants had fully recovered.

Mentorship and supportive supervision of PDC

USAID Ingobyi Activity initiated a one-day mentorship visit by PDC mentors to health centers to strengthen the capacity of nurses and social workers in PDC. To achieve this goal, Ingobyi first indentified 16 PDC nurses who had been oriented on mentorship in October 2021. During this quarter, mentorship was conducted in health centers to support 46 PDC providers on the use of PDC tools, refreshing them on PDC protocols to improve the quality of PDC services. To reinforce the mentorship and provide additional support to facilities, Ingobyi conducted seven supportive supervision visits at the two hospitals and five health centers championed for hospital PDC ownership and oriented 13 staff working in neonatal and pediatric units on PDC. As a result, six lost-to-follow-up cases returned; moreover, three vulnerable families received home visits and were linked to local authorities and nutrition programs for social and nutritional support, respectively.

On-site PDC training

During the PDC implementation process, Ingobyi observed lower enrollment PDC rates in Ruhengeri Hospital than in Murunda Hospital. To address this issue, Ingobyi Activity conducted on-site PDC training to improve the ownership and sustainability of PDC services at both hospitals. Thirteen providers (four medical officers and nine nurses) working in pediatrics and neonatal units at Ruhengeri Hospital attended the three-day on-site training. Topics covered included: introduction to early childhood development and PDC; general nutrition care and managing malnutrition in infants younger than six months and between 6-9 months old children; introduction to specific conditions seen in PDCs (including preterm, low birth weight, hypoxic-ischemic encephalopathy, trisomy 21, cleft lip/cleft palate, hydrocephalus, global and other developmental delays); introduction to play and communication; as well as observation practice in the hospitals' PDC service. Hospital providers made immediate post-training efforts to identify lost-to-follow-up cases, and PDC enrollment increased from 14% to 70%.

Challenges in PDC implementation

The PDC mentorship activities were interrupted due to mentors shifting to COVID-19 vaccination activities. Ingobyi Activity will continue to collaborate with hospital administrators to make appropriate rotations that would include PDC mentorship processes.

Additionally, none of the existing PDC mentors is trained as an international Guide for Monitoring of Child Development (GMCD) master trainer to facilitate that training to other mentors. Furthermore, the lack of a PDC electronic medical record system limits the documentation of PDC services, thus making it difficult to obtain all required information to monitor PDC progress, achievements, and challenges. To address these two issues, USAID Ingobyi Activity conducted technical meetings with Partners in Health managers to facilitate the process of master training in GMCD and ensuring the availability of electronic medical records. Next quarter, Partners in Health will facilitate a training of trainers on GMCD and make a PDC electronic medical record system available for installation at Ruhengeri and Murunda hospitals after obtaining MoH approval.

Child health social and behavior changes interventions

In this quarter, USAID Ingobyi produced and aired two radio sketches with key messages on the need to avoid harmful traditional practices toward children, the results of which are children living with long term consequences of uvula, epiglottis, and primary dentition removal. One radio sketch focusing on how to monitor child growth through measurement of the mid-upper arm circumference and the importance of a balanced diet was broadcast.

Child health quality improvement projects

As part of mentorship and supportive supervision, USAID Ingobyi Activity supported facilities to analyze and review child health data, analyze gaps, prioritize key interventions, and develop and implement actions using a QI approach. Up to 48 child health QI projects were implemented in this quarter, most of which concerned improving the use of antibiotics in IMCI services. Up to 79.2% of QI project targets were achieved by the set timeline, 10.4% were still in progress at the end the reporting period, while 10.4% did not reach the targets and were overdue as of the end of reporting period (see Annex E for details).

Trends in child health

Under-five consultations in IMCI services

USAID Ingobyi Activity’s interventions, such as mentorship, supportive supervision, and QI projects, seek to ensure that under-five children are consulted in a specific space dedicated to IMCI services, instead of in the general OPD. This aim is to ensure that children are comprehensively assessed for all major childhood illnesses using the IMCI algorithms and are treated by skilled health providers. As a result of these efforts, the

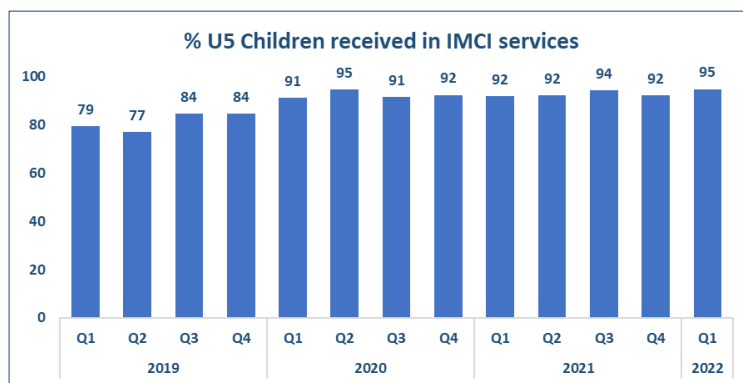


Figure 15: Percent of children under five receiving IMCI services

percentage of children treated in IMCI services increased by 15% since the baseline (Figure 15), and Ingobyi’s support continued to keep it at more than 90% since quarter 1 of FY20 (Figure 8). USAID Ingobyi Activity will continue to support facilities to ensure that the coverage and quality of IMCI services remains high.

Diarrhea

Dehydration caused by diarrhea is a major cause of illness and death among young children, even though the condition can be easily treated with oral rehydration therapy. USAID Ingobyi Activity supports the implementation of IMCI and ICCM strategies to reach vulnerable children in facilities and at the community level, respectively, to increase their chances of receiving appropriate care when presenting with diarrhea. Figure 16 shows

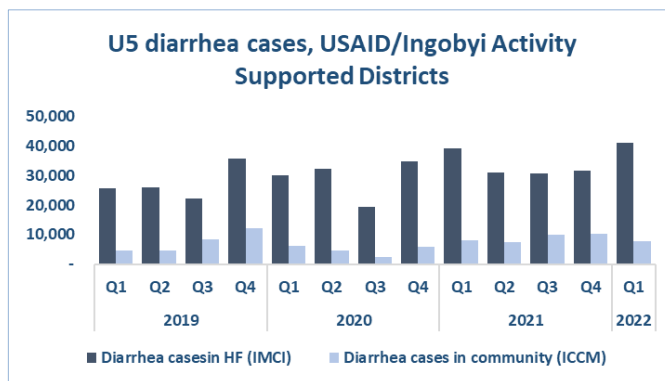


Figure 16: Number of under-five children with diarrhea in Ingobyi-supported districts

an increase in diarrhea cases, where a large proportion is treated at the facility level, despite the country’s commitment to improving care at the community level by building the capacity of CHWs to offer treatment commodities, increasing early care-seeking, and reducing the burden on higher levels of care. The involvement of CHWs in COVID-19 activities and stockout of some commodities, such as zinc and oral rehydration salts, can explain the low contribution of CHWs in managing cases in the community. Ingobyi will learn from these results to increase CHW mentorship and to reshape the SBC interventions aimed at increasing the demand of child health services at the community level and increasing messages on hygiene to prevent diarrhea.

Pneumonia

Acute respiratory infection is among the leading causes of childhood morbidity and mortality in Rwanda and throughout the world, and pneumonia is its most serious outcome in young children. In a death audit analysis conducted by USAID Ingobyi Activity for all under-five deaths that had occurred in 2020 (excluding perinatal deaths), pneumonia was the most common cause of death, at 18%. Ingobyi Activity supports the GoR to implement IMCI and ICCM as initiatives it has prioritized to address common childhood illnesses.

Pneumonia prevention and management interventions conducted by Ingobyi Activity during the current reporting period included: messaging through the *Urunana* radio soap opera to improve recognition of danger signs and early health-seeking behavior; capacity-building of health providers through IMCI mentorship to identify, classify, and treat pneumonia cases or refer severe cases to hospitals; routine supportive supervision; and the provision of IMCI booklets and

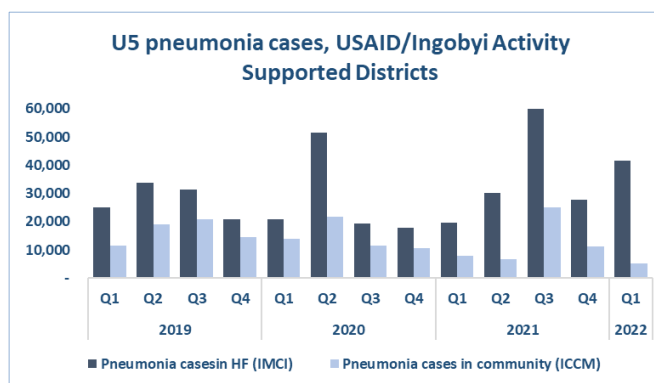


Figure 3: Number of under-five children pneumonia in Ingobyi-supported districts

registers. Most of the pneumonia cases are treated at the facility level, despite the GoR's commitment to provide early care at the community level (Figure 17). The involvement of CHWs in COVID-19 activities and stockout of some commodities such as amoxicillin can explain the low contribution of CHWs in the management of cases in community. Ingobyi Activity-initiated community mentorship interventions are expected to increase the confidence of CHWs to identify and manage pneumonia cases.

V. Malaria Prevention and Treatment

In this quarter, USAID Ingobyi Activity in collaboration with the RBC/MOPDD continued to support the implementation of malaria control interventions and the strengthening of quality health services to reduce the malaria burden in the 20 supported districts. Key malaria accomplishments are summarized below.

Supporting the RBC/MOPDD to develop health messages promoting malaria prevention and prompt care-seeking

In this quarter, Ingobyi Activity supported the RBC/MOPDD to produce short health messages promoting malaria prevention and prompt care-seeking, including consistent use of LLINs, particularly for pregnant women and children. Ingobyi Activity hired a videographer consultant who worked with the Ingobyi technical team and stakeholders throughout the production cycle (i.e., in pre-production, production, and post-production) to create easy-to-understand, high-quality audiovisual materials. The messages focused on prompt care-seeking; the importance of consistent LLIN use; how to hang, use, care for, and repair the nets; and existing vector control measures, as highlighted in the National Malaria Strategic Plan (July 2020 to June 2024). As a result, the following episodes were produced: vector control measures (episode 1); malaria prevention (episode 2); and the importance of consistently using and how to care for the LLINs (episode 3); and prompt malaria care-seeking (episode 4), as well as a special video on the most vulnerable people (pregnant women and children under five).

To promote health equity for deaf patients, sign language for these specific messages were also produced. Ingobyi Activity will distribute these messages in its supported districts. Short video messages will be uploaded on flash drives to be shared with all supported health centers. Videos will be played on TV screens stationed near the patient waiting areas. Additionally, the RBC/MOPDD plans to upload these messages to the Rwanda Health YouTube channel, so they can be accessed beyond the Ingobyi-supported districts.

Care provider capacity-building

Timely diagnosis, treatment, and prevention are key to reducing malaria burden. In quarter one of FY22, USAID Ingobyi Activity continued to strengthen hospital and health center providers' capacity to manage malaria, including severe malaria, through trainings, supportive supervision, and mentorship. Capacity-building for providers emphasized the prompt and correct treatment of malaria cases at all levels of care through ICCM and home-based and health facilities management of malaria cases according to national treatment guidelines.

Following the training of care providers from 12 hospitals on national malaria treatment guidelines in FY21, USAID Ingobyi Activity trained providers at the 14 remaining hospitals and their respective health center staff. As a result, a total of 669 care providers from 14 hospitals and 185 health centers

were trained on national integrated malaria treatment guidelines in quarter 1 of FY22. Participants included two medical staff, four nurses, and a director of nursing from each hospital, together with the head of the health center, malaria focal person, and CEHOs from health centers.

To increase the number of trained providers and to address recurrent staff turnover issues, job training for additional care providers was also initiated. The on-the-job training not only increased the number of providers trained at health centers but also encouraged knowledge-sharing within health facilities. A total of 299 care providers, including 43 medical staff, 209 nurses and midwives, 47 lab technicians and other supporting staff from hospitals and health centers, were supported through on-the-job training by Ingobyi staff in collaboration with district trained trainers and trained staff from health facilities. USAID Ingobyi Activity will continue to support malaria supportive supervision and clinical mentorship around malaria case management by district-based malaria supervisors together with malaria specialists to strengthen provider capacity-building through knowledge sharing sessions in supported health facilities.

Updating National Malaria Diagnosis Quality Assurance and Quality Control guidelines

Rwanda's vision (in its National Strategic Plan 2020–2024) is to be a malaria-free country to contribute to socioeconomic development. To support this vision, USAID Ingobyi Activity supports implementation of evidence-based interventions like strengthening and implementing appropriate malaria control interventions and delivering quality health services to reduce malaria burden. However, findings from supportive supervision demonstrated a gap in malaria diagnosis, including the limited capacity of providers to quantify and specify malaria parasites. Also, some facilities lacked malaria tests and updated quality control and quality assurance guidelines to support providers in decision-making. To facilitate quality malaria diagnosis and management, USAID Ingobyi Activity in collaboration with the RBC/MOPDD conducted a two-day workshop to update malaria tests and the Quality Assurance and Quality Control manual. The updated manual outlines Rwanda's malaria diagnosis and quality assurance activities for all diagnostic methods, including rapid diagnostic tests and microscopy, based on the WHO Malaria Microscopy Quality Assurance Manual (2016). The primary objective of the manual is to define SOPs for malaria diagnosis, setting standards for malaria commodity procurement, setting standards for PT, internal quality control and other quality assurance activities, defining standards for malaria trainings and on-site visits, and informing stakeholders on the malaria quality assurance activities being implemented. USAID Ingobyi Activity will continue to support malaria case management and ensure quality malaria diagnostic tests are carried out in alignment with national integrated malaria treatment guidelines.

Malaria prevention and demand creation

In Rwanda, malaria transmission and increase occurs every year, with peaks in May–June and November–January. Following the reduction of COVID-19 incidence in Rwanda, USAID Ingobyi Activity targeted the November–January malaria increase episode to increase health education sessions at health facilities and in communities and sensitize the population on malaria prevention strategies, malaria danger signs, and early care-seeking behavior when symptoms like fever are felt. To ensure malaria prevention messages are reaching communities in need, malaria hot spot sectors and villages were identified and targeted for SBC messaging at community outreach events and for engagement in malaria prevention activities. Malaria messages were delivered in 19 high malaria burden sectors of Kamonyi, Bugesera, Nyaruguru, and Nyamagabe districts, reaching a population of 5,155.

With the support of district-based malaria supervisors and the health center-based malaria focal person, malaria SBC messages were initiated at the hospital level. Sixty-one malaria health education sessions were delivered in hospitals, reaching 6,009 participants, while 554 sessions were delivered at the health center level, reaching a population of 18,092 clients.

Additionally, malaria messages were delivered through the *Urunana* soap opera focusing on the signs and symptoms of malaria; integrated preventive measures; consequences of sharing drugs; benefits of adherence to medical prescription; importance of sleeping under mosquito nets, especially for pregnant women and children under five; the benefits of early care-seeking for anyone suspecting malaria; and the benefits of health insurance. Two radio magazine programs were also produced and aired: the first highlighted key malaria prevention measures including sleeping under a mosquito net, removing bushes around the house, and removing stagnant water, etc. and the second encouraged early care-seeking whenever someone feels unwell to avoid severe malaria, which can lead to death.

USAID Ingobyi Activity broadcast two radio sketches on nine community radio stations offering malaria prevention tips for pregnant women and information on what to do to avoid severe malaria and its consequences. One broadcast radio spot focused on the benefits of sleeping under a mosquito net, especially for pregnant women and children under five.

Malaria prevention in pregnant women and children under five

As recommended by WHO, Rwanda seeks to achieve universal coverage of LLINs through mass and routine distribution to the country's most vulnerable groups (children under five years and pregnant women). To support this goal, USAID Ingobyi Activity promoted LLIN uptake and early malaria care-seeking behavior among pregnant women and children under five during ANC and immunization visits. Ingobyi Activity continued to support malaria prevention activities targeting vulnerable groups through health education sessions and supportive supervision activities to ensure accessibility and proper use of LLINs. Findings from supportive supervisions revealed an issue of stockouts of LLINs for pregnant women and children under five at health centers, though a national-level refill was planned for the next year. To overcome the issue, the RBC/MOPDD and Ingobyi Activity conducted a need assessment in all 325 supported health centers. At most health centers, there were discrepancies between the HMIS stock data and the physical stock of available LLINs, which created difficulties in planning for LLIN redistribution. As such, USAID Ingobyi Activity supported the RBC/MOPDD in quantifying the actual number of available LLINs at all supported facilities, identifying health facilities in need, and planning and supporting the inter-district redistribution of LLINs from health centers with large stocks to those without, to cover at least six months of stock. A total of 24,550 LLINs were redistributed between districts, and 49 supported health centers that had reported a LLIN stockout or risk of a stockout received their refills through an external redistribution process.

To overcome the issue of discrepancies between LLIN actual stock and HMIS stock data, Ingobyi Activity supported health centers to make LLIN stock adjustments in the HMIS and requested HMIS correction where needed. This effort was made to ensure that data about actual LLIN stock matched HMIS data, in preparation for further HMIS data use in the upcoming LLIN distribution to health facilities.

USAID Ingobyi Activity will continue to collaborate with the MOPDD to ensure that all supported HCs have LLINs for their ANC and immunization program, that they are distributed to all eligible mothers and children, and that LLINs are correctly reported in the HMIS.

Strengthening the quality of malaria service delivery

Quality improvement of malaria services

In collaboration with the MOPDD, Ingobyi strengthened malaria control initiatives by fostering a culture of malaria data-driven decision-making from the district level to the community level. This effort was made through a joint workshops that brought together Ingobyi Activity, MOPDD, and district officials to discuss data, with the aim of improving malaria delivery services and surveillance.

The two-day district-level workshops focused on the status of malaria prevention, management, and surveillance interventions and the creation of district improvement plans. To ensure district leadership involvement in improving malaria services, Ingobyi supported the MOPDD and district officials to understand the status of malaria service delivery compared to the national target, identify gaps in their respective districts, and plan strategies to overcome gaps based on existing malaria control and prevention guidelines. In this reporting quarter, 15 of 20 districts developed improvement plans for the next six months. A total of 74 participants from the districts participated in these workshops, including nine health unit directors, 12 hospital directors general, 18 malaria supervisors, 17 community supervisors, and 18 data managers. The workshops provided opportunity for peer learning, as nonperforming districts learned from performing ones.

QI projects initiated

- Eleven projects on increasing timely care-seeking through strengthening of HBM and ICCM services
- Ten QI projects on increasing the number of targeted malaria data quality audits at the community and health facility level
- Seven QI projects on increasing LLIN distribution via ANC and immunization programs
- Five QI projects on reducing severe malaria cases
- Two QI projects on malaria aiming at reducing community malaria drug and commodities stockouts and reducing malaria incidence in the identified malaria hotspot sectors
- One QI project on enhancing the quantification and specification of plasmodium parasites and increasing the number of care providers trained on malaria guidelines

To ensure malaria care delivery improvement plans are implemented, in quarter 2 of FY22, USAID Ingobyi Activity will conduct targeted integrated QI and peer learning supportive supervisions in high-burden sectors and will support the implementation of planned interventions at the district, health center, and community level. USAID Ingobyi Activity will also support five remaining districts to start the malaria services improvement process in the subsequent quarter. These workshops will be conducted every six months, and districts will share their achievements.

Health facility supportive supervisions

In quarter 1 of FY22, Ingobyi Activity continued to work with the RBC/MOPDD to support health providers in delivering quality malaria services through supportive supervisions by Ingobyi staff, MOPDD supervisors, and district-based malaria supervisors using an integrated supportive supervision tool. This activity focused on malaria screening, diagnosis, management, and treatment; health

education; malaria prevention in pregnancy; and malaria drug and commodity supply chain management at the health facility and community levels. During each visit, Ingobyi provided on-the-job coaching to address identified gaps and reinforced data review and use for program improvement. Providers reached through supportive supervision included medical doctors, nurses, midwives, store managers, data managers, CEHOs, and lab technicians. At the hospital level, malaria supportive supervisions and mentorship were conducted jointly by malaria specialists and hospital-based malaria supervisors who supported staff from OPDs and internal medicine, emergency, pediatric, maternity, and pharmacy departments to ensure proper malaria management interventions. The support focused on managing severe malaria cases, treating malaria in pregnancy, adhering to malaria guidelines, and using data for decision-making.

At the health center level, malaria supportive supervisions and mentorship focused on malaria prevention, case management, SBC, monitoring and evaluation (M&E), and surveillance, among other topics. Departments supported included OPD, laboratory, pharmacy, and M&E. During this quarter, 2,235 staff were supported through supportive supervision visits by district-based supervisors and specialists, including 1,378 nurses and midwives, 343 laboratory technicians, 249 data managers, and 265 CEHOs at health centers. At the hospital level, 668 clinicians, including 237 medical staff, 398 nurses and midwives, and 33 laboratory technicians were reached and supported on malaria care. Among reached clinicians, 1,316 (65%) were supported on malaria case management, with a focus on the correct management of simple cases, appropriate pre-transfer management of severe cases, and the correct management of severe cases in a hospital setting. As a result of previous supportive supervision recommendations, in this quarter, 68 health posts received regular support from health centers to ensure the proper management of malaria cases, drugs, and commodities. Table 11 highlights supportive supervision key achievements, remaining gaps, and next steps.

Table 4: Key findings and actions from supportive supervision for malaria interventions

Facility level	Assessed items	Supportive supervision achievements in quarter 1 (FY22)	Remaining gaps	Next steps
Hospital	Care providers' capacity-building	All hospitals have at least three qualified trainers for the national integrated malaria treatment guidelines; staff trained as trainers are working in supported hospitals; the capacity-building of 243 additional trained providers on malaria treatment guidelines was initiated at the hospital level.	Not all hospital care providers are trained on the malaria treatment guidelines.	Continue support on-the-job training on new malaria treatment guideline
	Infrastructure and equipment supply	All supported health facilities are equipped with at least three hard copies, together with a soft copy of the national integrated malaria treatment guidelines.	Pre-printed blood smear and RTD registers were missing.	Ingobyi will advocate for the availability of pre-printed blood smear registers.
	Service delivery and organization	All hospitals conducted malaria supportive supervision visits for all health centers on a quarterly basis to ensure quality malaria services are delivered according to standards; a progressive increase in the quality of care provided around malaria case management and SBC at hospital was observed; all hospitals are conducting blood smear quality control at HCs, and blood smear and RTD registers are available at all hospitals.	Five hospitals have not yet started to deliver health education sessions; quantifications and specifications of malaria parasites in blood smear tests are missing.	Malaria SBC messages at hospital should be reinforced; the quantification and specification of malaria parasites should be supported in hospitals.
	Data use for decision-making	Three-fourths (75%) of districts are equipped with knowledge and skills around malaria data analysis and use and have started a six-month improvement plan based on data-driven identified gaps; a hospital core malaria surveillance team was formed in 75% hospitals—the team includes the director	Malaria data validation meetings are not regularly conducted at all hospitals and once done, there is no triangulation in malaria data analysis; the malaria hospital team is not trained on new indicators; there is no weekly malaria community and health post data reporting system for hospital catchment area compilation, analysis, and use;	Ingobyi will support hospital malaria surveillance teams to ensure malaria data validation meetings are held regularly and discuss QI progress during coordination meetings; trainings of the hospital malaria team and strengthened malaria data analysis and use at the hospital level will be conducted on a weekly basis; Ingobyi will support hospitals in conducting audits of severe malaria cases and deaths

		general of the hospital, the health unit director, the malaria supervisor, the community supervisor, and the data manager; five supported hospitals that reported malaria deaths in the previous quarter conducted internal malaria death audits.	there is no severe malaria case audits to inform care delivery.	audits and will use recommendations from the audit to prevent future deaths.
Health center	Care providers' capacity-building	At least three providers from all supported HCs were trained on the national integrated malaria treatment guidelines; 56 additional care providers from eight health centers received on-the-job capacity-building by hospital malaria trainers; 100% of health centers were supported through quarterly supportive supervision.	Most health center and health posts staff are not yet trained on the national integrated malaria treatment guidelines; most health centers did not conduct supportive supervisions to health posts—only 68 health posts were supported in this quarter.	On-the-job training on the national malaria treatment guidelines will be conducted for untrained staff at health centers; Ingobyi will advocate for health post staff to receive on-the-job orientation on the guidelines; advocacy for health post supportive supervisions will continue.
	Infrastructure and equipment supply	All supported health facilities are equipped with at least three hard copies and soft copies of national integrated malaria treatment guidelines; 49 supported health centers that reported LLIN stockout and risk of stockout received a refill of LLINs through an external redistribution process with six-month security stock; no major stockout of malaria medicines or commodities was reported for supported health centers.	Of supported health centers, 24 in need were not covered by the LLIN redistribution; guidelines were missing at health posts under the supervision of health centers; pre-printed blood smears and RTD registers were missing at all HCs; and stockout of LLINs were reported in some health centers. in	Ingobyi will advocate for the availability of malaria treatment guidelines and for pre-printed blood smear registers at health posts; Ingobyi will support the external LLIN redistribution in the remaining HCs; Ingobyi will support and advocate for new health center store managers' support around electronic logistics management information system use.
	Service delivery and organization	All health centers were supported through supportive supervision visits to ensure quality malaria services are delivered; there was an increase in malaria health education sessions	High malaria burden health centers need more support to ensure quality service delivery and quality malaria surveillance; there is low coverage of home-based management of malaria (HBM)/ICCM in some HC catchment areas; the quantification and specification of malaria	Targeted supportive supervisions in high burden malaria sectors will be conducted; HBM and ICCM coverage QI projects will be strengthened and supported at health centers; malaria health education sessions will be strengthened at health centers; a quantification and specification of malaria parasite project will be initiated at

	delivered at health centers compared to previous quarters.	parasites is missing; health post supportive supervisions and malaria health education sessions are insufficient at some health centers; patients' temperatures and history of fever are poorly recorded, leading to clinicians requesting malaria laboratory tests for all fever cases; care providers are not performing full physical examinations of malaria clients to ensure proper diagnosis.	health centers; Ingobyi will encourage and advocate for health post supportive supervisions for quality care; malaria case management support will be continued for care providers during supportive supervisions, ensuring that all fevers are well recorded, full physical examinations occur, and patients benefit from malaria tests applied according to guidelines.
Data use for decision-making	All supported health centers have a trained malaria surveillance core team composed of the head of the health center, CEHO, data manager, and malaria focal person nurse.	Health centers identified with high malaria incidences do not have a clear data-driven improvement plan; malaria teams are not trained on new malaria indicators; malaria data validation meetings are not conducted at all health centers and where it is done, data are not analyzed; a weekly malaria community and health post data reporting system is unavailable; severe malaria cases audits are missing.	Ingobyi will support the health center malaria surveillance team to ensure malaria QI activities are implemented; weekly and monthly malaria data validation meetings at health centers will be strengthened; weekly malaria data analysis and use at the health center level will be strengthened; the HC malaria team will be trained on the malaria new indicators; HCs will be supported to conduct severe malaria case audits and follow recommendations from the audits.

Malaria data quality audit

The vision of Rwanda’s National Strategic Plan 2020–2024 is to become free from malaria. However, starting in January 2021, an increase in malaria incidence was observed in some districts, the most affected of which were Nyagatare, Bugesera, Nyamagabe, Kamonyi, and Nyaruguru. Findings from previous quarter reports revealed discrepancies between



Photo 3:CHW from Kamabuye HC is mentoring CHW on proper completion of stock cards



Photo 3:Community malaria data quality audit at Katabagemu sector

CHWs’ community data source documents and their monthly reports, as well as the inadequate use of different data collection tools. To ensure CHWs are receiving support to promptly and correctly diagnose, manage, and report on malaria cases in the community, Ingobyi Activity in collaboration with RBC/MOPDD and hospital staff conducted a community and health center malaria data quality audit (DQA) in sectors with increased malaria incidence in Nyagatare, Bugesera, Nyaruguru, and Nyamagabe districts and reinforced the culture of internal community malaria data quality audits by hospital and health center supervisory teams. To strengthen continuous internal malaria data quality auditing, the malaria DQA involved the hospital supervisory team; the health center malaria core team, including heads of health centers; data managers; and CEHOs. To amplify impact and promote the sharing of best practices, a peer learning approach was used, whereby neighboring health center staff were invited to support and participate in the community malaria data quality audit. This effort was made to ensure that more staff are coached on the malaria DQA, oriented on DQA tools, and are supported in their planning and conducting of a malaria DQA in their catchment areas.

A total of 51 villages located in eight sectors were reached, eight health centers were assessed, and 94 CHW reports were audited. In a peer learning practical session, 15 hospital supervisors, including data managers, community supervisors, and malaria supervisors, were coached on malaria DQA, and 24 CEHOs were coached to ensure continuous internal malaria DQA activities. Additionally, 19 health centers were assessed for malaria data quality, involving data managers and the malaria focal person. Data discrepancies were observed between key malaria indicators at health centers and at the community level. Figure 18 and Table 12 highlight the discrepancies and their causes found during the DQA.

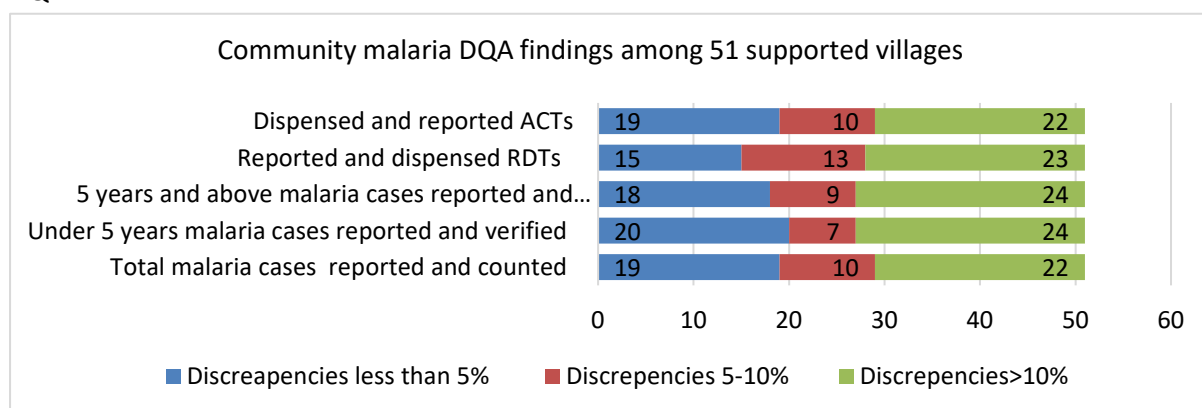


Figure 4: Findings from the DQA conducted in 51 supported villages

Table 5: Detailed findings from malaria data quality audit

Level	Strengths	Gaps	Actions taken	Next steps
Health center	Malaria drugs and commodities are available, and the registers for malaria drug distribution are well completed; malaria drugs and commodities stock cards are available and well completed.	Malaria data discrepancies were found in most of the supported health centers due to: suspected malaria cases treated through mobile consultation system benefit from malaria diagnosis tests, but are not recorded in consultation registers; discrepancies between malaria tests and fever cases; and poor documentation of fever and history of fever in OPD registers; misunderstanding of the new malaria indicators, in addition to counting and typing errors; and empty data elements caused by the incompleteness of some data element in the HMIS. The Electronic Logistics Management Information System was not updated in some HCs, leading to community malaria drug stockouts and decreased coverage of malaria patients treated in HBM/ICCM.	Ingobyi advocated for highlighting clients tested for malaria while consulting through Babbly in the laboratory register and provided mentorship to health center data managers on the new malaria indicators; Ingobyi mentored care providers in documenting fever and history of fever in OPD registers; Ingobyi recommended that malaria data discrepancies be corrected.	A training of health center data managers and malaria focal person will be conducted on the new malaria indicator reporting.
Community	HBM and ICCM services are delivered to the community.	Discrepancies in data between drugs distributed by CHWs and reports of cell coordinator, and between malaria cases and artemisinin-based combination therapy and positive rapid diagnostic tests due to: reporting errors; misunderstanding of malaria reporting indicators; and duplication in reporting of treated clients. Stockouts were reported, and community treatment registers and stock cards were incomplete or misused; stockouts of malaria drugs and risk of stockout are not reported in the Rapid SMS system; HBM coverage decreased in September 2021 due to IRS activities (CHWs were involved in these activities); positive cases detected by rapid diagnostic test were not treated due to stockout and some people were treated though they had tested negative.	The accuracy of malaria data recorded in July–September 2021 was verified; mentorship and supportive supervision were conducted around malaria case management and reporting to CHWs; Ingobyi teams verified and advocated for the availability of data collection tools for CHWs, discussed data quality issues and proposed the correction of erroneously reported data.	The community malaria DQA and mentorship by the health center malaria core team and hospital supervisory team should be reinforced; malaria treatment tools will be printed and distributed to CHWs.

Child health and malaria interventions at the community level

USAID Ingobyi Activity supported the implementation of ICCM and the home-based management of malaria (HBM) program. Through this program, CHWs-binômes⁹ diagnose and treat malaria, diarrhea, and pneumonia in children aged two to 59 months; diagnose and treat malaria in adults through HBM; and provide preventive messages to the community. During this quarter, USAID Ingobyi Activity supported different interventions aiming to improve ICCM/HBM services at the community level.

ICCM and HBM mentorship

To strengthen the capacity of CHWs in the management of malaria and childhood illnesses and contribute to the reduction of the burden of malaria case management at the facility level, Ingobyi Activity supported HCs to conduct mentorship of CHWs in ICCM and HBM. During this reporting quarter, 650 IMCI nurses and CEHOs from 326 HCs conducted ICCM and HBM mentorship and supportive supervision at the community level. Through their mentorship visits, ICCM/HBM mentors supported 10,033 CHWs-binômes in calculating age in months, assessing and identifying danger signs (for simple malaria, severe malaria, pneumonia, and diarrhea), using diagnostic tools (mid-upper arm circumference tapes, timers, thermometers, rapid diagnostic tests, and various disease-specific algorithms), interpreting results, adhering to treatment protocols, and completing ICCM/HBM treatment registers, as well as appropriate waste management. Among key gaps identified were stockout of amoxicillin and nurse turnover, which created a gap in community mentorship implementation in some HCs. To address the challenges, USAID Ingobyi Activity, through supportive supervision visits, worked with hospitals to provide on-site orientation of 17 newly appointed nurses from six districts (Musanze, Rutsiro, Huye, Ruhango, Ngororero, and Nyabihu) on the community health mentorship approach and use of mentorship checklists. The trained mentors started their mentorship sessions during this quarter. Ingobyi Activity will continue to advocate for the availability of amoxicillin at the community level. During the next quarter, Ingobyi will continue to support mentorship activities in the supported districts.

ICCM/HBM routine supportive supervision

In addition to mentorship, USAID Ingobyi Activity conducted routine quarterly supportive supervision to improve community health services at both health center and village levels. At the health center level,



Photo 17: Ingobyi malaria and community health specialists during a group supervision in Bugesera

Ingobyi Activity, in collaboration with community health supervisors, conducted supportive supervision to ensure that HCs provided effective and coordinated support to CHWs. During this quarter, a total of 161 health providers (IMCI nurses, CEHOs, and pharmacists-in-charge) from 20 districts were supported. The team oriented and supported them on the appropriate use of supervision tools; the analysis and use of community health data to orient appropriate support to CHWs; the use of referral forms to improve linkage between HCs and CHWs; and the management of community drugs and commodities

⁹ A binôme refers to a male/female pair of CHWs.

(including quantification and forecasting). USAID Ingobyi Activity extended the support and facilitated CEHOs from 326 HCs to reach 10,176 CHWs-binômes in ICCM/HBM. During the supervision, CEHOs reached CHWs using one-on-one and small group supportive supervision approaches. During their visits, CEHOs discussed with CHWs their role in the early identification of malaria cases, timely referral of complicated cases, proper reporting, and the importance regular community sensitization on early care-seeking behavior. They assessed the availability and use of updated national standard tools; the completeness of registers; management of community health commodities/drugs; the availability and use of PPE to ensure the safe provision of services during the COVID-19 pandemic; and compliance with IPC measures. Key gaps included lack of monthly report registers, incompleteness of treatment registers among some CHWs, and the lack updated registers. To address the identified gaps, USAID Ingobyi Activity distributed 16,301 ICCM/HBM treatment registers and monthly report registers in 16 supported districts.

ICCM/HBM mentorship coordination meetings

During this quarter, USAID Ingobyi Activity supported 15 districts to conduct a one-day ICCM/HBM level mentorship coordination meeting. The meeting brought together DHU members, health facility managers, and ICCM/HBM mentors. A total of 482 mentors attended the meeting. Participants discussed the ICCM mentorship implementation progress; shared experiences and best practices; discussed the performance against key ICCM/HBM indicators and their role in improvement; and discussed key challenges hindering the delivery of quality ICCM/HBM services. A group discussion methodology used to generate ideas and more discussion among mentors, which created an opportunity for peer learning. The ICCM/HBM mentorship coordination meeting was used to train mentors on QI projects and update them on the use of mentorship checklists. Recommendations from the meeting were further presented at district and facility



Photo 18: ICCM/HBM mentors from Musanze discussing key challenges during a coordination meeting

leaders' coordination meetings to orient leadership-related actions to improve community mentorship. During quarter 2, Ingobyi Activity will continue to support these meeting in all supported districts.

VI. Cross-cutting Interventions

This section summarizes key cross-cutting accomplishments in quarter 1 of FY22. Interventions presented in this section include referral system strengthening; SBC communications; gender integration; IPC; environmental monitoring and mitigation; QI; community participation and engagement; data demand and use; learning; and district support.

A. Strengthening Referral Systems

Support the MoH to disseminate new transfer forms and integrated national health sector referral guidelines

In quarter 1, Ingobyi continued supporting the MoH to improve the functionality of the referral system and referral linkages between and across RMNCH and malaria services by training supported health facility staff on the use of new referral tools (transfer forms and referral guidelines). The aim of this training was to strengthen the capacities of HC staff to be able to adhere to the referral guidelines. In the reporting period, Ingobyi aimed to train 218 participants from six districts (Nyagatare, Gatsibo, Rwamagana, Ngoma, Bugesera, and Gasabo). Targeted participants were health center managers (Titulaire) and QI focal persons. In total, 94% of targeted participants were trained (205 out of 218). It was noted that most participants were not aware of the newly designed referral tools (accessible at www.moh.gov.rw/publications/legal-framework), and most had never seen the Integrated National Health Sector Referral Guidelines booklet published in October 2020. At the end of training, participants requested that Ingobyi support the MoH to develop a referral policy and procedures adapted to HCs.

Support the MoH to review and print outpatient and inpatient registers

By MoH request, Ingobyi supported the revision of existing outpatient and inpatient registers. The purpose of the revision was to ensure that malaria information, referral, and systematic screening of key conditions are captured and that age group information is collected to capture data on global indicators. This review was proposed in response to recommendations from a review of HMIS data collection tools, which highlighted the following gaps in the two registers: some key information on malaria was not being captured; ages captured did not allow the MoH to report on global indicators; information about lab tests and results came before clinical signs and symptoms; and information was missing for the systematic screening of some conditions, including HIV and noncommunicable diseases. Ingobyi organized working sessions with targeted MoH technical units (MCCH, malaria, HIV, tuberculosis, noncommunicable diseases, nutrition, mental health) to ensure revised registers are comprehensive and integrated. The final versions of the two registers were approved by MoH and RBC division managers and endorsed by MoH leadership in November 2021. New areas that were added included: key malaria information (history of fever within 48 hours, results of temperature and malaria tests taken, and pregnancy status); ages disaggregated according to WHO recommendations; and findings from systematic screening of tuberculosis, HIV, sexually transmitted infections, noncommunicable diseases, and malnutrition. The registers are designed to capture information about referrals in, referrals out, counter referrals, and the linkage between community and facility by documenting CHW-referred cases. In addition, the flow of information was organized as recommended by clinicians. Upon validation, Ingobyi supported the printing and delivery of the outpatient, inpatient, and IMCI registers to facilities countrywide. In total, 20,700 registers (10,380 OPD registers, 5,120 inpatient registers, 5,000 IMCI registers, 100 delivery registers, and 100 PNC registers) were printed and delivered.

B. Social and Behavior Change Interventions

USAID Ingobyi Activity utilizes various approaches and relevant tools that drive communication for behavior change and ensure consistency and coordination among implementers/partners to deliver SBC messages. These approaches include outreach events and radio broadcasts.

Community outreach events

Using internal and external data on different performance indicators, Ingobyi Activity works with districts to identify and hold outreach events for hard-to-reach communities in need of health messages related to improving care-seeking behavior. This reporting period, Ingobyi Activity conducted eight community outreach events in eight districts (Nyagatare, Muhanga, Kamonyi, Nyamagabe, Huye, Nyaruguru, Rutsiro, and Rubavu) that reached 6,465 people (2,977 males and 3,488 females). During the community outreach events, Ingobyi Activity provided health education messages delivered by staff, health center providers, and CHWs to encourage uptake of RMNCH and malaria services. In addition, Ingobyi Activity worked with nearby health centers to offer different services, including FP, HIV testing, pregnancy testing, nutrition counseling, and screening for noncommunicable diseases, during the outreach events.

Radio broadcasts

Ingobyi Activity uses a serial radio drama known as the *Urunana* soap opera to disseminate key messages on reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and malaria prevention and treatment. Ingobyi Activity also uses this platform to disseminate messages on COVID-19, including preventive measures, fighting misinformation, and vaccine hesitancy. The serial drama is aired twice weekly on Radio Rwanda and Radio10, which have nationwide coverage, and Ingobyi produced and broadcast 26 episodes this quarter. In addition, short radio sketches usually targeting one or two health behaviors are aired weekly or biweekly on nine community radio stations. These sketches highlight challenging behaviors and offer solutions to change them. Additionally, 13 sketches were broadcast on nine community radios, and 13 radio mentions were aired on KISS FM radio.

Another radio broadcast used by Ingobyi Activity to disseminate RMNCH and malaria prevention and treatment messages is the *Umuhoza* magazine show, which is broadcast right after the *Urunana* drama episodes. This show allows listeners to call in and discuss various health topics touched on by the serial drama and have their issues and queries answered by Ingobyi Activity technical staff and other health professionals. Ingobyi Activity also utilizes interactive radio talk shows on different radio stations to discuss community health issues. Ingobyi and various hospital staff are invited as guests to facilitate the talk shows and discuss different health topics, listen to listeners' feedback, and provide responses to their questions. On average, at least 48,000 individuals actively participate in various SBC media broadcasts every month by calling in, providing feedback through text messaging, or leaving comments on social media. This quarter, eight *Umuhoza* magazine episodes on RMNCH, malaria, and COVID-19 were broadcast on Radio10.

The achievements and results of the SBC interventions are highlighted under each technical area of the report.

Listeners' feedback collected

During the quarter, Ingobyi compiled feedback from listeners on RMNCH, COVID-19, and malaria messages. Those messages were disseminated through the *Urunana* radio soap opera, *Umuhoza* radio magazine, radio sketches, and social media platforms. Of the listeners, 448 voluntarily sent in their feedback via text message after listening to the radio soap opera, mostly stating how they are benefiting from the radio programs. On average, 7,419 people listened to the *Urunana* radio soap opera through the *Urunana* YouTube channel (<https://www.youtube.com/c/IKINAMICOURUNANAOfficial/videos>). From the community radio stations that had broadcast radio sketches, Ingobyi collected feedback from 1,148 listeners, while 1,462 listeners provided feedback after listening to the *Umuhoza* radio magazine. In total, 10,477 listeners gave feedback after listening to all radio programs in quarter 1. Listener feedback is used to inform the development of new messages, adjust the content of existing messages, and to counteract rumors and misinformation in subsequent broadcasts.

C. Gender Integration

Gender integration in health services is the process of creating knowledge and awareness of, and responsibility for, addressing gender-related issues in health systems. Gender integration activities seek to support the implementation of gender-transformative approaches that aim to address and change gender norms that restrict the ability of women, men, children, and adolescent to access health services.

Gender integration in RMNCH activities

Ingobyi Activity worked with health facilities to ensure gender integration in service delivery and to address gender-related barriers to RMNCH and malaria services. Health providers are sensitized to consider the specific needs of men and women when providing routine services, such as encouraging male involvement in ANC, delivery, FP, and other RMNCH and malaria services. In addition, all health provider training organized by Ingobyi Activity integrates gender to ensure providers are well equipped to integrate gender into their activities and to identify and respond to gender issues. During this quarter, gender considerations were integrated in a training of 30 national trainers on CRH and a training on income-generating activities for 136 women, including 58 teenage mother members of savings groups. These trainings included teaching skills on how to cope with family well-being issues, such as stigma, family conflicts, GBV, malnutrition, and lack of health insurance to access health care.

Improving the capacity of IOSCs and HCs to respond to GBV

Following the supportive supervision of GBV management activities at IOSCs and health centers conducted during FY21, one of the challenges identified was that most staff members in charge of GBV case management had not been trained due to staff turnover. In collaboration with the RBC and national GBV trainers, Ingobyi provided GBV case management training to staff of supported IOSCs, who cascaded that training to health providers from HCs in their catchment areas. In total, 96 staff from 25 supported IOSCs were trained; these included GBV officers, psychologists, investigators, medical doctors, and 256 health providers (including GBV focal points and mental health in-charges) from HCs in the catchment areas of ten supported hospitals. The training focused on the holistic management of GBV cases, active identification of GBV cases, provision of first aid before referral, and follow-up for reintegration at the community level. The training for the remaining HCs will continue in the next quarter.

Supportive supervision to IOSCs and HCs

Ingobyi Activity conducted supportive supervision in 12 IOSCs and supported the IOSCs to conduct supportive supervision of 302 of 325 HCs in the 20 supported districts. The objectives of supportive supervision at IOSCs were to ensure holistic services are provided to GBV victims, including psychosocial counseling for all victims, and at health centers to ensure the active identification of GBV cases, the provision of emergency contraception and post-exposure prophylaxis, and documentation. Table 13 shows a summary of findings during supportive supervision.

Table 6: Summary findings from supportive supervision for IOSCs and HCs

Key strengths, gaps, and actions proposed		
	IOSCs	Health centers
Strengths	All IOSCs visited offer holistic services by providing medical, psychosocial, and social support to GBV victims; all services required in IOSCs are available and organized; key staff are available, and at least two staff are permanent (GBV officer and the investigator officers), while medical doctors and psychologists are called when a victim at an IOSC needs their services; all needed staff in IOSCs (medical doctor, IOSC officer, investigator, and psychologists) received a refresher training on the GBV case management protocol; required prophylaxis commodities for HIV, sexually transmitted infections, tetanus, and emergency contraception are available; all sites visited used the updated 2020 version of the GBV register.	GBV focal points and other clinical staff at the health center level are available, and this quarter, their training started in different hospitals for early GBV management protocol, as well as active screening to identify GBV victims and referral; a GBV focal point was available to provide care to GBV victims at all HCs; updated GBV registers were available and used in most of the HCs; HCs were supported in completing victims' files and registers appropriately.
Gaps	The guidelines and protocol to guide GBV service for HIV/post-exposure prophylaxis, emergency contraception, and sexually transmitted infection prevention were available but not displayed at all IOSCs visited; the internal transfer form was not used; the algorithm for GBV case management was not displayed in some IOSCs; registration of GBV victims in the GBV register is not done immediately in some IOSCs; GBV client files are sometimes absent or not completed on time by medical doctors; there is no permanent psychologist to conduct counseling	Some of the HCs did not have designated rooms for GBV victims, and victims were received in the OPD; the GBV management protocol was not adhered to in most HCs; in some HCs, GBV cases were not systematically referred to IOSCs for comprehensive and holistic management or were referred without provision of pre-transfer care (e.g., post-exposure prophylaxis for sexual assault victims); the register that affects the reporting system was incomplete in some HCs; in many HCs, staff in charge of GBV management are not trained and other HC staff are not aware of the active identification of GBV victims in their services; teen mothers and physical violence cases are not registered in the GBV register; some teen mothers delivered at the health center level; there are staff shortages in health centers.

	to all victims, though an office is allocated for this person in the IOSC.	
Actions	Ingobyi team discussed with IOSC staff the importance of using GBV files and recording GBV clients immediately after admission; files were distributed to all supported IOSCs; discussions were held with psychologists on the possibility of working permanently in IOSCs, as they have offices there.	An on-site orientation was held for supervised staff on the use of GBV files and register completeness, as well as active screening methods to identify GBV victims at every facility service entry point; Ingobyi advocated for designated rooms for GBV victims; Ingobyi advocated to the head of health center to avail a specific room for GBV victims to assure confidentiality during counseling; GBV data from the last three consecutive months were reviewed.
Next steps	Ingobyi will continue to build the capacity of IOSC staff through supportive supervision and mentorship; Ingobyi will work with the MoH and RBC to ensure the GBV register is integrated into the electronic medical record system.	IOSCs and Ingobyi will finalize staff training in GBV management for all HCs; recording all GBV cases in the GBV register and using GBV files will be emphasized; screening for GBV cases in all services will be considered (an orientation of all staff in active screening will be planned).

Support follow-up for GBV victims and social reintegration

GBV case management requires follow-up to support GBV victims to cope with issues they face and their social reintegration. Ingobyi Activity provided technical and financial support to IOSCs to conduct home visits and group therapy sessions for GBV victims in their catchment areas. During this quarter, IOSC staff conducted home visits for 167 GBV victims in all supported districts. The objectives of the home visits were to assess GBV victims' well-being after being discharged from IOSCs, update them on litigation of their cases, and support their reintegration into their families and communities. Ingobyi also supported the IOSCs to conduct group therapy sessions. The objective of group therapy sessions is to help the victims to overcome the pain and trauma caused by GBV through sharing stories, ideas, advice, and experiences with other victims. During this quarter, IOSCs were supported to conduct 37 sessions, including 33 for teen mothers and four victims of intimate partner violence. In total, 304 GBV victims, including six males, were reached.

Community awareness for GBV prevention and male involvement in RMNCH and malaria

Ingobyi Activity used different approaches to promote community awareness of, and response to, GBV. The following activities were conducted in quarter 1.

Participation in the 16 days of activism against

GBV: The annual Global 16 Days Campaign kicks off on November 25, on International Day for the Elimination of Violence against Women, and runs until December 10, on Human Rights Day. Ingobyi Activity collaborated with four supported districts (Musanze, Muhanga, Nyanza, and Nyagatare) to organize community events that ensure community awareness of available GBV services,



Photo 19: Walking at Nyanza District/ Busasamana Sector during 16-day event

particularly at IOSCs, encourage communities to break the silence around GBV, and promote timely reporting for immediate response.

Use of media to disseminate messages in the community: The *Urunana* radio soap opera episodes disseminate messages about the consequences of intimate partner sexual violence and child abuse, as well as messages on the benefits of male involvement in RMNCH services. Radio talk shows on Radio10 and in collaboration with Masaka IOSC were used to sensitize the community on breaking the silence around GBV and supporting victims in seeking services in a timely manner.

US Ambassador visit to Nyagatare IOSC

To support the 16 days of activism against GBV, the US ambassador to Rwanda visited Nyagatare IOSC on November 30, 2021. During the visit, the ambassador was joined by district authorities, hospital management, Ingobyi staff, and USAID's Health Office director. Hospital leaders presented the overall care provided at their facility and emphasized its gender interventions. The dignitaries then conducted a tour of the IOSC, during which staff explained services, patient flow, and the referral system used to connect clients to other services within and outside the hospital. The ambassador met three GBV victims who had spoken out about their personal experiences.



Photo 4: Visitors posing at the entrance of IOSCs at Nyagatare Hospital

Support the RBC in reviewing and updating the GBV case management training manual and protocol

The RBC initiated a process to review and update the GBV case management training manual and protocol. The existing protocol was developed in 2009 and lacks essential elements in the management of GBV, including psychosocial support, new protocols for emergency contraception, FP, CRH, and management of HIV. Ingobyi Activity is collaborating with other stakeholders to provide technical expertise in this process.

D. Infection Prevention and Control

Hospital-acquired infections seriously affect the delivery of quality health services. The major types of these infections are catheter-associated urinary tract infections (40%), surgical site infections (20%), ventilation-associated pulmonary infections (15%), cutaneous infections (8%), and bacteremia transmitted primarily by intravenous catheterizations (6%), among others (11%). Infections are a major cause of maternal, newborn, and child morbidity and mortality in Rwanda. As such, IPC is a critical area of focus for Ingobyi Activity. Ingobyi prioritizes low-cost, bundled interventions using systems QI approaches for improved infection control. These interventions are implemented through on-site training, mentorship, routine and consistent supportive supervision, and RRTs to manage outbreaks and emergencies, as well as support to health facilities to acquire critically needed IPC materials.

Review of the IPC policy and development of guidelines, SOPs, and training materials

USAID Ingobyi Activity continued to work along the MoH and a hired consultant to produce national guidelines, standard SOPs, and training manuals on IPC. During this quarter, Ingobyi reviewed and gave feedback on drafts developed by the consultant; in the next quarter, Ingobyi will plan a workshop to bring together national IPC stakeholders and the MoH to revise these documents.

Participation in national technical working groups

During this quarter, the Ingobyi IPC team participated in two TWG meetings: the safe motherhood sub-TWG and the risk communication and community engagement TWG. At the safe motherhood sub-TWG, Ingobyi presented results from environmental swabbing and conducted a presentation on Ingobyi risk communication and community engagement activities related to COVID-19. The meetings were chaired by the RBC/MoH and attended by other relevant stakeholders. The aim of the presentations was to disseminate findings from Ingobyi work to nurture learning and collaboration among stakeholders.

Routine supportive supervision

In this reporting quarter, USAID Ingobyi Activity conducted supportive supervision to 22% (72/325) of health centers and 85% (22/26) of supported hospitals. The supportive supervision aimed at providing continuous support to facilities to reinforce IPC measures during service delivery and put in place IPC systems expected to maintain attained improvements. During the supervision, Ingobyi IPC staff provided refreshers on IPC standard precautions to health providers; reviewed IPC shortcomings from different departments; supported providers in addressing some of those gaps; instituted an IPC plan for continued implementation of IPC activities at the facility level; and advocated for IPC conducive systems improvements to facility managers, the districts, and the MoH. Ingobyi worked with hospitals to review the results of the environmental swabbing conducted at the end of FY21 and continued to promote environmental cleaning and improved hand hygiene to reduce the reservoir of harmful germs and break the infection chain. Detailed findings and actions from the IPC supportive supervision at hospitals and health centers are summarized in Table 14.

Table 7: IPC supportive supervision findings from hospital and health centers

	Assessed items	Availability of IPC SOPs and protocols	Compliance to IPC standard precautions	Infrastructure and equipment	IPC commodities and supplies	Disease surveillance and response to outbreaks
Hospitals	Strengths	Each hospital has in place local IPC SOPs endorsed by the hospital IPC committee and hospital management.	In FY21, USAID Ingobyi Activity conducted a massive training of hospital staff in IPC, with a focus on dedicating and empowering an IPC focal point to lead IPC activities, as well as improving hospital managements' awareness and support for IPC interventions.	Basic IPC infrastructure and equipment, including hand hygiene facilities; running water; sterilization machines; laundry; washing machines; etc., were available in most hospitals.	PPE and other supplies for COVID-19 prevention are available and used.	IPC teams, QI teams, and RRTs in charge of disease surveillance and response are available; data systems and data managers are available.
	Gaps	Most of the hospital IPC SOPs are not updated to the most recent WHO IPC guidance.	Despite training and routine supportive supervision, recurrent gaps in compliance to IPC standard precautions are observed due to: lack of a continuous IPC education program to ensure each newly recruited staff is trained in IPC; lack of clinician involvement in environmental cleaning and decontamination of reusable devices; high staff turnover, including cleaners; lack of full-time hospital staff dedicated to IPC; and the non-provision of prophylactic antibiotics, etc.	Incinerators and sterilizers are nonfunctional at some facilities; the availability of running water in maternity and neonatology is inconsistent; sluice rooms are absent; neonatal room infrastructure is insufficient, as are incubators in neonatology; handwashing facilities are insufficient; there is high bed occupancy; there is a lack of designated areas for cleaning and decontaminating medical equipment; there is poor signage and delimitation of restricted areas.	Some hospitals experienced shortages of IPC commodities and supplies, including disinfection and cleaning materials, gloves, linens, and Caesarean section kits, leading to frequent sterilization, color-coded bags, etc.	There are still gaps in the consistent surveillance of infections that lead to delays in response; there is a lack of anti-microbial resistance surveillance due to a lack of laboratory capacity; there is limited integration of IPC teams, QI teams, and RRTs in the surveillance and response to outbreaks; the current focus has shifted to COVID-19; there is poor capacity of hospital department data review to inform changes in infection rates to inform health providers' rapid response.
	Actions and recommendations	USAID Ingobyi Activity is supporting the	Ingobyi IPC staff worked with the IPC committees and staff working	Ingobyi Activity advocated for the improvement of IPC	Ingobyi worked with hospitals to improve	Ingobyi coached hospital teams on disease

	Assessed items	Availability of IPC SOPs and protocols	Compliance to IPC standard precautions	Infrastructure and equipment	IPC commodities and supplies	Disease surveillance and response to outbreaks
		development of a national IPC guideline and SOPs that will be used by the hospitals to adapt theirs. During supportive supervision, Ingobyi worked with the hospitals to make some updates based on the WHO recommendations.	in neonatology and maternity wards at each supported hospital to strengthen them to practice and implement IPC standards as per WHO guidelines; giving guidance on developed IPC QI projects aimed to reduce health care-associated infections; Ingobyi participated in hand hygiene monitoring, data collection, and data use to improve hand hygiene practices; Ingobyi emphasized the importance of involving clinicians in cleaning and decontamination, involving leadership in IPC; demonstrations were given on chlorine solution preparation and its proper use in cleaning and disinfecting materials and surfaces.	infrastructure and equipment at the hospital level—as a result of this advocacy, most hospitals' washing machined were upgraded; handwashing facilities improved, including availing tip taps as alternatives in areas where sinks were not functional; Kabgayi Hospital received a new sterilization machine; in addition, Ingobyi is in the process of supporting the repair of broken sterilization machines at Shyira, Kabgayi, and Nyanza hospitals.	budgeting and planning for IPC commodities and supplies; followed up with cleaning companies to ensure the consistent availability of cleaning and disinfection products; linens were made available especially in neonatology to limit the usage of family clothes in incubators.	surveillance and response; Ingobyi worked with the teams to analyze data and identify indicators of focus for surveillance, including neonatal infections and surgical site infections; antimicrobial resistance was also supported through environmental checks, such as swabbing and observations; Ingobyi used a QI approach to support hospitals providing targeted interventions to respond to post-Caesarean section and newborn infections. More details are provided under QI and RRT sections.
Health centers	Strengths	Some health centers had posters on standard IPC precautions, mainly hand hygiene, waste management focused on injection safety and waste separation, and the preparation of cleaning and decontamination solutions.	Health center managers acknowledge the IPC challenges, and they are keen to learn and improve IPC measures; IPC measures were reinforced due to the COVID-19 pandemic.	There was increased availability of tip taps for hand hygiene.	Cleaning and decontamination solutions were available in most health centers.	Data systems to support surveillance were available.

	Assessed items	Availability of IPC SOPs and protocols	Compliance to IPC standard precautions	Infrastructure and equipment	IPC commodities and supplies	Disease surveillance and response to outbreaks
	Gaps	Most of the health centers did not have the guiding SOPs and posters.	Surfaces and medical equipment in delivery rooms were ineffectively cleaned and decontaminated; there were shortages of cleaning staff; the involvement and ownership of IPC interventions by clinical staff were limited; the sterilization monitoring/sterilization process in some health centers was ineffective; waste management was ineffective, and there was noncompliance with hand hygiene procedures.	The infrastructure is poor, with insufficient latrines, lack of running water, and special issues with waste disposal-incineration.	There were shortages of appropriate PPE, especially gynecological gloves in the maternity; there were insufficiently labeled waste bins, safety boxes, etc.	There is poor outbreak preparedness; COVID-19 triage/screening is not done regularly; there is a lack of isolation units or designated rooms for isolation in health centers; there is poor data use for planning; there is a lack of a dedicated surveillance team.
	Actions and recommendations	Ingobyi Activity worked with a supervised health center to draft quick SOPs on precautions and posted those in maternity, postpartum, ANC, and FP departments; facilities were encouraged to extend the SOPs to other services, including laboratory, immunization, and OPD.	Ingobyi Activity provided a quick orientation to health center staff on the IPC standard precautions, worked with them to highlight critical IPC areas and gaps, encouraged them to prioritize IPC measures, and encouraged the CEHO to conduct routine IPC compliance audits to promote continuous improvements.	There is a need to advocate at the health center level for improved infrastructure conducive to IPC measures.	Ingobyi encouraged facility managers to improve availability of IPC commodities; some were procured, though most of them still don't have the resources to procure these commodities.	Ingobyi worked with the facility managers and the data manager to improve data analysis and use aimed at closely monitoring potential outbreaks; Ingobyi supported the improved screening for COVID-19 symptoms and supported health centers to respond to IPC gaps using QI approaches.

Support hospitals to develop and implement IPC QI projects

USAID Ingobyi Activity promoted the use of QI approaches to keep a close look on neonatal and post-Caesarean section infections. During this quarter, 21 of the 26 hospitals had an active QI project to reduce post-Caesarean section infections, and four had projects aimed at reducing neonatal infections. Some of the QIs were developed following an observed increase of infection in post-Caesarean sections or Klebsiella outbreaks. The methodology included reviewing data on infections, working with facilities to identify areas of improvement; identifying and prioritizing interventions; developing an action plan with targets, a timeline, and responsible persons; and then implementing the actions. Interventions included: scheduling and conducting general cleanings; refreshers on Caesarean section protocols regarding skin preparation; hand hygiene and prophylactic antibiotics; delimitation and limitation to restricted areas; refreshers and coaching on the preparation and use of disinfectants; mentoring health providers and cleaners in IPC standard precautions; and advocating for the availability of IPC equipment, commodities, and supplies. The QI projects were led by heads of services and supported by IPC focal points, who were responsible for conducting continuous compliance auditing to detect potential shortcomings in a timely manner. Mentors, facility management, and the Ingobyi team were kept informed of the progress of the actions to support needed adaptations. As a result, 67% (14 out of 21) of the hospitals reduced Caesarean section infections, while all four hospitals reduced neonatal infections. Among 25 QI projects implemented in this quarter, 52% (13 out of 25) achieved their targets at or before their due date, 12% (three out of 25) were not achieved, while 36% (nine out of 25) are ongoing.

Observed trends in key IPC outcomes

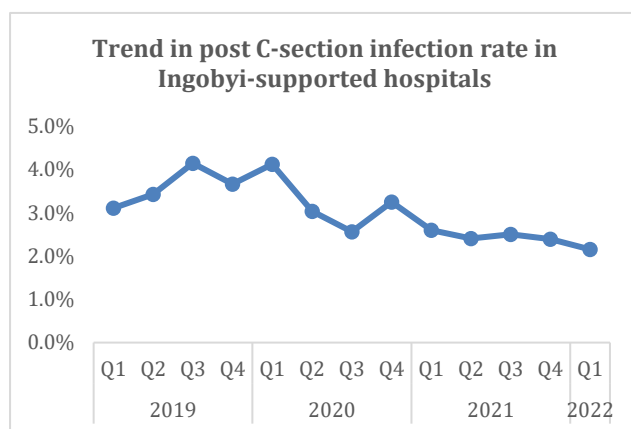


Figure 19: Trend in post-Caesarean section infection rate at Ingobyi-supported hospitals

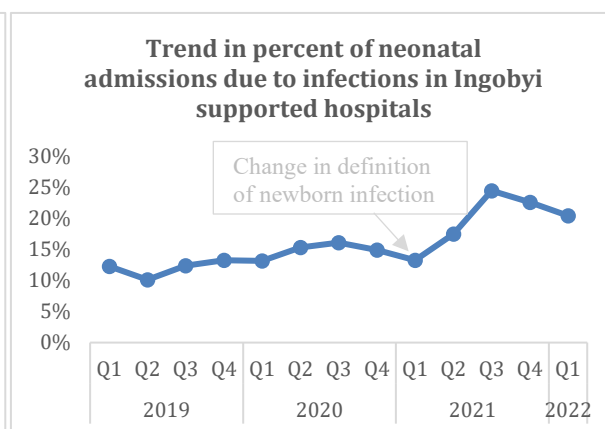


Figure 20: Trend in the percent of neonatal admissions to Ingobyi-supported hospitals due to infections

Neonatal and maternal infections are ranked among the major cause of morbidity and mortality for mothers and neonates. Following multidimensional IPC interventions implemented by Ingobyi Activity, there has been a remarkably consistent decrease in the proportion of mothers who develop a post-Caesarean section surgery infection (Figure 19). The reduction was also observed in the proportion of neonatal admissions due to infections, from quarter 3 of FY20 until February 2021. An increase in neonatal infection was observed following a change in the national reporting system: the indicator “neonatal suspected sepsis” was changed to “neonatal infection” to provide a better picture of the infection burdens in newborns (Figure 20). Ingobyi continued to support facilities making improvements through IPC mentorship, monitoring, supportive supervision, and advocacy for

infrastructure changes that allow the application of the standard IPC measures. As a result, a reduction in the proportion of newborn infections was observed again starting in quarter 3 of FY21.

E. Disease Outbreak Preparedness and Prevention

Since the COVID-19 outbreak, the GoR has implemented several public health measures aimed at slowing spread of the disease. However, the country has been facing a series of the outbreak waves, including the current one, believed to be caused by the newly discovered Omicron variant. During this quarter, the USAID Ingobyi Activity continued to work alongside the MoH and RBC to implement vaccination activities and support COVID-19 risk communication.

Supportive supervision of vaccination activities

As part of the support to the GoR's COVID-19 response, USAID Ingobyi supported the RBC to conduct supportive supervision at 136 vaccination sites. The supervision was conducted by Ingobyi vaccination advisors seconded to the RBC vaccination department. The objectives were: to ensure that contact details are correctly captured at the vaccination site during the first dose to facilitate subsequent follow-up; to review vaccination records to ensure eligible clients are receiving the full vaccine course and that vaccination sites are supported in following-up with those not coming to their next appointment; to ensure that clients presenting with side effects are managed appropriately based on national guidelines; to ensure that stock availability is assessed and reported promptly to district hospitals and the RBC; to ensure support in coordinating vaccine distribution and ensuring stock and the cold chain are maintained; and to ensure that IPC protocols are adhered to during vaccination, with coaching and technical assistance provided to address identified gaps.

During supervision at the vaccination sites, some challenges were observed, including a shortage of vaccination staff (too few data managers), protective measures not being followed (no social distancing due to overcrowding), and some resuscitation stands being not well set (no emergency trolley, set far from vaccination site). Recommendations given to vaccination sites following the visits included: reorganization of the sites to allow for social distancing; installation of handwashing stations/provision of hand sanitizers; and adding vaccination personnel, including data managers, to reduce crowding. As of November 30, 2021, USAID Ingobyi continued to support the RBC with 30 data managers to support data entry at 27 vaccination sites in Gasabo and Kicukiro districts. In addition, during December 2021, the two Ingobyi vaccination advisors seconded to the RBC were deployed to manage the vaccination sites at Kimironko Market and Nyabugogo car park, one of the busiest in Kigali. During this support, 306,020 individuals received their first dose of COVID-19 vaccine, 137,634 received their second/full dose, while received 6,955 booster shots (their third dose).

Supporting COVID-19 risk communication strategy

Ingobyi Activity supported the RBC to raise public awareness about COVID-19 vaccination and preventive measures through radio talks and spots. During this quarter, Ingobyi supported eight radio talk shows on Radio10 and seven community radio stations: Radio Huguca, RC Nyagatare, RC Rubavu, Energy Radio, Radio Ishingiro, Radio Izuba, and Radio Isangano. The shows provided information on COVID-19, with an emphasis on dispelling vaccination-related rumors and misconceptions; compliance with COVID-19 prevention measures, including for fully vaccinated individuals and those in home-based care; and updates on the Omicron variant.

The talk shows were conducted by Ingobyi IPC staff jointly with RBC staff and leaders from the supported districts. The radio talk shows were broadcast during prime time to attract maximum listenership. Listeners were allowed to call in to ask questions or comment on the discussion topics, and the panelists responded. More than 150 questions were asked and answered during the shows. In addition, COVID-19 prevention and vaccination messages were integrated into the *Urunana* serial drama.

F. Environmental Monitoring and Mitigation

Environmental monitoring was conducted and mitigation measures taken in all Ingobyi supported activities during the quarter, including during trainings, mentorship, supervision, and integrated outreach events (see Annex B for details). Waste generated at the outreach sites was deposited at the nearest health center for proper management and disposal. In addition, during outreach activities, Ingobyi Activity ensured that waste was segregated and disposed of as per MoH guidelines. During monitoring and supportive supervision visits to health facilities, Ingobyi teams observed waste management practices to ensure that they complied with national waste management guidelines. Health providers in Ingobyi-supported hospitals were trained and coached on IPC, health and safety, and protection of the work environment by Ingobyi staff and district-based mentors during supportive supervision and mentorship visits, respectively. Ingobyi staff also discussed waste disposal with health providers and facility management. For trainings conducted in hotel settings, waste materials were taken to the nearest hospitals for safe disposal. Noninfectious waste was disposed of alongside other hospital waste per guidance in the national waste management protocol.

G. Quality Improvement

QI is an approach to improve service systems and processes through the routine use of health and program data to meet patient and program needs. Ingobyi Activity works with the MoH and health facilities to consistently identify and address gaps in QI in all technical areas through supportive supervision, mentorship, and data reviews. In this reporting period, Ingobyi continued supporting facilities in QI via the outlined activities below.

Support the MoH to disseminate primary health care standards for RMNCH

The GoR has made strong commitments to ensuring the highest achievable quality during the provision of essential health services, particularly PHC services that follow set standards for best outcomes at minimum cost. A national health care accreditation program was established to guide health facilities in defining, implementing, and measuring standards of the expected quality standards of service delivered. The MoH also went further to develop PHC accreditation standards as one of numerous strategies to improve quality of service delivery at the health center level. The process of institutionalizing PHC standards in the majority of districts supported by USAID Ingobyi has been slow, and some health providers from health centers are not aware of the PHC standards and QI approaches.

During this quarter, USAID Ingobyi Activity supported the MoH to conduct a two-day orientation training with the aim of strengthening the capacities of HC staff to adhere to PHC standards for continuous quality management and improvement of services offered. The training was organized in six sessions, one for each district. Participants were MoH staff from HCs and DHUs in six Ingobyi-supported districts (Gasabo, Bugesera, Rwamagana, Ngoma, Gatsibo, and Nyagatare). HC managers or the acting focal person for QI at each HC were targeted for the orientation, while QI officers at the

hospital level were among facilitators. In total, 202 (81 females and 121 males) were trained, including health center managers and QI focal persons. The training was facilitated by the director of the health unit at the district level and the quality officer from the hospital. The content of the orientation included QI approaches, PHC standards, the composition of QI and IPC committees, as well as their roles and responsibilities. At the end of each session, participants committed to establishing QI and IPC committees by the end of January 2022, which that will lead to the adoption of the standards. The same orientation training will be expanded to other supported districts in the next quarter.

Build the capacity of hospital heads of departments and hospital managers to utilize quality improvement methodologies and develop QI projects

The QI process facilitates the identification of gaps in the health care system and prioritizes actions to address the core causes of major obstacles. During this quarter, Ingobyi Activity in collaboration with the MoH conducted a mentorship training on QI methodology and the development of QI projects for heads of departments, service unit managers, hospital senior leaders, and managers of four hospitals (Ngarama, Nyanza, Rwamagana, and Ruhango). The content of training included service delivery improvement approaches, problem identification strategies, QI project development, QI tools and techniques, change management, and leadership principles. This training strengthened the capacity of hospital staff in QI and increased their confidence in identifying service delivery gaps and supporting the development and implementation of QI projects. In total, 105 hospital staff (54 females and 51 males) attended the training and initiated QI projects aiming at reducing post-Caesarean section infections, birth asphyxia cases, and neonatal hypothermia cases. Ingobyi will follow up on QI projects initiated by the hospital and continue mentorship to support hospitals in meeting their targets.

H. Community Participation and Engagement

Savings groups

During this quarter, Ingobyi supported the savings groups formed in FY21 to ensure they continued to stand on a strong foundation, invest in profitable activities, and grow into confident businesses. Within the eight districts of Huye, Rubavu, Rutsiro, Bugesera, Nyagatare, Rwamagana, Ruhango, and Ngororero, Ingobyi Activity supported 79 savings groups with 1,531 members (1,190 females and 341 males), including: 376 teenage mothers, 252 persons living with disability or representing disabled family members, and 114 mothers of children with malnutrition-related problems. During monitoring and coaching visits, more emphasis was put on record-keeping, savings group management, saving and loans recording, shares and emergency fund recording, and loan repayment management. Together, the savings groups saved \$11,831.41 and a social fund of \$1,122.72. Ingobyi Activity is promoting the uptake of community-based health insurance among savings group members to ensure their access to health services and encourages renewal of health insurance in the next quarter.

Patient Voice Program-Citizen Voice and Actions

Patient Voice Program-Citizen Voice and Actions (PVP-CVA) is a citizen engagement approach that informs health facility leadership and districts on how the community views the services provided to them and the challenges, and offers citizens the opportunity to participate in efforts to improve service delivery. In quarter 1, Ingobyi Activity supported the formation and training of 22 PVP-CVA working groups with 436 members (256 males and 180 females) and facilitated 58 community-level scorecard meetings with 1,811 members (661 males and 1,150 females) to discuss barriers to health

care access. These barriers included negative provider attitudes, long waiting times, disrespectful provider behavior, lack of privacy, poor hygiene, and shortage of staff, among others. Additionally, 73 supported health centers were monitored as they implemented action plans developed during scorecard meetings to follow up on progress and positive changes in service delivery and care. Out of the 810 issues identified across 73 facilities, 562 (69.4%) were resolved, and the groups are working to address the remaining issues according to the action plans developed during the scorecard meetings.

I. Data demand and use

Data demand and use interventions implemented by Ingobyi Activity include the promotion of data quality, demand, and use at the community, facility, district, and central levels. Interventions conducted in quarter 2 included RDQAs, routine supportive supervision on data quality and use, hospital-to-health center coaching on data management, supporting facilities to identify and correct data quality issues in the HMIS including the *système d'information sanitaire communautaire* (SISCOM), and supporting the hospital M&E team and DHU to analyze and present data during quarterly coordination and DHMT meetings.

Conduct routine data quality audits

Ingobyi conducted RDQAs to improve the quality of the data collected and reported in the HMIS at hospitals and health centers in 20 supported districts. In this reporting period, the audit was conducted in 118 facilities. The health facilities were selected based on potential data quality and/or service delivery gaps identified through joint analysis of HMIS data with facility data managers and a review of data received from the MoH for reporting progress. The main purpose of the visits was to assess data quality and data use gaps at each facility and to provide guidance and capacity-building as needed. Each visit presented an opportunity for the Ingobyi team to hold open discussions with data managers, health center managers, and other health providers on data validation, SOPs for data management, the promotion of internal RDQAs, and the need for using data to improve service delivery and health outcomes. Table 15 summarizes findings from the RDQAs conducted.

Table 8: Key findings and actions from routine data quality audits

Strengths, gaps, and recommended actions from RDQAs to facilities	
Strengths	No shortage of RMNCH tools (e.g., registers, files) were observed; according to health providers who voluntarily participated in the DQA, feedback received was essential for improvement of data management and service provision; it was noted that in facilities where a DQA was conducted in quarter 4 of FY21, the discrepancy rate had decreased to below 5%; all visited facilities had proof of approved HMIS reports that had been sent to the next level on time; DQAs conducted by hospital data managers improved from focusing on accuracy only to considering other dimensions of data quality, like reliability, completeness of tools, integrity, consistency, and timeliness.
Gaps	A few health centers have large data discrepancies for audited data elements (pneumonia and diarrhea); internal data quality assessments, validation meetings, and data quality checks (for missing data or outliers) are not regularly conducted by some health facilities before the HMIS is locked; data discrepancies in the data reported in the HMIS were due to both counting errors and incompleteness of data collection tools; some health providers misunderstand some reported data elements; hospital data managers are too busy to follow up on the accuracy of data contained in the dashboard created by district health data analysts; the IMCI and GBV registers at some HCs are incomplete; new data managers are not familiar with HMIS reporting tools, use of the pivot table, and the WHO data quality tool.

Actions	Health center data managers were oriented on how an internal quarterly DQA is conducted; challenging data elements were explained using the draft of metadata dictionary under finalization and clinical protocols or guidelines; health facility data managers were supported to fill in the logbook for requesting data editing in the HMIS and advocacy efforts were made to unlock HMIS data for concerned health facilities to be able to correct discrepancies; in collaboration with an Ingobyi specialist, health providers were coached on how to complete IMCI and GBV registers.
----------------	---

Note: In quarter 2, the Ingobyi monitoring, evaluation, and learning (MEL) team will conduct RDQAs in the remaining facilities and will follow up in facilities where the RDQA was conducted in quarter 1 of FY22. The team will to ensure that data managers: conduct quarterly internal DQAs, data validation meetings, and monthly data quality checks before the HMIS is locked; use a pivot table and WHO data quality tool to check data inconsistencies and outliers and make corrections before the HMIS is locked; and use dashboards created by Ingobyi and discuss data quality issues with Ingobyi specialists, district-based mentors, and heads of services before editing in the HMIS.

Support health facilities to identify and correct data quality issues in the HMIS including SISCOM

In close collaboration with health facility data managers, the Ingobyi MEL team supports the identification of potential reported data quality issues and follows up on corrections during the HMIS reporting window. The objective is to ensure data quality issues are minimized before the database is locked, at which point data managers must deal with the long and difficult process of data cleaning a locked data set. Ingobyi is using the WHO data quality tool incorporated into the District Health Information Software (DHIS)-2 to quickly and efficiently check for outliers and missing values in data reported into the HMIS and SISCOM. Overall, 162 health facilities were identified as having reported at least one outlier, of which 148 were corrected (91%). For the 14 remaining health facilities, the logbook for requesting data editing in the HMIS was sent to the wrong person at MoH who did not have the authority to re-open the system. In fact, each province has a designated staff person with credentials for opening the HMIS for data editing. In quarter 2, Ingobyi will continue supporting facilities to identify and correct data quality issues in the HMIS and more focus will be placed on facilities with data quality issues not yet corrected. In addition, this practice is being promoted and shifted to data managers of supported hospitals to ensure timely data quality checks and correction.

Conduct supportive supervision on data quality and use for QI at hospitals and HCs

To improve data quality and use for QI in supported health facilities, Ingobyi’s MEL team conducted routine supportive supervision in 146 health centers and 25 hospitals. Ingobyi Activity moved from routine supervision to evidence-based supportive supervision. In quarter 1, the visited health facilities were selected based on gaps identified during internal data review meetings organized by the Ingobyi MEL team to discuss data received from the MoH for quarter 4 of FY21, reporting on progress and mentorship visits. The frequency and amount of support is guided by findings from the data review, and support is directed either to support improvement in data quality or in service delivery. Table 16 summarizes the findings at health center and hospital levels.

Table 9: Key findings and actions from supportive supervision on data demand and use

	Hospital	Health center
Strengths	Hospital data managers are conducting regular data analyses and making presentations in different health forums, including coordination and staff meetings; all hospitals are conducting internal data quality verification and data validation on a regular basis before the HMIS is locked; health data and service delivery gaps identified during data analysis are discussed during technical coordination meetings, district mentorship meetings, and DHMT meetings; findings from supervisions and the implementation status of recommendations are presented and discussed during coordination meetings, and actions are taken to mitigate identified gaps.	Some health centers are currently using electronic medical records in service delivery and reporting, which helps to easily aggregate and generate monthly reports; there were no shortages of data collection tools observed in this reporting period; the majority of health centers conduct data quality verification and validation regularly; data correction requests are sent to the MoH staff designated for opening the HMIS; health data and service delivery gaps identified during data analyses are discussed during community coordination and morning staff meetings.
Gaps	Medicalized HCs do not have an appropriate HMIS reporting format.	IMCI and GBV registers remain incomplete in some HCs; in health facilities using electronic medical records for service delivery, data managers do not have access for either data quality control or data reporting; a copy of the HMIS report is not kept by heads of services in most of HCs visited; some HCs are no longer conducting data review, verification, internal DQA, and validation meetings due to COVID-19 vaccinations; information on CBP-FP is not recorded in the FP client file in most HCs visited; analyzed data are lacking sound interpretation.
Actions taken	Ingobyi is advocating for putting in place its specific reporting form based on the defined health service package, by the next revision of HMIS reporting forms.	Ingobyi organized a feedback meeting with facility staff to discuss issues related to the incompleteness of IMCI and GBV registers, missing CBP-FP information, the importance of record-keeping, and data review and validation before the HMIS is locked; using suitable examples, data managers were coached on how to go beyond data and seek explanations; Ingobyi advocated to HC managers that data managers should have access to electronic medical records for data quality control; the schedule of services will be reviewed to ensure that COVID-19 vaccinations are not hampering other activities.

Note: In quarter 2, the Ingobyi MEL team will continue supervision at the remaining health centers and at least two health posts per district and will conduct follow-up on implemented recommendations in visited facilities visited, specifically assessing the completeness of IMCI and GBV registers and recording CBP-FP information in the FP client file and conducting data quality control for facilities using electronic medical records.

Data management coaching

In this reporting period, Ingobyi continued to support hospitals to deliver coaching on data management, with the aim of building the capacity of health center data managers and health providers to address their own data quality and data use gaps. As per Ingobyi guidance, coaching at

the health center is done by hospital data managers, while validation is done by the Ingobyi MEL team. The data management coaching supported by Ingobyi focuses on seven data management competencies: documentation and reporting, data validation procedures, internal DQA and data cleaning, data analysis and interpretation, DHIS2 (data analysis and visualization), Excel (data analysis, visualization, and performance monitoring through dashboards), and tracking of QI projects. In quarter 1, 98 health centers were reached by coaching activities. Health centers were selected based on data quality gaps flagged during monthly HMIS data quality verifications and on findings from previous visits. Figure 21 below summarizes scores obtained by coached HC data managers in this reporting period and the percentage of those validated.

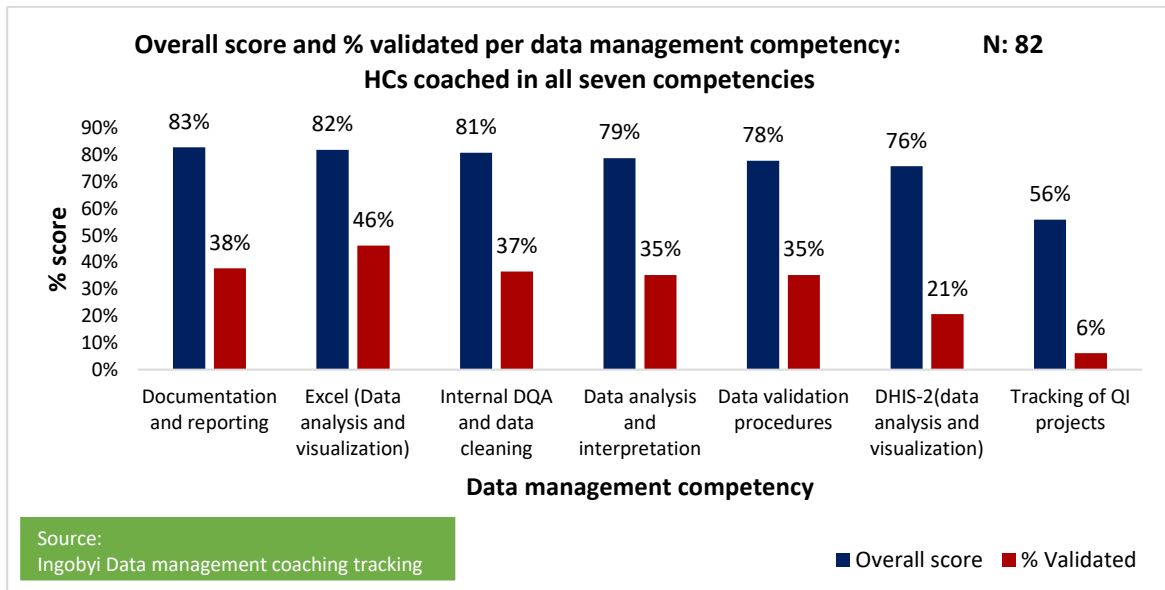


Figure 21: Overall score and % validated per data management competency

Among the 98 coached health centers; 84% (82) were coached on all seven defined data management competencies; the rest were coached on some components. Coached data managers performed better on documentation and reporting (83%); the lowest performance was recorded on tracking QI projects (56%). With the adopted benchmark for validation being $\geq 90\%$ for each competency, a high number of data managers were validated in Excel data management and visualization, while tracking QI projects had the lowest number of data managers validated. It was noted that the lack of an orientation on QI was the main cause of this low score on tracking QI projects. In quarter 2, Ingobyi will continue supporting hospital-level data managers to conduct data management coaching for the same cohort until they are all validated on all topics.

Supporting hospital M&E teams and DHUs to analyze and present data during quarterly coordination and DHMT meetings

As per MoH guidance, hospitals must conduct monthly coordination meetings for the health facilities in their catchment areas to discuss progress and challenges and to address gaps in service delivery. In addition, districts must conduct quarterly DHMT meetings to discuss the management and coordination of health services. These meetings are attended by district leaders and decision-makers, including vice mayors of social affairs, hospital directors general, DHU directors, district health promotion officers, directors of district pharmacies, and Rwanda Social Security Board and health center representatives. The forums provide opportunities to continuously inform decision-makers on the performance of key health indicators and to encourage them to address observed service delivery

issues. The Ingobyi MEL team provided technical assistance in analysing data and preparing a PowerPoint presentation for these meetings to ensure that the data analysis, visualizations, and interpretations were sound, such that decision-makers could make decisions based on evidence. In this reporting period, the Ingobyi MEL team worked with hospital-level data managers to generate data for key indicators to be presented during coordination and DHMT meetings, then supported the data manager to develop a PowerPoint presentation. In total, 22 PowerPoint presentations were prepared for technical coordination meetings and four for DHMTs meetings. Data presented included service data for RMNCH, malaria, GBV, referrals, community health, IPC, and epidemic diseases such as COVID-19. During the meetings, hospital data managers made presentations, and there was deep discussion on health data (progress, gaps, and status of implementation of recommendations from the last meeting). Moreover, the meetings provided an opportunity to review health-related data against the district targets, discuss progress made in service delivery, agree on root causes of observed issues in service delivery and data quality, and agree on a plan for improvement. All discussions and actions taken aimed at increasing health indicator performance, increasing the quality of service delivery, improving data quality, and encouraging ownership of routine data reviews. Ingobyi uses the findings from these meetings to provide continuous, customized support to facilities in implementing identified actions as part of routine supportive supervision and mentorship.

J. Learning agenda

Ingobyi Activity initiated a series of learning activities focused on various technical aspects of RMNCH and malaria to inform necessary changes or improvements in the quality of services and interventions. Below is a summary of progress made on each learning activity during the reporting period.

Determine the reach and acceptability of SBC messages

The survey aims to assess the effect and outcomes of key SBC interventions related to RMNCAH and malaria services, particularly messages disseminated to targeted populations through radio, community outreach, and health education sessions at health facilities. This survey followed a quick formative qualitative survey conducted in FY20 to assess the relevance of messages and inform needed adaptations. This study determined the population exposure to RMNCH and malaria SBC messaging and access to services, sources of information, knowledge, attitudes, and practices about RMNCH and malaria prevention and treatment and the acceptability of SBC messages. Data have been collected and analyzed. A first draft of the survey report was shared with Ingobyi technical staff for review, input, and suggestions, and the final report is expected by end of January 2022. As part of the learning, the Ingobyi team has conducted a further analysis on the effect of SBC interventions on maternal and newborn health; a research manuscript is available. The team intends to disseminate the results through MoH TWGs, district partners, and journal publication.

Impact of integrating IPC on provider compliance

This learning aims to assess the impact of integrating IPC into the mentorship model to improve health provider IPC knowledge, improve compliance with protocols, and reduce practice gaps and related hospital morbidities and mortalities. As part of this learning, the Ingobyi team completed data collection, data analysis, and produced a draft manuscript on the predictors of compliance to hand hygiene among health workers; a research manuscript is available. The team intends to disseminate the results through MoH TWGs, district partners, and journal publication.

Effectiveness of eLearning in training CHWs

This learning activity aims to assess the use of eLearning to continuously improve the knowledge and skills of CHWs on community-based maternal and neonatal health using smartphones and digital learning courses. During the pilot of the eLearning platform, Ingobyi Activity conducted a study including 36 CHWs. All pilot participants (100) took pre- and post-tests for two eLearning courses (CBMNH and ICCM), and study participants also took the same assessment six months after the pilot concluded to determine if they had retained information from the eLearning courses. The study suggests that smartphone-enabled refresher trainings of CHWs is effective in improving their knowledge and skills. The average score increased from 86.48% in the pre-test to 98.20% in the post-test, with a mean difference of 11.7%. The team intends to disseminate the results through MoH TWGs, district partners, and journal publication. However, further studies are recommended to explore the feasibility of scaling up these interventions.

Assess missed opportunities in identifying pregnant women in OPDs and other services

This study aims to identify missed opportunities in OPD-ANC linkage to improve referral procedures for pregnant women attending lower PHC facilities in Rwanda. The newly developed and disseminated referral documents will be used to document internal referrals. Ingobyi Activity is supporting a Master of Public Health student to collect, analyze, and document the results of this study. Protocol development is complete, and results are expected in quarter 2 of FY22. As part of the learning, Ingobyi will conduct an additional study to assess the rates of compliance with, and barriers to providing, the recommended package of services for first-time ANC clients at selected health facilities supported by USAID Ingobyi Activity. Data collection is underway. A research report and manuscript for potential publication are expected in quarter 3 of FY22.

Effectiveness of clinical mentorship in improving obstetric and neonatal health care services

The study will assess determinants of maternal near-misses in mentored district hospitals in Rwanda. Specifically, we will assess the characteristics, process indicators, and protective factors related to quality of care among pregnant/childbearing women managed as maternal near-misses in mentored district hospitals. Protocol development is complete, and results are expected in quarter 2 of FY22.

Follow-up of at-risk babies to inform PNC service improvement

The implementation of PDC activities started in quarter 4 of FY21; Ingobyi will analyze and document results to inform the scale-up of this intervention to other districts. The learning will assess the survival outcomes of high-risk infants in Musanze and Rutsiro districts, where PDC is implemented. Protocol development is complete, data will be collected in quarter 2, and data will be analyzed in quarter 3. A manuscript with results will be available in quarter 4 of FY22.

Determine the effectiveness, efficiency, and feasibility of mentorship at health posts

This learning project will explore the feasibility of clinical mentorship at health posts in Nyanza District. Data analysis is underway, and results are expected by the end of quarter 2 in FY22.

Support Rwandan postgraduate students' research through operational research grants in maternal, newborn, and child health

To generate evidence and actions to improve the quality of RMNCH and malaria services and also to build the capacity of health professionals to conduct operational research using routine program data, USAID Ingobyi Activity launched a call for applications to provide small research grants of up to \$5,000. The grants support targeted studies by postgraduate students selected from medical and public health institutions in Rwanda. Four postgraduate students were selected to conduct research in Ingobyi-supported facilities on the following topics: factors associated with respectful maternity care during labor and childbirth at Kabutare and Kibagabaga hospitals; missed opportunities in ANC to improve internal referral linkages within health centers of the Rwamagana hospital catchment area; IPC in health care facilities—knowledge and practices assessment among health workers at Kibagabaga District Hospital; and factors associated with labor companionship at Kacyiru and Remera Rukoma Hospitals.

All student researchers have completed protocol development and have secured the required ethical approvals from their respective universities. Data collection and analysis are planned for quarter 2 of FY22, and manuscripts with results will be available in quarter 3.

K. District-level support

To optimize the performance of the district health system and allow it to appropriately respond to RMNCH and malaria needs, USAID Ingobyi Activity supports the districts to improve the system's functionality across its defined roles and responsibilities, which include planning, monitoring, and evaluation; coordination and supervision of decentralized health systems; community participation; and health resource management. The following paragraphs outline support provided to the districts.

Support districts to organize and conduct quarterly mentorship and facility coordination meetings

Ingobyi Activity supported ten districts to conduct quarterly health facility mentorship and health coordination meetings that bring together DHU members, hospital leadership, health center managers, and district-based mentors. The meetings are conducted over two days. The first day is dedicated to discussing the progress of clinical mentorship in the districts and serves as an opportunity for mentors to update themselves on specific technical competencies, new protocols, and QI methodologies, as well as harmonize mentorship tools and get updates on their use. Recommendations from mentors' coordination meetings are presented to district and facility leaders' technical coordination meetings, which is conducted on the second day. The technical coordination meeting serves as an opportunity to review health-related data against the district targets, discuss progress made in service delivery, and find solutions for the root causes of observed issues in service delivery. Key data/service areas discussed included RMNCH, malaria, gender, referral systems, IPC, and epidemic diseases, such as COVID-19. The coordination meetings are an opportunity to resolve challenges or problems mentioned in the mentorship coordination meetings, identify actions to address them, and support implementation of recommendations to improve service quality. In total, 943 individuals (493 males and 450 females) including 513 health providers and 430 other district-level participants attended the meetings. Ten districts did not manage to conduct the quarterly mentorship and coordination meetings due to COVID-19 prevention measures, restrictions, and vaccination activities. The identified critical services and areas that needed a response from the districts, the RBC, and the MoH were reported to the DHUs; after discussion, recommendations were

submitted to the district executive committee (composed of the mayor, vice mayors, and district executive secretary).

Development of joint annual health action plans and monitoring implementation

To achieve its goal of contributing to the reduction of infant and maternal mortality in Rwanda, in quarter 1, Ingobyi, in collaboration with the MoH, supported health planning sessions in three districts, Musanze, Ngororero, and Rubavu. During planning activities, RMNCH and malaria indicators were reviewed by the participants from the DHUs, hospitals, HCs, and health posts; new plans and targets were developed from the existing districts' and health facilities' strategic plans. One of the achievements of the planning process was the review of the plan to distribute ultrasound echography machines donated to the district and how they would be used to reduce maternal and newborn deaths common at Bigogwe medicalized HC and at other health facilities.

DHMT quarterly meetings

Ingobyi Activity supported Nyanza, Kicukiro, Muhanga, Ngororero, Gatsibo, Kamonyi, Bugesera, and Rubavu districts to conduct quarterly DHMT meetings. The team supported DHMT members to prepare for the meetings and establish agendas, attended the meetings, and made technical contributions to the discussions. The local elections held in mid-October 2021 ushered in new DHMT members, particularly in the position of vice mayor of social affairs, who plays a critical role as the leader of the DHMT. Therefore, the Ingobyi team took advantage of the quarterly meetings to orient the new members on their role with respect to managing district health programs, in line with the new district health guideline developed and approved in 2018 by the MoH. The Ingobyi team used the occasion to conduct an orientation training (for the new members), and a refresher (for those already in position) on how to apply the DHMT planning and management tool and to understand its utility in assessing DHMT performance. Due to the election season and repeated mass COVID-19 vaccination campaigns, several planned DHMT meetings were postponed. The DHMT meetings are used as an opportunity to review health-related data, including data on RMNCH and malaria, and discuss health indicators related to RMCH, such as ANC, FP, teenage pregnancies, home deliveries, maternal and newborn mortality cases, and malaria services, among others. DHMT members also review the status of health services delivery at health facilities and in the community, as well as COVID-19 preparedness and response measures in their districts.

Actions taken by DHMTs have produced tangible results, including some reported for this quarter. For instance, in Gicumbi District, the DHMT has increased oversight of district budgets by closely reviewing reports and discussing progress with health facility staff. In Muhanga, the DHMT successfully advocated for the purchase of an additional ambulance using funds reallocated from other district projects. The Huye DHMT mobilized funds from district partners to purchase motorcycles that are currently used to transport COVID-19 vaccines to remote vaccination sites.

Support the Joint Action Development Forum

USAID Ingobyi Activity supported nine JADF meetings attended by 252 participants (183 males and 69 females) from Kicukiro, Gicumbi, Kamonyi, Nyanza, Rwamagana, Gatsibo, Nyagatare, Musanze, and Rubavu. JADF is a platform that coordinates development partners and their activities at the district level. The JADF meetings discuss social, economic, and development challenges that affect their districts, including challenges faced by the health sector. Key recommendations and actions are

generated, and follow-up is done by respective sector leaders. Ingobyi Activity's zonal teams attended the meetings and provided project updates. Ingobyi also used the opportunity to present key challenges facing health facilities, such as staffing, equipment, and infrastructure issues, among others, and appealed to district leadership to prioritize addressing these challenges in their annual plans.

4. Collaboration with USAID Implementing Partners and Other Stakeholders

Ingobyi/Rwanda Integrated Health Systems Activity collaboration

In quarter 1, Ingobyi attended a five-day Rwanda Health Application Platform (RHAP) training of trainers organized by RIHSA. Within the framework of collaboration with RIHSA, Ingobyi is expected to support rollout of the RHAP at district and hospital levels. The training included: how to navigate the platform and how to use its main features, which include analysis (settings, calculation, and filter results), dashboards, data quality, and alerts. At the end of the training, a plan for RHAP rollout at district and hospital levels was developed, which is expected to happen in the next quarter. The suspension of HMIS access credentials remains a challenge for Ingobyi, as only MoH staff with HMIS credentials can access the RHAP. Ingobyi will continue to work directly with facility data managers to routinely review data and identify and address data quality issues, providing technical support as necessary.

USAID Ingobyi Activity collaborated with RIHSA and MOMENTUM Country and Global Leadership to prepare a presentation for, and participate in, a two-day Respectful Care Learning Exchange workshop organized by USAID headquarters. Ingobyi and RIHSA co-presented on the status of respectful care/respectful maternity care (RC/RMC) in Rwanda at national and service delivery levels, as well as systems of redress and accountability, monitoring, and community engagement. Ingobyi, RIHSA, and MOMENTUM Country and Global Leadership, in collaboration with the RBC, are planning to conduct a workshop for MCH stakeholders to discuss gaps identified in this area and develop a clear action plan to close those gaps.

Parliamentary advocacy and partnership

Ingobyi Activity has a seconded staff at the Rwandan Parliament who serves as a liaison to parliamentarians and advocates on resolutions regarding RMNCH and malaria issues, coordinates capacity-building efforts for members of parliament, and provides technical assistance in organizing parliamentary discussion sessions on RMNCH and malaria.

During this quarter, Ingobyi supported the preparation of and participated in a one-day member of parliament capacity-building activity entitled "*Parliamentarians as think-tank, catalysts and mobilizers on socio-economic transformation issues*," held on October 22, 2021. Among the resolutions were the new parliamentary network/forum reforms to abide with the new parliamentarians' roles as think-tank members, catalysts, and mobilizers.

In addition, Ingobyi coordinated preparations for and participated in the 2021 Network of African Parliamentary Committees of Health annual meeting. This two-day virtual meeting gathered

parliamentary members from different African countries, who discussed the parliamentary roles in accelerating progress and the unfinished agenda of the ICPD and SDGs , as well as the potential of emerging health technologies for tackling health challenges in Africa during and after the COVID-19 pandemic period.

Lastly, a delegation of members of parliament, supported by Ingobyi, participated in an advocacy event organized by the National Union of Disability Organizations in Rwanda to launch a five-year program dubbed “Make a Way” whose main objective is ensuring access to more inclusive SRH services, especially for young people with disabilities. This one-day meeting was held on November 29, 2021.

5. Implementation Challenges

Increased workload due to mass COVID-19 vaccination campaign

Many health providers, including mentors, mentees, data managers, and district officials were shifted to mass COVID-19 vaccination activities, which led to insufficient time for mentorship and a decreased rate of mentees validation. Data managers were overloaded with data entry during this COVID-19 vaccination period, which has hampered some other crucial data management functions, such as conducting data quality assessments, data quality checks, data analysis, and data management coaching activities. In addition, some facilities turned FP service delivery rooms or youth corners into COVID-19 vaccination spaces, which reduced privacy and confidentiality during service provision. Ingobyi discussed these concerns with health facility management, proposing to use afternoon hours to support mentorship and supervision activities and to reorganize staffing and work schedules to minimize the impact of the additional workload on the quality of health services.

Turnover and frequent rotation of health providers

Staff turnover and/or frequent rotation in health facilities is a major hindrance to QI, service delivery, and capacity-building efforts. Inconsistent availability of mentees remains a continuing hindrance to capacity-building efforts, and Ingobyi has had to continually enroll new mentees to replace those who leave or are deployed to other units. To address this challenge, Ingobyi Activity continued to advocate with district and hospital authorities for increased staffing and reduced frequency of rotation to enable existing health facility staff to fully benefit from ongoing capacity-building opportunities.

Equipment and commodity shortages

Shortages of equipment at some health facilities and stockout of some commodities continue to hamper the delivery of quality maternal and newborn services. Ingobyi continued to advocate with hospital and district leadership to consider prioritizing these items in their annual budgets and to ensure a continued supply of required commodities. Ingobyi Activity also raised these concerns with the MoH and requested attention and action to resolve them. The ongoing procurement of limited lifesaving MCH equipment through the USAID Global Health Supply Chain Program, implemented by Chemonics, will somewhat alleviate this problem, though delivery of the equipment is long overdue.

6. Lessons Learned

Providing CRH services during weekend days boosts the use of these services by adolescents

In previous project years, Ingobyi invested in improving the functionality of youth corners established at the health center level. However, in Rwanda, most adolescents are students and can only visit youth corners during weekends and holidays. In FY22, Ingobyi supported health centers to open and provide CRH services during the weekends. Ingobyi learned that in a country like Rwanda, the provision of CRH services during weekend days increases adolescents' use of youth corners and associated services.

Routinely presenting facility data to health providers leads to reduced reporting errors

Previous efforts to reduce data quality errors were focused on routine data quality audits and capacity-building of data managers. However, less effort was expended for health providers, who normally are the ones documenting care, aggregating information in registers, and conducting initial counting and reporting of health indicators. In its effort to increase data use and demand among facility-level care providers, Ingobyi initiated routine monthly data presentations to facility staff within their departments and units. This was a golden opportunity for providers to learn how the data they produce can be used to understand gaps in service delivery and facilitate improvement in care. Ingobyi learned that these presentations improved ownership, boosted performance on health indicators, and reduced reporting errors.

7. Short-Term Technical Assistance

Jennifer Wesson, a US consultant, traveled to Rwanda in October to conduct Ingobyi Activity's mid-term evaluation. The consultant conducted interviews with key health sector stakeholders, including at the MoH and RBC, among others. The mid-term evaluation report is expected next quarter.

8. Activities Planned for Quarter 2 of FY22

The following activities, organized by technical areas, are planned for quarter 2 of FY22.

Family planning

- Conduct outreach activities at health centers to increase access to permanent FP methods (tubal ligations and no-scalpel vasectomies).
- Provide needed FP kits to supported health facilities.
- Support two youth-led organizations to implement youth-centered innovations.
- Conduct supportive supervision of health facilities.
- Support district-based mentors to conduct mentorship in the health centers.
- Conduct quarterly FP compliance monitoring visits to supported facilities and communities.
- Train health providers on FP methods using the LDHF approach.

Adolescent and youth sexual and reproductive health

- Provide health centers with essential materials needed in youth corners (TV screens and accessories).

- Reinforce CRH messages among youth through social media platforms and at health facilities.
- Support health centers to provide CRH services during weekends.
- Continue implementation of youth-centered innovations and initiatives.
- Conduct the ASRH national coordination meeting.
- Train health providers on the new adolescent health module.

Maternal health

- Conduct trainings for hospital-level health providers on EmONC.
- Conduct trainings for HC-level providers from ten districts on EmONC.
- Organize fistula screenings and support repair sessions at an already established repair center.
- Train obstetricians/gynecologists in fistula repair.
- Supervise hospital-level mentorship and supportive supervision by professional associations (RSOG and RAM).
- Conduct routine monitoring and supportive supervision to ensure district-based mentors deliver quality mentorship and conduct LDHF trainings on required standards and protocols.
- Support the supervision of health posts in ANC and maternity services.
- Support district-based mentors to conduct mentorship and LDHF trainings at health centers.
- Conduct district mentorship coordination meetings to discuss mentorship progress and delivery of RMNCH and malaria services.
- Support implementation of clinical mentorship from health center to health posts in Nyanza District.
- Support the design and printing of the Rwandan national version of the pregnancy wheel.
- Support the printing of MNH tools for the supported districts.
- Support the procurement of lifesaving equipment.

Newborn health

- Support mentorship on nursing care, nurturing care, and family-centered care in neonatal units.
- Extend neonatal nurse mentorship to the remaining 18 facilities not yet covered.
- Train the remaining staff from six high-volume hospitals to ensure that all neonatal health workers are trained on the national neonatal protocol 3rd edition.

Child health

- Participate in national TWGs related to RMNCH.
- Support district-based mentors to conduct mentorship in health centers.
- Conduct supportive supervision of health facilities.
- Support the RPA in conducting clinical mentorship and supportive supervision at 26 hospitals.
- Train new providers at the hospital level in child health.
- Train health providers working in pediatric and emergency wards from eastern and western zone facilities on ETAT+.
- Train health center-level providers from ten districts on IMCI and the Integrated Management of Childhood Illness Computerized Adaptation and Training Tool.
- Support PDCs implemented in Musanze and Rutsiro districts and follow up with Partners in Health on the GMCD training of trainers for PDC mentors.
- Support the MCCH Division to conduct the national IMCI health facility survey.

- Analyze and present findings of the IMCI survey to health facility leaders and providers, and provide technical support to address identified gaps.

Social and behavior change

- Conduct a training of teachers in Nyagatare District.
- Conduct training of in-school and out-of-school youth from Nyagatare, Gatsibo, and Musanze districts on CRH and peer education.
- Conduct quarterly integrated outreach activities focused on RMNCH and malaria prevention in hard-to-reach communities.
- Conduct a five-day workshop to update SBC messages and approaches on RMNCH; gender; IPC; epidemic-prone diseases, including Ebola virus disease and COVID-19; and malaria services based on results from the SBC assessment.
- Conduct parent-adolescent communication sessions in the community.
- Produce at least 20 weekly *Urunana* radio soap opera episodes, to be broadcast on Radio Rwanda and Radio10.
- Produce and broadcast five *Umuhoza* radio magazines focusing on RMNCH, COVID-19, and malaria.
- Produce 12 radio sketches to be broadcast on seven community radio stations.
- Ensure 12 radio mentions will be broadcast on Radio KISS FM.
- Conduct seven radio talk shows on community radio stations.
- Conduct one content review workshop and one long-term storylining workshop for the *Urunana* soap opera in March 2022.
- Conduct one audience surveillance activity in the western zone in February 2022.

MPCDSR

- Conduct supportive supervision of MPCDSR in hospitals.
- Disseminate findings of the confidential inquiry into perinatal and maternal deaths.
- Conduct peer learning workshop with hospitals MPCDSR committees.

Infection prevention and control

- Conduct mentorship and supportive supervision to ensure compliance with IPC standards (including disease outbreaks/epidemic prevention) at supported hospitals and health centers.
- Facilitate QI projects at supported facilities, focusing on those identified as having poor IPC practices.
- Carry out environmental swabbing at 26 supported hospitals.
- Conduct 16 radio talk shows on one national and five community radio stations.
- Continue to conduct supportive supervision at COVID-19 vaccination sites.
- Continue to develop national IPC guidelines, SOPs, and training materials.

Gender integration

- Conduct supportive supervision to IOSCs from supported districts in collaboration with the RBC and Kacyiru Referral IOSC.
- Provide technical and financial support to IOSCs to conduct supportive supervision to HCs in their catchment area.

- Provide technical and financial support to IOSCs to finalize HC trainings in the remaining 15 hospital catchment areas.
- Provide technical and financial support to IOSCs and HCs to conduct GBV victim follow-up through home visits and group therapy sessions.
- Support the 20 supported districts to organize quarterly linkage meetings with stakeholders working in GBV response.
- Work with existing community mechanisms (e.g., friends of families) to sensitize families on GBV prevention, speaking out about GBV, and challenging social norms that perpetuate GBV.
- Collaborate with SBC team to engage couples' champions to support male involvement in RMNCH and the prevention of intimate partner violence.

Referral systems

- Print additional standard transfer forms for facilities in the 20 supported districts.
- Provide technical support to the MoH to finalize HC-level patient transfer protocols and regulations aligned with the integrated national health sector referral guidelines.
- Support the MoH to disseminate new referral tools (approved transfer forms and integrated national health sector referral guidelines).

Malaria prevention and treatment

- Continue supporting malaria supportive supervision activities at the facility level.
- Support CEHOs from the 20 districts to conduct quarterly supportive supervision visits of CHWs to strengthen ICCM and HBM services.
- Train cell coordinators from five districts on the use of supervision tools, interpretation of community data elements, and community drug requisition forms.
- Train CEHOs from Nyanza District on the updated/revised comprehensive community health package.
- Support CHWs' coordination meetings to discuss RMNCH and malaria indicators and services.
- Facilitate community mentors to conduct quarterly community health mentorship in Ingobyi-supported districts.
- Conduct a multi-stakeholder workshop to share lessons learned from the eLearning pilot testing phase.

Quality improvement

- Train Nyanza health post mentors and health providers on the development and implementation of QI projects.
- Support the MoH to disseminate PHC accreditation standards for RMNCH in the remaining 14 districts.
- Support five hospitals that did not achieve level 1 of accreditation standards to develop missing policies and procedures.
- Conduct QI supportive supervision.

Health system strengthening

- Collaborate with RIHSA in the rollout of RHAP to districts and hospitals.
- Continue conducting RDQAs and supportive supervision.

- Continue supporting data management coaching in the same cohort of 98 HCs coached in quarter 1 of FY22.
- Train health center providers and new data managers on data management and QI.
- Continue supporting health facilities to identify and correct data quality issues in the HMIS including SISCOM.
- Provide technical assistance to hospital M&E teams and DHUs to analyze and present data during quarterly coordination and DHMT meetings.
- Support the MoH/RBC to conduct the annual facility assessment.

Data use and demand

- Support the MoH to develop and/or update documentation related to the HMIS.
- Support the MoH to develop national guidelines for the district coordination meeting.
- Support the MoH-HMIS unit to map, link, and clean the HMIS data element names.
- Support the MoH/RBC to revise HMIS reporting forms to reflect recent changes in programs.
- Conduct RDQAs and supportive supervision in health facilities to improve data quality and use for planning and decision-making.

Learning agenda

- Continue conducting the initiated series of learning activities focused on various technical aspects of RMNCH and malaria.
- Disseminate mid-term evaluation and SBC study results.

District support

- Continue supporting districts to organize quarterly coordination meetings.
- Support DHMT quarterly meetings.
- Support DHMT supervisions in supported health facilities.
- Support JADF activities based on need (general assembly, open days, and JADF evaluation).
- Organize JADF meetings.

Community engagement

- Conduct CVA trainings in selected HCs.
- Facilitate and support community scorecard meetings.
- Conduct supportive supervision/monitoring in previously trained HCs to track progress on action plans developed for identified service delivery gaps.
- Facilitate income-generating activities and conflict management trainings in Gatsibo, Gicumbi, Bugesera, Nyagatare, Rwamagana, and Ruhango.
- Conduct campaigns among savings groups increase uptake of community-based health insurance (*Mutuelle de Santé*).

9. Management and Administration

Ingobyi Activity's senior management and support teams at IntraHealth headquarters continued to ensure the effective implementation of approved FY22 workplan activities and the efficient administration of the award. Ingobyi replaced two staff who resigned during the quarter.

Personnel recruitment

Two staff members, a DHMT functionality technical advisor and an informatics and data use advisor, were recruited to replace previous incumbents who had left Ingobyi Activity for other opportunities. One logistics officer was dismissed for poor performance. The total staff head count at the end of the quarter was 147, including 124 IntraHealth and 23 partner staff.

Sub-award management

Ingobyi Activity worked with eight sub-awardees during the quarter—five nongovernmental organizations and three medical professional associations—and continued to provide technical support to them through routine sub-grant monitoring. Ingobyi finance and grants staff conducted site visits to review financial and programmatic documents to ensure compliance with USAID and IntraHealth policies and procedures. During these site visits, the team reviewed and verified supporting documents and financial and cost share reports submitted by sub-grantees to IntraHealth.

Cost share tracking and documentation

Ingobyi Activity's cost share commitment is \$4,857,602. The total cumulative cost share contributed to date is \$9,156,648, which surpasses the life of program commitment. Though additional cost share contributions were collected this quarter, analysis and approvals had not been completed by the end of the reporting period. The cost share will be reported in quarter 2. The bulk of the cost share is derived from in-kind contributions made by the GoR, as well as through health work force labor, including CHWs.

10. Annexes

A. Indicator performance table

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
Goal: Reduction in maternal and infant mortality in Rwanda, as well as increased self-reliance of the GoR											
GO-1	Institutional maternal mortality ratio (per 100,000)	Impact	DHIS2	Annual	161	89	N/A	N/A			
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%	36.6%	36.6%	42.1%	15.0%	115%	In this FY, Ingobyi introduced focused support to facilities to improve ANC visit planning; and track planned visits as well as missed visits; coupled with engaging CHWs for home visits of those whose appointment dates are due and overdue . This is in addition to continuous dissemination of SBC messages around ANC visits.
IR-1.2	Percentage of pregnant women who attend 1st ANC visit during 1st trimester	Outcome	DHIS2	Quarterly	35%	45.6%	45.6%	49.8%	9.0%	109%	
IR-1.3	Number of children under 5 tested for malaria at the community level	Outcome	DHIS2	Quarterly	386,722	186,824	46,706	57,450	23.0%	31%	The number of children who consulted for malaria increased due to improved availability of community health services. Ingobyi Activity also built the capacity of CHWs through training, supportive supervision and mentorship. This strengthened confidence and skills in managing malaria cases at the community level. Also, malaria SBC interventions increased early care-seeking behavior for malaria. Besides, there was no major stockout of malaria commodities reported at the community level.
IR-1.4	Number of malaria cases in pregnancy	Outcome	DHIS2	Quarterly	21,358	7,319	1,830	1,099	-39%	15%	Prevention of malaria in pregnancy is one of Ingobyi's major areas of support to the national malaria program. The decrease in number of malaria cases in pregnancy could be explained by the availability of interventions like IRS in selected districts. In addition, malaria district level supervisors focused on malaria prevention measures, such distribution of LLINs to pregnant women during ANC and early seeking of care among pregnant women. Malaria prevention in pregnancy was also strengthened by focused malaria SBC

¹⁰ Deviation from the target is calculated by subtracting the result from the target, then dividing by the target

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
											activities implemented in all Ingobyi-supported districts.
IR-1.5	Number of women who received surgery for fistula repair	Outcome (3.1.6-Z02)	DHIS2	Annual	104	95	N/A	N/A	N/A		
IR-1.6	Number of people reached by a U.S government funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Output (GNDR-6)	DHIS2	Annual	16,313	15,102	N/A	N/A	N/A		
IR-1.8	Number of USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year	Output (HL7.2-2)	Ingobyi records	Annual	16,314	28,516	N/A	N/A	N/A		
IR-1.9	Number of new users of FP methods	Outcome	DHIS2	Quarterly	254,127	348,928	87,232	90,177	3.0%	26%	
IR-1.10	Proportion of facilities offering both short-term FP methods and LARCs	Outcome	Ingobyi records	Annual	81%	81.0	N/A	N/A	N/A		
IR-1.11	Percent of USG-assisted service delivery sites providing family planning counseling and/or services	Outcome HL.7.1-2	Ingobyi records	Annual	100%	100.0	N/A	N/A	N/A		
IR-1.12	Number of children under five (0-59 months) reached by nutrition-specific interventions through USG-supported programs	Output (HL.9-1)	DHIS2	Quarterly	1,607,344	2,547,954	636,989	809,422	27%	32%	In this reporting quarter, Ingobyi supported MCH week during which 204,307 children under five were screened for malnutrition. In addition, to strengthen linkages and expand services, nurses from the health facilities together with CEHOs conducted community health mentorship and supportive supervision, which increased the capacity of CHWs in screening/reporting and early referral of identified cases.
IR-1.12	Estimated potential beneficiary population for maternal, newborn and child survival program: number of live births	HL.6-1	DHIS-1	Annual	217,841	212,157	N/A	N/A	N/A		
Sub-IR 1.1: Increased availability of RMNCH/malaria services											
IR-1.1.1	Number of mobile outreach events conducted to provide integrated health services to hard-to-reach, vulnerable communities	Output	Ingobyi records	Annual	N/A	40	N/A	N/A	N/A		
IR-1.1.2	Percentage of health centers that provide youth-friendly services	Output	Ingobyi records	Annual	N/A	80%	N/A	N/A	N/A		
Sub-IR 1.2: Improved healthcare-seeking behaviors for RMNCH/M services											

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
IR-1.2.1	Percentage of births registered taking place at a facility	Outcome	DHIS2	Annual	97%	> 97%	N/A	N/A	N/A		
IR-1.2.2	Number of small grants awarded to young people for innovative proposals	Output	Ingobyi records	Annual	N/A	2	N/A	N/A	N/A		
IR-1.2.3	Cust: Number of individuals in the target population reporting exposure to USG funded Family Planning (FP) messages through/on radio, television, electronic platforms, community group dialogue, interpersonal communication or in print (by channel/# of channels)	Output	SBC data	Annual	N/A	1,920,736	N/A	N/A	N/A		
IR-1.2.4	Percent of audience who recall hearing or seeing a specific USG-supported family planning/reproductive health (FP/RH) message	Output (HL.7.2-1)	SBC evaluations	Annual	N/A	80%	N/A	N/A	N/A		
IR-1.2.5	Percent of individuals who adopted a family planning method as a result of participation in integrated health services to hard-to-reach, vulnerable communities.	Outcome	Outreach events reports	Annual	N/A	20%	N/A	N/A	N/A		
Sub-IR 1.3: Strengthened referral linkages for RMNCH/malaria services between, and across, different services and levels of service delivery											
IR-1.3.1	Proportion of mothers in labor referred to higher level for delivery with known outcome	Outcome	Facility registers	Annual	N/A	68%	N/A	N/A	N/A		
IR 2: Improved quality of RMNCH/M services along the continuum of care in targeted districts											
IR-2.1	Number of women giving birth who received uterotonics in the third stage of labor (or immediately thereafter) through USG-supported programs	Output (HL 6.2-1)	DHIS2	Quarterly	172,599	210,954	52,739	53,063	0.0%	25%	
IR-2.2	Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Output(H6.3-1)	DHIS2	Quarterly	5,813	6,553	1,638	1,412	-13.0%	22%	Despite an observed reduction in the number of newborns not breathing at birth who were resuscitated; the rate of successful resuscitation continued to increase. As of this quarter, USAID Ingobyi results accumulated an increase of 18 percentage points from the project quarterly baseline. Ingobyi Activity put much effort on labor monitoring, referral systems and QI initiatives that focused on the prevention of perinatal asphyxia. All support was delivered through district-based mentorship and supportive supervision. The reduced number of newborns resuscitated newborns is a

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
											reflection of the overall reduction in number of births during the quarter.
IR-2.3	Number of Newborn who receive post-natal care within two days of birth in USG supported facilities.	Outcome (3.1.6.3-Z01)	DHIS2	Annual	171,538	203,075	N/A	N/A	N/A		
IR-2.4	Number of cases of child diarrhea treated in USG-assisted programs	Output (HL 6:6-1)	DHIS2	Quarterly	106,849	181,962	40,032	53,154	32.0%	29%	Ingobyi identified and trained new binômes (CHWs) on ICCM in addition to community-based mentorship and supportive supervision conducted by nurses and CEHOs, which resulted into increased capacity of CHWs in treatment/reporting and early referral of identified diarrhea cases.
IR-2.5	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 (3.1.6-63)	DHIS2	Annual	172,659	212,221	N/A	N/A	N/A		
IR-2.6	Number of newborns receiving antibiotic treatment for infection through USG-supported programs	Output (3.1.6.62)	DHIS2	Annual	4,364	3,038	N/A	N/A	N/A		
IR-2.7	Proportion of low birth weight babies (less than 200gr) admitted to facility-based KMC services	Outcome	DHIS2	Quarterly	70%	77%	77%	74.2%	-3.0%	96%	
IR-2.8	Percentage of newborns put to the breast within 1 hour of birth	Outcome	DHIS2	Quarterly	92%	95%	95%	95.8%	0.0%	101%	
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	20,182	N/A	2248	N/A		
IR-2.1.2	Number of health workers trained in case management with artemisinin-based combination therapy (ACT) with USG funds	Output(3.1.3.1-1)	Ingobyi records	Annual	N/A	2,923	N/A	N/A	N/A		
IR-2.1.3	Number of LDHF+ Mentors providing trainings	Output	Ingobyi records	Quarterly	N/A	663	663	651	-1.0%	98%	
IR-2.1.4	Proportion health providers receiving mentorship by LDHF+ mentors	Output	Ingobyi records	Quarterly	N/A	30%	30%	30%	0.0%	100%	

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
Sub-IR 2.2 Institutionalized quality improvement approaches for RMNCH/malaria interventions											
IR-2.2.1	Proportion of supported health facilities that have CQI projects with detailed action plans	Outcome	Ingobyi records	Annual	N/A	70%	N/A	N/A	N/A		
Sub-IR 2.3 Improved standardization of RMNCH/malaria services											
IR-2.3.2	Number of Citizen Voice Action groups created to engage with the community on participation on community health service	Output	CVA notes	Annual	N/A	TBD	N/A	N/A	N/A		
IR 3: Strengthened performance of the health system at central and decentralized levels											
IR-3.1	Proportion of DHMTs functional as per guidelines	Outcome	DHMT assessment reports	Annual	N/A	85%	N/A	N/A			
IR-3.2	Percent of USAID-supported facilities that performed a data quality assessment in the past quarter and reported their findings.	Outcome	Coaching reports	Annual	N/A	>90%	N/A	N/A			
Sub-IR 3.1 Strengthened capacity at the national and decentralized levels to plan and manage RMNCH/malaria services											
IR-3.1.1	Percent of project-supported districts conducting quarterly district coordinating meetings	Output	Quarterly district coordination meeting notes	Annual	N/A	>90%	N/A	N/A			
Sub-IR 3.2 Strengthened capacity of hospitals to achieve RMNCH/malaria related accreditation indicators											
IR-3.2.1	IR-3.2.1 Percent of USAID-supported district hospitals achieving Level 1 of the national accreditation process	Outcome	Hospital accreditation progressive assessment	Annual	64%	85%	N/A	N/A			
IR-3.2.2	Proportion of women with eclampsia that received magnesium sulfate according to national EmONC protocols	Outcome	DHIS2	Quarterly	90%	100%	95%	97%	2.0%	102%	
Sub-IR 3.3 Strengthened capacity for district planning, reporting and M&E frameworks											
IR-3.3.1	Percent of health facilities that used data to analyze progress toward achieving their implementation plan goals	Outcome	Coaching reports	Annual	N/A	100%	N/A	N/A			
IR-3.3.2	Percent of DHMTs reporting programmatic decisions made based upon data	Outcome	Quarterly district coordination	Annual	N/A	>90%	N/A	N/A			

#	Indicators	Indicator type	Data source	Frequency	Baseline	Y4 Target	Q1 target	Q1 result	Deviation from the target ¹⁰	Contribution to Y4 target	Deviation narrative
			meeting notes								
IR 3.3.3	Proportion of mothers received postpartum modern family planning (PPFP) methods	Outcome	DHIS2	Quarterly	44%	61%	61%	67.5%	10.0%	111%	
IR-3.3.4	Health System Responsiveness through Continuity of Care: Average of the service gaps between a) ANC1 and ANC4; b) DPT1 and DPT3*, in health system strengthening project catchment areas supported by USAID	Outcome	DHIS2	Annual	N/A	3.9%	N/A	N/A			

B. Environmental monitoring and mitigation

Activity	Specific environmental threat	Mitigation measures	Outstanding issues	Next steps
Mobile outreach activities	Generation of medical waste during outreach activities	During this reporting period, Ingobyi Activity conducted integrated community outreach events in hard-to-reach communities aimed at increasing awareness of, and access to, RMNCH and malaria information and services as well as COVID-19 preventive messages. During outreach, the provision of FP methods was the main contributor of medical waste generation. All the waste that was generated was treated as per the waste management standards, and transported to the nearest health centers for adequate disposal. Safety boxes were availed for sharps infectious waste management.	Some health facilities did not have appropriate waste incinerators.	Advocate for incinerators to be repaired and/or maintained.
District- and national-level trainings	Training generating medical waste	Some sessions of coordination meetings, DHMT meetings and other classic trainings and workshops were conducted during the quarter. The wastes that were generated included facial masks, papers, water bottles, bottle caps and boxes. These generated wastes were collected by the hotel for recycling.	None	None
Mentorship, on-site training and supervision activities	Generation of medical waste during on-site mentorship, LDHF training, and supportive supervision	Several activities, such as EMONC training, on-site neonatal protocol training, LDHF training, and supportive supervision were conducted at the facility level. Ingobyi teams ensured that appropriate waste management was maintained as per the protocols, at the visited health facilities. Ingobyi Activity advised health facilities to safely store wastes that are potentially accessible by the community.	There is need to reinforce waste storage practices before incineration. At some health centers waste collection and disposal is still a concern.	Ingobyi staff will continue to monitor the progress during supportive supervision. Advocacy for availing incinerators or burners and safe waste storage units.

C. Family planning compliance updates

Activities	Purpose	Targeted audience	Status	Next steps
Preventive activities				
Orient Ingobyi staff on US FP and abortion legal and policy requirements (for new staff in Ingobyi, the eLearning course as part of their 90-day probationary requirement, and annually thereafter)	Ensure all Ingobyi staff trained on FP compliance in person or through global eLearning course.	All Ingobyi staff	All new Ingobyi staff completed the online US Abortion and FP requirements 2021 version and HIV/AIDS Legal and Policy Requirements 2021 version.	Orientation and training of all newly recruited staff will continue and refresher training for existing staff will be done annually.
Orient Ingobyi sub-grant staff on US abortion and FP requirements	Ensure FP compliance in the activities implemented by Ingobyi sub-grant staff	Professional associations and other sub-grantees	The refresher course was conducted for mentors from professional associations during their orientation meeting in addition to the online course on US abortion and FP requirements version 2021	Ingobyi will ensure all sub-grant staff and all mentors complete the annual refresher course.
Organize quarterly meetings of Ingobyi/FP compliance committee	Ensure coordination of FP compliance monitoring activities at all levels	Committee including technical and administrative Ingobyi staff	FP compliance was discussed during the monthly meetings in all zones as recommended by the FP compliance committee. Ingobyi FP compliance committee discussed on quarterly basis the situation of FP compliance in supported health facilities.	FP compliance will continue to be on the agenda of zonal monthly meetings and the FP compliance committee meeting will continue to be organized once a quarter as planned.
Organize quarterly meetings of FP compliance district focal points to share experiences, discuss current status and relevant risks if any which would compromise the FP compliance at service delivery level	Ensure FP compliance through discussion on any related issue in Ingobyi-supported districts	FP compliance district focal points	FP compliance was discussed in all district coordination meetings, and DHMT meetings conducted in all 20 supported districts. Participants were DHMT members, heads of health facilities, MNCH, FP/youth reproductive health mentors and FP nurses.	Ingobyi will continue to include FP compliance as a topic of discussion during planned quarterly coordination meetings and DHMT meetings in all supported districts.

Activities	Purpose	Targeted audience	Status	Next steps
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	USAID Ingobyi Activity ensured that every staff, mentors and trainers supporting the facilities completed an online course on US abortion and FP compliance requirements, 2021 version. The orientation on these requirements was included to the agenda of various Ingobyi supported trainings and meetings, including but not limited to, the mentorship program; training on hormonal IUD, training on DMPS-SC, training of trainers on adolescent health module; CHW coordination meeting; District coordination meetings; DHMT meetings and CVA group trainings, among others. At least 1395 individuals (493 males and 902 females), including Ingobyi staff and health providers, oriented 2353 CHWs (1.440 females and 913 males), 73 members of CVA (F= 44 M=29) and 107 individuals (63 males and 44 females) were oriented during quarterly coordination meetings.	Ingobyi will continue to orient staff who were not yet oriented in supported districts. Integration of FP compliance in all trainings and meetings will continue as needed
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	FP flip charts and posters are available in all supported health facilities, but some are very old and need replacement.	Ingobyi will continue to support the printing and distribution of FP client files and IEC materials as needed
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	All new field staff were oriented on FP compliance monitoring and reporting mechanism	The zonal coordinators will continue to ensure that FP compliance monitoring is integrated in all field visits.

Activities	Purpose	Targeted audience	Status	Next steps
Carry out facility FP compliance monitoring visit 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-grants organizations	USAID Ingobyi Activity conducted quarterly FP compliance visits to health facilities to audit their compliance with US abortion and FP compliance requirements. Up to 162 health facilities were visited with no observed violations. However, a few challenges were observed in some health facilities: stockout of FP methods, especially Implanon NXT, microgynon, Jadelle, and Depo-Provera at the community level. To address these gaps, the Ingobyi team conducted on-site refresher orientation of staff on US abortion and FP compliance requirements as needed; advocated with health facility managers, the RBC, and Rwanda Medical Supply for an improved supply of FP methods.	Ingobyi staff will continue to monitor FP compliance and the FP compliance committee will continue to conduct quarterly FP compliance monitoring visits to supported districts.
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	Documentation is done on a regular basis. This includes staff and sub-awardees certificates, orientation reports, meeting minutes and attendance lists as well as monitoring visit reports.	All updates will be kept in both soft and hard copies.

D. Success Stories

Story 1: Ruhashya Health Center: Innovating for CRH accessibility



Photo: Youth session at Ruhashya HC - organized twice a week to discuss CRH

To increase the accessibility of sexual and reproductive health (SRH) services and information for youth, the MoH has initiated the creation of safe spaces for youth in all health centers (HCs) across the country. This safe space, termed a “youth corner,” is meant to be separated from other services offered by HCs to create confidentiality for youth who seek information or services about SRH. Youth corners in most HCs had gone dormant, as they were failing to attract youth. The reasons for their disuse included the lack of provider skills at the health center level to develop messages and offer service packages suitable for the youth. Thus, it has been difficult to mobilize youth to visit the youth corners and avail themselves of SRH services.

Through its partnership with the MoH/RBC, the USAID Ingobyi Activity is supporting HCs to revamp youth corners by building the capacity of health providers through training, mentorship, and supportive supervision, as well as providing comprehensive reproductive health (CRH) education materials. In Ruhashya HC, Ingobyi Activity conducts supportive supervision and supports district-based mentors to conduct regular mentorship. Before Ingobyi’s support, the HC’s youth corner was practically nonexistent. “Our youth corner was not well structured. Despite the fact that we were supposed to have it running, we were still receiving the youth in the same places we receive adults. This made it difficult for the youth who wanted to access the services. For example, if a young man or woman contracts any STD, they would hesitate to come here to receive treatment, fearing that they would meet a relative in the services. With the support of USAID Ingobyi Activity to reorganize the

youth corner, the youth are much more interested in seeking and consulting SRH services,” said Kagabo Venuste, nurse-in-charge of the youth corner at Ruhashya HC.

With the support of Ingobyi Activity, a room was identified to be dedicated as the youth corner. This dedicated space has made the youth feel more comfortable in seeking SRH services compared to when their services were mixed with other services. Youth were also given a dedicated time during the week to discuss CRH matters. Through USAID Ingobyi Activity’s supportive supervision, Ruhashya HC was encouraged to “think outside the box” and find ideas that would encourage youth to use the youth corner and attend sessions created for them. With that in mind, nurse Venuste Kagabo came up with an idea of forming youth groups aimed at CRH education.

However, instead of just convening to talk about SRH—which was the initial purpose—the groups were also turned into savings groups. At their weekly meetings, attendees contribute 100 Rwf for savings and 20 Rwf to an emergency fund. Whenever a member has a project, he/she can borrow the money and repay the loan at a low interest rate. With the emergency fund, any member with an emergency is assisted through the fund. “I am part of *Twitezimbere Rubyiruko*. I borrowed 10,000 RWF and was able to start a small chicken farm. I now have five chickens. As I sell eggs, I am financially free that I don’t bother my parents for clothes and other basic needs. I feel like this is very important for me because as I can afford what I need, no one can indulge me into unsafe sexual behaviors under the pretext of solving my financial needs. These can result into unwanted pregnancies or contracting STIs [sexually transmitted infections],” said Madeleine from Ruhashya sector.

Like Madeleine, Janvier Niyomugabo is part of a youth group gathering at Ruhashya HC. He says that the fact that there is a space dedicated to them as youth is very important. He says that despite having received similar information about CRH in schools and sometimes at home, the youth corner provides more information. “We are able to get information that we are normally afraid of asking of our parents. Here, we are free to talk about CRH as we are all young and feel like we can ask any question about SRH. When we attend the groups, some of my fellow youth are attracted by the saving component of the groups and end up getting very interested by the CRH education we receive,” added noted Janvier.

These types of innovations have resulted in a significant reduction in unwanted pregnancies in Ruhashya sector. “It has been a while since I have heard that a neighbor in my village or even in the entire sector has had an unwanted pregnancy. Like two years back, it was common to hear about cases,” commented Madeleine on the state of unwanted pregnancies. In fact, Ruhashya has registered only two unwanted and teen pregnancies in the 2020/2021 fiscal year.

So far, 54 CRH youth groups have been created in the Ruhashya HC catchment area, and they have, to date, managed to save more than 378,000 RWF from their weekly savings. Since there are still health centers that are struggling to attract youth to their corners, Ruhashya HC can serve as a good example of how others can use innovation to solve this issue. Innovations, such as creating youth savings groups, are ensuring that youth become and stay interested in using the youth corner, as well as the services it offers.

Story 2: Pediatric Development Clinic (PDC): an effective weapon against neonatal mortality

According to the 6th Rwanda Demographic and Health Survey (2020), the infant mortality rate increased from 32 to 33 per 1000 live births between 2015 and 2020. This increase has been attributed to the neonatal mortality rate, which did not markedly decline over the same period, possibly due to low rates in PNC visits 2 and 3. To address this issue, Ingobyi implemented pediatric development clinics (PDCs) at Ruhengeri and Murunda hospitals and the health centers within their catchment areas.

Case presentation

One of the first clients enrolled after launching the PDC at Ruhengeri Hospital in mid-September 2021



was baby JW. She was born preterm at 29 weeks of gestation, weighing 900 g, following maternal preeclampsia. She had been born after spontaneous vaginal delivery and was admitted to the newborn unit for further management. While there, she benefited from the usual routine inpatient care, in addition to the newly initiated PDC services, including family-centred care, nesting, intermittent and continuous Kangaroo Mother Care, and breastmilk fortification. At the same time, the parents benefited from health education on breastfeeding, danger signs

in newborns, and hygiene. Baby JW's mother would come to newborn unit every two to three hours to do intermittent Kangaroo Mother Care and provide the baby with fortified breast milk, even when still on oxygen. Baby JW was later discharged after one month with a weight of 1.9 kg to continue with Ruhengeri hospital PDC services as an outpatient. She was later brought back at two months weighing 4.1 kg and will be followed up for any future prematurity complications while in the PDC until she is two years of age.

Ingobyi staff documented a cohort of similar infants from Murunda and Ruhengeri hospitals who were born with high-risk conditions like Baby JW, who also responded favourably to the services provided through the hospitals' PDCs. These positive preliminary findings are exciting and have been disseminated to the Child Health TWG and during the World Prematurity Day event celebrated at the 5th RPA annual conference.

Story 3: eLearning platform as a game changer to improve CHWs' service delivery



Photo: Antoinette Niragire using her smartphone to access a CBMNH course through the national eLearning platform

In Rwanda, the existing approaches to train CHWs involve classroom-based teaching, where CHWs attend a five-day training course in one location and are taught didactically by a CHW supervisor. However, these training approaches have often been met with operational challenges, such as limited funding and restrictions associated with in-person gatherings, especially during the current COVID-19 pandemic. To address these challenge, the GoR in collaboration with USAID Ingobyi Activity introduced eLearning courses as an approach to train CHWs. Through this approach, with guidance from the MoH, CHWs received smartphones and accessed the courses on the MoH eLearning platform. The courses included Community Based Maternal and Neonatal Health (CBMNH), Integrated Community Case Management (ICCM), and Home Based Management (HBM) of malaria in adults. In addition to multimedia content, the eLearning courses also included pre- and post-course quizzes, all of which could be accessed offline to allow CHWs without good network connection to still benefit from the courses. The pilot project was launched in two rural districts, Rutsiro and Ngoma, with a total of 100 CHWs who participated and completed the courses.

Antoinette Niragire is an eLearning pilot participant CHW from Rutsiro district, Rukaragata village, Kigeyo cell and is serving within the Kinihira Health Center catchment area. She completed the CBMNH eLearning course and appreciated the approach in comparison to the classic in-person trainings. Niragire says that attending in-person trainings is not an easy thing to do: “I have been traveling long distances to attend trainings at HC. This means that I had to dedicate a day or even more to the trainings. During the trainings period, I was not able to provide services to my fellow community members especially home visits to pregnant women and newborns,” said Antoinette.

The design of the CHW eLearning courses included narrated videos and pictures, which not only made it easier for CHWs to complete the courses independently but also enabled them to utilize course materials in their work with the communities they serve. As attested by Antoinette, the multimedia content added value to their work and performance. “It is easier for me to use the smartphone and application when I conduct visits to my pregnant women. Before, I used to show them only pictures that are in the counseling cards as job aids. Now, with the smartphone, I also use videos that are in the smartphones to illustrate better what I want to tell them, and they understand easier,” said Antoinette on the advantages of using smartphones not only in training but also as a job aid in daily work.

Juliette Nyirasamayose is a mother of two boys and is one of the beneficiaries of Antoinette’s support as a CHW. She lives in Rukaragata village, Kigeyo cell, Kigeyo sector, Rutsiro district. She gave birth to her youngest son at the health center, and he was a healthy baby weighing 2.8 kg. However, due to misinformation from relatives and neighbors on how to care for the newborn, after a few days, her child lost weight, dropping from 2.8 to 2.2 kg. Wondering what was causing her baby to lose weight, she was advised by her relatives that her child has an illness that can only be cured by traditional healers. “I asked my relatives and they told me that my child is suffering from an illness called *ingongwa* (in local language) and that I have to consult traditional healers, instead of going to the health center,” said Juliette. Following her relative’s advice, she took her child to traditional healers, and she was prescribed some medicines. She gave her baby the medicines, but they had no effect on her child’s condition.



Photo : Juliette Nyiransabayose and her son, who is now a healthy baby

After noticing that her child’s condition was deteriorating, Juliette decided to seek support from Antoinette, her CHW. Antoinette assessed the nutritional status of the child and found the child was suffering from moderate malnutrition. She, therefore, advised the mother on key practices that should

help improve the child's condition. From the eLearning course, Antoinette showed the mother the video on how to use Kangaroo Mother Care (KMC) to improve the baby's weight. "I advised Juliette on appropriate feeding of the child, breastfeeding, and KMC practices. I conducted weekly visits to monitor the growth of the child and the efforts of the mother in terms of child feeding and breastfeeding," said Antoinette. She further highlighted the benefits of using eLearning into the training: "The support I gave to Juliette, I used my smartphone and showed the video in the eLearning course to demonstrate the practice of KMC. This helped a lot and Juliette liked the video and started to practice," added Antoinette.

A few months later, the child's weight gradually improved to 5.2 kg after eight months. The mother is full of appreciation for Antoinette's support, and she is happy to see her child growing well. "I really thank Antoinette for her tireless support. I appreciated the KMC practice and now my child is in good health as you can see," said Juliette on the progress made by her child. She also decided to provide advice to other parents on the proper practices toward the growth of newborns. "I would also like to advise mothers to respect the advice from CHWs and ensure adequate and proper nutrition of their children to avoid similar problems," added Juliette.

To expand this approach and best practices to other districts, Ingobyi Activity in collaboration with the MoH and RBC plans to share lessons learned from the pilot phase to guide the scale-up of this approach to other districts.

E. Summary of QI Projects Currently Implemented in Health Facilities. DH = district hospital; HC = health center; PH = provincial hospital.

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
<i>Project related to Maternal Health</i>										
<i>To increase coverage rate of 1st ANC Standard in health facilities</i>	<i>Rwaza HC</i>	48%	55%	1-Nov-2020	1-Nov-2021	48%	53%	68%	Completed	Target achieved
	<i>Gashaki HC</i>	70%	75%	1-Jan-2021	1-Dec-2021	70%	59%	44%	Completed	Target not achieved
	<i>Ruramba HC</i>	36%	100%	2-Jan-2021	31-Dec-2021	63%	54%	59%	Completed	Target not achieved
	<i>Kitabi HC</i>	32%	70%	9-Feb-2021	31-Dec-2021	55%	36%	54%	Completed	Target not achieved
	<i>Uwinkingi HC</i>	24%	60%	24-Feb-2021	31-Dec-2021	38%	46%	48%	Completed	Target not achieved
	<i>Nyarusiza HC</i>	37%	65%	20-Feb-2021	31-Dec-2021	64%	55%	58%	Completed	Target not achieved
	<i>Camp Nyabiheke HC</i>	30%	40%	4-Nov-2020	30-Jun-2022	49%	52%	39%	Ongoing	NA
	<i>Rwamagana HC</i>	47%	55%	1-Nov-2021	30-Jun-2022	NA	NA	New	New	NA
	<i>Mutenderi HC</i>	46%	60%	1-Jul-2021	30-Jun-2022	New	54%	46%	Ongoing	NA
	<i>Kivumu HC (Rutsiro)</i>	45%	75%	1-Aug-2021	30-Jun-2022	NA	New	53.9%	Ongoing	NA
	<i>Biruyi HC (Rutsiro)</i>	28%	46%	1 July 2021	31-Mar-2022	New	58%	59%	Achieved	Target achieved
	<i>Cymbili HC (Rutsiro)</i>	53%	65%	1-Sep-2021	1-Sep-2022	NA	New	17%	Ongoing	NA
	<i>Karumbi HC (Rutsiro)</i>	21%	50%	7-Jul-2021	30-Jun-2022	New	28%	25%	Ongoing	NA
	<i>Murunda HC</i>	39%	57%	1-Sep-2021	31-Aug-2022	NA	NA	52%	Ongoing	NA
<i>Nyakiriba HC</i>	6%	46%	10-Sep-2021	30-Jun-2022	NA	NA	23%	Ongoing	NA	

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
To increase ANC 4 standard visit coverage rate	Nyange HC	35%	55%	1-Jun-2021	30-Jun-2022	New	45%	36%	Ongoing	NA
	Rilima HC	31%	50%	1-Jun-2021	30-Jun-2021	New	38%	36%	Ongoing	NA
To increase the rate of mothers and their neonates who benefit from PNC 4 services	Byimana HC	23.3%	50%	1-Jan-2021	31-Dec-2021	54%	58%	70%	Completed	Target achieved
	Gitwe HC	30.8%	60%	1-Jan-2021	31-Dec-2021	32%	36%	76%	Completed	Target achieved
	Muremure HC	42.7%	70%	1-Jan-2021	31-Dec-2021	57%	59%	88%	Completed	Target achieved
To decrease the rate of PPH	Gitwe DH	3%	2%	1-Nov-2021	1-Sep-2022	NA	NA	1.2%	Ongoing	NA
	Ruhango PH	3%	1%	1-Nov-2021	1-Sep-2022	NA	NA	2.0%	Ongoing	NA
To increase proper Management of Preeclampsia	Ngarama DH	50%	100%	1-Nov-2021	30-Sep-2022	NA	NA	50.0%	Ongoing	NA
Project related to IPC										
To reduce post-Caesarean section infection	Gitwe DH	1.4%	0.5%	1-Jul-21	1-Dec-21	NA	New	0.7%	Completed	Target achieved
	Nyanza DH	4%	3%	21-01-2021	1-Dec-21	2.0%	2.1%	2.0%	Completed	Target achieved
	Kigeme DH	4%	2%	1-Jan-2021	1-Dec-2021	2%	2%	1%	Completed	Target achieved
	Kibagabaga DH	6.0%	2.0%	1-Dec-2020	1-Dec-2021	3.8%	0.9%	1.2%	Completed	Target achieved
	Kabgayi DH	5.2%	2.00%	1-Jun-21	21-Dec-21	NA	3.2%	1.4%	Completed	Target achieved
	Kigeme DH	4.0%	2.0%	1-Jan-21	1-Dec-21	2%	3%	1%	Completed	Target achieved
	Kabutare DH	4.5%	2.0%	1-Jan-21	1-Dec-21	2.8%	2.4%	3.0%	Completed	Target achieved
	Kibungo DH	1.5%	1.00%	1-Jul-21	30-Jun-22	NA	New	2%	Ongoing	NA
	Gatunda DH	2.0%	1.00%	1-Jul-21	30-Jun-22	0.1%	1%	1.3%	Ongoing	NA

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Murunda DH	3.8%	1.9%	1-Nov-21	1-Sep-22	NA	NA	4.1%	New	NA
	Ngarama DH	2%	1%	1-Jul-21	30-Jun-22	NA	2%	0.0%	Completed	Target achieved
	Kabutare DH	2%	1%	1-Nov-21	1-Aug-22	NA	NA	2.96%	Ongoing	NA
	Kaduha DH	4%	2%	15-Dec-21	1-Sep-22	NA	NA	New	New	NA
	Nyanza DH	2%	2%	1-Nov-21	1-Sep-22	NA	NA	2.20%	Ongoing	NA
	Ruhango PH	5%	1%	1-Nov-21	1-Sep-22	NA	NA	2.0%	Ongoing	NA
	Shyira DH	11.0%	4%	30-Sep-21	31-Dec-22	NA	NA	4.0%	Ongoing	NA
	Ruhengeli RH	2.5%	2%	1-Oct-21	1-Jan-23	NA	NA	5.0%	Ongoing	NA
	Kabaya DH	4.0%	1%	30-Oct-21	31-Dec-22	NA	NA	0.0%	Achieved	
	Murunda DH	2.9%	1%	30-Oct-21	31-Dec-22	NA	NA	8.0%	Ongoing	NA
	Byumba DH	5.0%	2%	1-Jul-21	1-Dec-21	2.9%	4%	0.7%	Completed	Target achieved
	Masaka DH	3.1%	2%	1-Dec-20	1-Apr-21	NA	2.50%	0.9%	Completed	Target achieved
	Rwamagana PH	2.5%	2%	1-Jul-21	30-Jun-22	NA	NA	2.9%	Ongoing	NA
	Kiziguro DH	1.0%	0.5%	1-Jul-21	30-Jun-22	NA	NA	2.0%	Ongoing	NA
	Nyamata DH	3.7%	2.5%	1-Nov-21	31-Dec-22	NA	NA	3.0%	Ongoing	NA
To reduce neonatal infections	Muhororo DH	16.0%	10%	25-Sep-21	31-Dec-22	NA	20%	7.0%	Ongoing	NA

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Kabaya DH	29.0%	14%	26-Oct-21	31-Dec-22	NA	NA	8.0%	Ongoing	NA
	Gisenyi DH	6.3%	4%	25-Oct-21	31-Dec-22	NA	NA	2.0%	Completed	Target not achieved
	Remera Rukoma DH	46.0%	10%	1-Jun-21	1-Dec-21	NA	10.4%	24.5%	Completed	Target not achieved
Project related to Newborn Health						April to June 2021	July to sept 2021	Oct to Dec 2021		
To reduction of birth Asphyxia	Kabaya DH	2.7%	2%	1-Nov-2021	1-Apr-2022	NA	NA	1.8%	Ongoing	N/A
	Munini DH	3.26%	2%	6-Dec-2021	30-Sep-2022	NA	NA	7.4%	New	
	Nyagatare DH	3%	1.50%	15-Nov-2021	30-Sep-2022	NA	NA	New	New	
	Rutare HC	2%	1%	17-Nov-2021	15-Aug-2022	NA	NA	2.2%	New	
	Shyira DH	2.6	1%	1-Nov-2021	30-Sep-2022	NA	NA	0.8%	New	
	Gatunda DH	23.4	12	1-Nov-2021	Sept.2022	NA	NA	9%	New	
	Kabutare DH	0.56%	0.20%	25-Oct-2021	25-Jul-2022	NA	NA	New	New	
	Kaduha DH	2.1%	1.0%	1-Dec-2021	30-Sep-2022	NA	NA	3.1%	New	
	Kigeme DH	2.0%	1.0%	2-Dec-2021	30-Sep-2022	NA	NA	1.7%	New	
	Kiziguro DH	4.0%	1.5%	21-Nov-2021	30-Sep-2022	NA	NA	2.8%	New	
	Muhororo DH	3.7%	2.0%	1-Nov-2021	1-Sep-2022	NA	NA	1.75%	New	
	Ngarama DH	2.0%	1.0%	1-Nov-2021	1-Sep-2022	NA	NA	New	New	
	Nyagatare DH	3.0%	1.5%	11-Dec-2021	15-Sep-2022	NA	NA	2.70%	New	
	Rwamagana PH	3.2%	1.5%	1-Nov-2021	30-Sep-2022	NA	NA	2.10%	New	
	Kabutare DH	0.6%	0.3%	1-Nov-2021	1-Aug-2022	NA	NA	0.30%	New	
	Nyanza DH	1.3%	1.2%	1-Nov-2021	1-Sep-2022	NA	NA	0.60%	New	
Ruhango PH	1.8%	1.3%	1-Dec-2021	30-May-2022	NA	NA	New	New		
To reduce neonatal hypothermia within health facilities	kacyiru DH	38.0%	10%	1-Jul-2021	30-Dec-21	15%	22.3%	23.0%	Completed	Target not achieved
	Gitwe DH	40.0%	100%	15-Nov-2021	30-May-2022	NA	NA	New	New	

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	<i>Byumba DH</i>	81.0%	40%	1-Dec-2021	31-May-2022	NA	NA	New	New	
	<i>Gatunda DH</i>	44.0%	100%	1-Nov-2021	30-Sep-2022	NA	NA	42.3%	New	
	<i>Kibagabaga DH</i>	21%	15%	1-Nov-2022	30-Jun-2022	NA	NA	new	New	
	<i>Kiziguro DH</i>	41.6%	15%	1-Nov-2021	30-Oct-2022	NA	NA	New	New	
	<i>Muhororo DH</i>	32.5%	100%	24-Nov-2021	24-Jun-2022	NA	NA	New	New	
	<i>Murunda DH</i>	63.2%	40%	19-Nov-2021	30-May-2022	NA	NA	New	New	
	<i>Nyagatare DH</i>	60%	25%	15-Nov-2021	30-Sep-2022	NA	NA	New	New	
	<i>Gatunda DH</i>	44,1%	10%	1-Nov-2021	30-Sep-2022	NA	NA	18%	New	
	<i>Kigeme DH</i>	46%	20%	1-Dec-2021	30-Sep-2022	NA	NA	35%	New	
	<i>Nyagatare DH</i>	60%	25%	20-Dec-2021	1-Sep-2022	NA	NA	65%	New	
To improve weight gain monitoring for admitted neonates	<i>Remera Rukoma DH</i>	15%	100%	20-Dec-2021	31-Oct-2022	NA	NA	New	New	
To reducing prematurity case fatality rate	<i>Ruhango PH</i>	16.5%	100%	16-Nov-2021	31-May-2022	NA	NA	New	New	
To improve the newborn feeding charts monitoring	<i>Kaduha DH</i>	0%	100%	17-Nov-2021	16-Apr-2022	NA	NA	New	New	
To improve the newborn feeding charts monitoring	<i>Kiziguro DH</i>	0%	80%	1-Nov-2021	30-May-2022	NA	NA	New	New	
To Increase the rate of skin-to-skin practice	<i>Bigogwe HC</i>	48%	80%	1-Nov-2021	1-Sep-2022	NA	NA	New	New	
To increase the rate of successfully resuscitation in newborns	<i>Bigogwe HC</i>	66%	100%	21-Nov-2021	22-Sep-2021	NA	NA	New	New	

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
To increase the rate of successful resuscitation in newborns	Gitwe DH	87%	95%	1-Nov-2021	1-Sep-2022	NA	NA	75%	New	
<i>Project related to Child health</i>						<i>April to June 2021</i>	<i>July to Sept 2021</i>	<i>Oct to Dec 2021</i>		
To Improve the use of amoxicillin in treatment of pneumonia	Hanika HC	81%	100%	31-Jul-2021	31-Dec-2021	NA	96%	94%	Completed	target not achieved
To increase the rate of children screened for malnutrition in IMCI Service	Mweya HC	65%	95%	31-Jul-2021	30-Dec-2021	NA	70%	95%	Completed	Target achieved
	Kibirizi HC	76%	100%	31-Aug-2021	18-Dec-2021	NA	78%	86%	Completed	target not achieved
	Nyatanga HC	38%	64%	1-Aug-2021	31-Dec-2021	NA	41%	74%	Completed	Target achieved
	Kigeme HC	29%	78%	1-Oct-2021	30-Jun-2022	NA	New	52%	Ongoing	
	Gahombo HC	47%	90%	1-Jul-2021	1-Feb-2022	New	85%	21%	Ongoing	
To increase the % of pneumonia cases treated according to the protocol	Byimana HC	42%	75%	31-Jul-2021	1-Dec-2021	New	47%	70%	Completed	Target not achieved
To correct the use of antibiotics in IMCI services according to IMCI guidelines	Gituku HC	50%	90%	April 2021	Oct-21	NA	New	92%	Completed	Target achieved
	Munanira HC	7%	3%	Sep-21	Mar-22	NA	New	5%	Ongoing	
	Kizibere HC	30%	15%	Sep-21	Mar-22	NA	30%	81%	Ongoing	
	Kirwa HC	60%	95%	April 2021	Oct-21	NA	New	96%	Completed	Target achieved
	Gahengeri HC	50%	85%	April 2021	Oct-21	NA	New	90%	Completed	Target achieved
	Nzangwa HC	54%	95%	April 2021	Oct-21	NA	New	95%	Completed	Target achieved
	Sangaza HC	50%	90%	Apr-21	Oct-21	NA	New	91%	Completed	Target achieved
	Nyagahita HC	45%	90%	Apr-21	Oct-21	NA	New	94%	Completed	Target achieved
	Cyondo HC	60%	90%	Apr-21	Oct-21	NA	New	93%	Completed	Target achieved
	Rilima HC	54%	95%	May-21	Dec-21	NA	New	95%	Completed	Target achieved
	Jarama HC	60%	90%	May-21	Dec-21	NA	New	93%	Completed	Target achieved
	Karenge HC	43%	95%	May-21	Dec-21	NA	New	96%	Completed	Target achieved

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Mutenderi HC	55%	95%	May-21	Dec-21	NA	New	65%	Completed	Target not achieved
	Ruhuha HC	40%	90%	Jul-21	Dec-21	NA	New	91%	Completed	Target achieved
	Muhambo HC	45%	90%	Jul-21	Dec-21	NA	New	69%	Completed	Target not achieved
	Rukomo HC	34%	90%	Jun-21	Dec-21	NA	New	93%	Completed	Target achieved
	Gashanda HC	43%	90%	Jun-21	Dec-21	NA	New	92%	Completed	Target achieved
	Remera (Ngoma) HC	34%	90%	Jun-21	Dec-21	NA	New	75%	Completed	Target achieved
	Rukira HC	32%	90%	Jul-21	Dec-21	NA	New	90%	Completed	Target achieved
	Ntarama HC	43%	90%	Jul-21	Dec-21	NA	New	91%	Completed	Target achieved
	Juru HC	35%	90%	Jun-21	Dec-21	NA	New	95%	Completed	Target achieved
	Rukoma sake HC	50%	90%	Jun-21	Dec-21	NA	New	93%	Completed	Target achieved
	Zaza HC	33%	85%	Jun-21	Dec-21	NA	New	85%	Completed	Target achieved
To increase the number children correctly assessed and classified on nutritional status in IMCI Service	Nyange HC	60%	90%	April 2021	Oct-21	NA	New	93%	Completed	Target achieved
	Nzangwa HC	54%	95%	April 2021	Oct-21	NA	New	95%	Completed	Target achieved
	Matyazo HC	67%	80%	Sep-21	Mar-22	NA	New	73%	Ongoing	Target not achieved
	Nyakaliro HC	65%	90%	April 2021	Oct-21	NA	New	90%	Completed	Target achieved
	Gihinga HC	60%	90%	Apr-21	Oct-21	NA	New	92%	Completed	Target achieved
	Mwogo HC	52%	95%	May-21	Dec-21	NA	New	95%	Completed	Target achieved
	Ruhuha HC	60%	95%	Jun-21	Dec-21	NA	New	95%	Completed	Target achieved
	Gashanda HC	32%	85%	Jul-21	Dec-21	NA	New	73%	Completed	Target achieved
	Juru HC	34%	85%	Jul-21	Dec-21	NA	New	90%	Completed	Target achieved
	Zaza HC	40%	85%	Jun-21	Dec-21	NA	New	89%	Completed	Target achieved
	Kibondo HC	34%	85%	Jun-21	Dec-21	NA	New	85%	Completed	Target achieved
Rubona (Ngoma) HC	51%	90%	Jun-21	Dec-21	NA	New	93%	Completed	Target achieved	

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
To increase the percentage of U5 children presenting with simple malaria treated according to IMCI and malaria protocols.	Kamabuye HC	68%	95%	April 2021	Oct-21	NA	New	95%	Completed	Target achieved
To increase number of children screened for tuberculosis in IMCI services	Ngeruka HC	40%	90%	Jun-21	Dec-21	NA	New	91%	Completed	Target achieved
	Nyarugenge HC	35%	90%	Jun-21	Dec-21	NA	New	93%	Completed	Target achieved
To increase the rate of correct management of diarrhea and associated dehydration	Rubona (Rwamagana) HC	33%	85%	Jul-21	Dec-21	NA	New	87%	Completed	Target achieved
	Kigoma HC	78%	97%	Jul-21	Dec-21	New	86%	98%	Completed	Target achieved
To increase rate of correct screening for HIV in IMCI services according to the guidelines	Gituza HC	42%	85%	Jul-21	Dec-21	NA	New	86%	Completed	Target achieved
<i>Project related to FP/ASRH</i>						April to June 2021	July to sept 2021	Oct to Dec 2021		
To increase the number of PFP counseling and its documentation in delivery register	Busanza CS	45%	95%	Jun-21	30-Dec-21	NA	91%	93%	Completed	Target not achieved
	Musambira CS	53%	95%	May-21	30-Dec-21	NA	90%	92%	Completed	Target not achieved
	Bumbogo (ex-Gikomero I) CS	36%	90%	Jun-21	30-Dec-21	NA	89%	91%	Completed	Target achieved
	Rutare (gicumbi) CS	24%	98%	May-21	30-Dec-21	NA	85%	99%	Completed	Target achieved
	Gacuba II	78.6%	100%	15-Jul-2021	15-Jan-2022	NA	new	100%	Ongoing	Target achieved
	Mareba HC	27.1%	70%	1-May-2021	1-Oct-2021	new	66.0%	63%	Completed	Target not achieved
	Nyarugenge HC	19.0%	50%	6-Jun-2021	1-Dec-2021	new	37.0%	44%	Completed	Target not achieved
	Gihinga HC	40%	80%	30-Jun-2021	31-Dec-2021	new	40%	95%	Completed	Target achieved
	Ngeruka HC	15.9%	50%	1-May-2021	26-Nov-2021	New	43%	47%	Completed	Target not achieved
	Mutendeli HC	47%	80%	2-Jun-2021	31-Dec-2021	New	47%	41%	Completed	Target not achieved
	Rukumbeli HC	53%	75%	2-Jun-2021	31-Dec-2021	53%	68%	78%	Completed	Target achieved
Murara HC	75%	95%	1-Oct-2021	31-Mar-2022	NA	NA	New	Ongoing	NA	

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Nyundo HC	71%	100%	1-Sep-2021	1-Feb-2022	NA	New	100%	Ongoing	NA
	Mudende HC	25%	70%	1-Oct-2021	1-Apr-2022	NA	NA	new	Ongoing	NA
	Nyange A HC	76%	100%	1-Nov-2021	1-Feb-2022	NA	NA	New	Ongoing	NA
	Ntobwe HC	82%	100%	1-Nov-2021	1-Feb-2022	NA	NA	New	Ongoing	NA
	Rwempesha HCs	2%	50%	1-Oct-2021	1-Mar-2022	NA	NA	45%	Ongoing	NA
To increase the rate of PPFP and FP Client files classified correctly	Nyange Hc	30%	90%	1-Nov-2021	1-Feb-2022	NA	NA	New	Ongoing	NA
	Ruhengeri RRH	40%	80%	1-Nov-2021	1-Feb-2022	NA	NA	New	Ongoing	NA
	Nyakiliba HC	23%	80%	1-Oct-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
	Jomba HC	25%	80%	1-Oct-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
	Rwankeri HC	10%	80%	1-Sep-2021	1-Jun-2022	NA	NA	New	Ongoing	NA
	Nyakiliba HC	80%	100%	1-Aug-2021	1-Feb-2022	NA	NA	New	Ongoing	NA
	Kigufi HC	86%	100%	2-Aug-2021	2-Feb-2022	NA	new	100%	Ongoing	Achieved
	Kabere HC	70%	100%	1-Oct-2021	1-Dec-2021	NA	New	100%	Completed	Target achieved
	Karwasa HC	0%	80%	1-Oct-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
	Rwaza HC (Musanze)	0%	80%	1-Oct-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
	Musanze HC	0%	80%	1-Oct-2021	1-Apr-2022	NA	NA	New	Ongoing	NA
	Gashaki	30%	80%	2-Oct-2021	2-Apr-2022	NA	NA	New	Ongoing	NA
	Shingiro HC	0%	80%	1-Sep-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
	Murandi HC	0%	85%	1-Sep-2021	1-Mar-2022	NA	NA	New	Ongoing	NA
To increase the number of PPFP clients handed over from Kabaya DH to provenance HCs from 0% to 60% within three months	Kabaya DH	0%	60%	1-Jul-2021	31-Dec-2021	NA	New	100%	Completed	Target achieved
To increase number of ASRH IEC sessions in the health centers	Mudende (Rubavu)	50%	100%	Sep-21	31-Mar-22	NA	New	80%	Ongoing	NA

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Kibingo (Rutsiro)	70%	100%	Sep-21	31-Mar-22	NA	New	72%	Ongoing	NA
	Rutsiro (Rutsiro)	64%	100%	Sep-21	31-Mar-22	NA	New	85%	Ongoing	NA
	Mushubati (Rutsiro)	74%	100%	Sep-21	31-Mar-22	NA	New	95%	Ongoing	NA
	Bugeshi HC (Rubavu)	20%	80%	Sep-21	31-Mar-22	NA	New	60%	Ongoing	NA
	Mukura HC (Rubavu)	79%	100%	Sep-21	31-Mar-22	NA	New	85%	Ongoing	NA
	Nyabirasi HC (Rubavu)	22%	90%	Sep-21	31-Mar-22	NA	New	95%	Ongoing	NA
	Gasiza (musanze) CS	66%	80%	Sep-21	31-Mar-22	NA	New	85%	Ongoing	NA
	Karwasa HC (Musanze)	40%	80%	Sep-21	31-Mar-22	NA	New	82%	Ongoing	NA
	Rwaza HC (Musanze)	24%	80%	Sep-21	31-Mar-22	NA	New	85%	Ongoing	NA
	Kinigi HC (Musanze)	22%	100%	Sep-21	31-Mar-22	NA	New	90%	Ongoing	NA
	Busogo HC (Musanze)	60%	100%	Sep-21	31-Mar-22	NA	New	70%	Ongoing	NA
	Murandi HC (Musanze)	40%	70%	Sep-21	31-Mar-22	NA	New	75%	Ongoing	NA
	Kintobo HC (Nyabihu)	30%	60%	Sep-21	31-Mar-22	NA	New	70%	Ongoing	NA
	Bitenga HC (Rutsiro)	50%	75%	Oct-21	31-Mar-22	New	60%	60%	Ongoing	NA
	Kinunu HC (Rutsiro)	50%	75%	Nov-21	30-Apr-22	New	55%	55%	Ongoing	NA
	Nyakiliba HC (Rubavu)	8%	85%	Oct-21	31-Mar-22	New	25%	25%	Ongoing	NA
	Arusha (Nyabihu)	16%	70%	Oct-21	30-Apr-22	New	20%	20%	Ongoing	NA
Muhoza HC (Musanze)	35%	100%	Oct-21	31-Mar-22	New	50%	50%	Ongoing	NA	
To increase the number of IEC session on STIs topic	Karumbi HC (Rutsiro)	16%	80%	Sep-21	31-Mar-22	NA	New	40%	Ongoing	NA
To increase the number of IEC session on PFP topic in ANC Service	Mukura HC	86%	100%	Oct-21	1-Dec-22	NA	NA	New	Ongoing	NA
	KINIGI HC	28%	85%	Oct-21	1-Apr-22	NA	NA	New	Ongoing	NA
	GataragaHC	17%	80%	Sep-21	1-Mar-22	NA	NA	New	Ongoing	NA
	Rurembo HC	30%	70%	Nov-21	1-Mar-22	NA	NA	New	Ongoing	NA
	Gakamba HC	35%	70%	Nov-21	1-Mar-22	NA	NA	New	Ongoing	NA
To increase number of sensitizations outreach on reproductive health in the community	Congo nil (Rutsiro)	0%	50%	Sep-21	31-Mar-22	NA	New	60%	Ongoing	NA
	Kinhira HC (Rutsiro)	0%	100%	Sep-21	31-Mar-22	NA	New	50%	Ongoing	NA
	Murunda HC (Rutsiro)	0%	100%	Sep-21	31-Mar-22	NA	New	30%	Ongoing	NA

QI Project	Health Facility	Baseline	Target	Start date	End date	April to June 2021	July to Sept 2021	Oct to Dec 2021	Status	Target status
	Cymbiri HC (Rutsiro)	0%	100%	Sep-21	31-Mar-22	NA	New	70%	Ongoing	NA
	Rubona (Ngororero/Muhororo)	20%	80%	Sep-21	31-Mar-22	NA	New	60%	Ongoing	NA
	Gashubi HC (Ngororero/Muhororo)	0%	60%	Sep-21	31-Mar-22	NA	New	70%	Ongoing	NA
	Nyange HC (Musanze)	27%	100%	Sep-21	31-Mar-22	NA	New	100%	Ongoing	NA
	Sovu HC (Ngororero)	0%	75%	Oct-21	31-Mar-22	NA	New	50%	Ongoing	NA
	Rubaya HC (Ngororero)	0%	75%	Oct-21	31-Mar-22	NA	New	35%	Ongoing	NA
To decrease the number of under 18 years girls who give birth at health center	Nyakiliba HC (Gisenyi)	56%	15%	Sep-21	31-Mar-22	New	New	25%	Ongoing	NA
	Kigufi HC (Gisenyi)	71%	20%	Sep-21	31-Mar-22	New	New	30%	Ongoing	NA
	Gacuba HC (Gisenyi)	33%	0%	Sep-21	31-Mar-22	New	New	10%	Ongoing	NA
	Busigali HC (Gisenyi)	77%	25%	Sep-21	31-Mar-22	New	New	55%	Ongoing	NA
	Karambo HC(Gisenyi)	61%	20%	Sep-21	31-Mar-22	New	New	33%	Ongoing	NA
	Kabari (Rubavu) HC	60%	20%	Sep-21	31-Mar-22	New	New	10%	Achieved	
	Byahi (rubavu) CS	38%	10%	Sep-21	31-Mar-22	New	New	5%	Achieved	
	Murara CS (Rubavu)	39%	0%	Sep-21	31-Mar-22	New	New	20%	Ongoing	NA
	Jomba HC (Nyabihu)	18%	2%	Oct-21	31-Mar-22	New	New	16%	Ongoing	NA
	Rwankeri HC (Nyabihu)	20%	0%	Oct-21	31-Mar-22	New	New	12%	Ongoing	NA
	Nyundo HC (Rubavu)	50%	0%	Sep-21	31-Mar-22	New	New	20%	Ongoing	NA
Gisenyi HC (Rubavu)	22%	0%	Sep-21	31-Mar-22	New	New	5%	Ongoing	NA	