



Decentralization and Health Program

Twubakane Final Report

...Let's Build Together



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ACRONYMS

ACI	Anti-Corruption Initiative	M&E	Monitoring and Evaluation
AMTSL	Active Management of Third Stage of Labor	MINALOC	Ministry of Local Administration
ANC	Antenatal Care	MINECOFIN	Ministry of Economic Planning and Finance
BCC	Behavior Change Communications	MINISANTE	Ministry of Health
CHIS	Community-Based Health Information System	MPA	Minimum Package of Activities
CHW	Community Health Worker	MTEF	Medium-Term Expenditure Framework
CPA	Complementary Package of Activities	NDIS	National Decentralization Implementation Secretariat
CPR	Contraceptive Prevalence Rate	NHA	National Health Accounts
CYP	Couple years of protection	NSV	Non-Scalpel Vasectomy
CS	Child Survival	OJT	On-the-job training
DDP	District Development Plan	PAQ	Partenariat pour l'Amélioration de la Qualité
DHS	Demographic and Health Survey	PMI	President's Malaria Initiative
DIF	District Incentive Fund	PMP	Performance-Monitoring Plan
DIP	Decentralization Implementation Program	PMTCT	Prevention of Mother-to-Child Transmission
EDPRS	Economic Development and Poverty Reduction Strategy	PNILP	Programme National Intégré de Lutte Contre le Paludisme
EONC	Emergency Obstetric and Neonatal Care	RALGA	Rwanda Association of Local Government Authorities
FAM	Fertility Awareness-Based Methods	RDSF	Rwanda Decentralization Strategic Framework
FANC	Focused Antenatal Care	RFA	Rapid Facility Assessment
FP	Family Planning	RH	Reproductive Health
GBV	Gender-Based Violence	RIAM	Rwandan Institute of Administration and Management
GOR	Government of Rwanda	RNP	Rwandan National Police
HBM	Home-Based Management	RTI	Research Triangle Institute
HC	Health Center	SBA	Skilled Birth Attendant
HIV	Human Immunodeficiency Virus	SDM	Standard Day Method
HMIS	Health Management Information System	SDP	Service Delivery Point
HSSP	Health Sector Strategic Plan	SRA	Systems Research and Applications
IEC	Information, Education and Communication	SWAp	Sector Wide Approach
IMCI	Integrated Management of Childhood Illness	SWOT	Strengths, Weaknesses, Opportunities, Threats
ITN	Insecticide-Treated net	TA	Technical Assistance
IPT	Intermittent Presumptive Treatment	USAID	United States Agency for International Development
IUD	Intrauterine Device	USG	United States Government
JADF	Joint Action Development Forum	VCT	Voluntary Counseling and Testing
MCH	Maternal and Child Health	VNG	Netherlands International Cooperation Agency
		WHO	World Health Organization

TWUBAKANE IMPLEMENTING PARTNERS

- IntraHealth International (*lead partner*)
- RALGA
- RTI International
- Pro-Femmes Twese Hamwe
- Tulane University
- Government of Rwanda
- EngenderHealth
- Ministry of Local Government
- VNG
- Ministry of Health

EXECUTIVE SUMMARY

IntraHealth International, Inc., with its partners RTI International, Tulane University and others, is pleased to present this final report for Rwanda's Twubakane Decentralization and Health Program.

This report presents overall accomplishments, challenges and lessons learned by the Twubakane Program from January 2005 through January 2010. The Twubakane Decentralization and Health Program was a five-year USAID-funded program designed to increase access to and the quality and use of family health services in Rwanda. The program supported improved integrated service delivery in hospitals, health centers and communities by strengthening the capacity of local governments, health facilities and communities to plan for, budget, manage and offer high-quality services. The program worked in 12 districts of Rwanda—four in the Eastern Province, five in the Southern Province and three in the City of Kigali—and supported more than one-third of Rwanda's population of approximately 10 million.

The Twubakane Program built capacity to offer services at decentralized levels, and provided support for improving health *and* decentralization policies, protocols and strategies at the central level. Rather than developing Twubakane-branded materials, the program worked closely with ministries and other partners to invest in nationally adopted manuals and programs, and then assisted with dissemination, orientation/training on and use of these materials in the partner districts and health facilities. Over the course of five years, Twubakane contributed to the development of numerous policies, strategies and guidelines for decentralization and health, including the fiscal decentralization policy and equalization formula, revised health policies, including family planning, safe motherhood, child survival, behavior change communication and community health, and the economic development and poverty reduction strategy.

In addition to supporting significant policy support and health system reform, the Twubakane Program worked in close partnership with districts, hospitals, health centers and communities to achieve significant results. Nationally, the use of modern contraception in Rwanda increased from 4% in 2005 to 27% in 2007/2008. In Twubakane-supported districts, Couple Years of Protection increased seven-fold over the five years and the number of women delivering with skilled birth attendants in facilities increased by 75%. The Twubakane Program team was also proud to contribute to Rwanda's historic reductions in infant and child mortality between 2005 and 2007/2008. Community Health Workers are in place to locally address health issues such as malaria, diarrhea, nutrition and family planning. At the central ministry level, Twubakane and other partners collaborated to support improved capacity to develop and disseminate policies, programs and procedures. The MINALOC and the MINISANTE are building systems, policies, programs, and procedures for effective decentralization and service delivery. More than \$5 million were awarded in grants to the 12 districts and the City of Kigali to strengthen health service delivery at decentralized levels. Hospitals and health centers have stronger management skills and strategic plans are in place for selected facilities. Contributing to the management capacity, community health insurance programs – *mutuelles* – are stronger, with greater membership and provision of resources to facilities for care delivery. Finally, Community-provider partnership teams exist in 98% of health centers in Twubakane-supported districts and are working together to make improvements in health service delivery.

Rwanda's rapidly changing environment allowed for great successes and presented many challenges. Launching the Twubakane Program in a time of widespread reform necessitated implementing activities at both the central and decentralized levels while also responding to and supporting the changes as they

occurred at all levels. The close collaboration between the Twubakane staff and the GOR counterparts, and a variety of other partners, at all levels, contributed to fostering an integrated approach, both within the health sector, and among health, decentralization and good governance, and overall social and economic development.

INTRODUCTION AND BACKGROUND

The Twubakane Decentralization and Health Program, implemented by IntraHealth International, RTI International, Tulane University's Payson Center and other partners, was a five-year USAID-funded program that began in January 2005. Other partners included the Rwanda Association of Local Government Authorities (RALGA), EngenderHealth, VNG (Netherlands International Cooperation Agency) and Pro-Femmes.

The Twubakane Program's overall goal was to increase access to and the quality and use of family health services in health facilities and communities by strengthening the capacity of local governments, health facilities and communities to ensure improved health service delivery at decentralized levels. The program was designed to work in close collaboration with the Government of Rwanda, as represented by the Ministry of Health (MINISANTE) and the Ministry of Local Administration (MINALOC)

Initially funded at \$24 million, the Twubakane Program received a total obligation of \$28,379,327 from USAID. Twubakane's cost-share and leveraging added approximately \$6,491,899 of associated cash and in-kind programming, for a total program effort of more than \$34,871,226 million.

Twubakane's approach was designed to include central-level policy and technical support as well as hands-on district, health facility and community capacity building to support Rwanda's transition to a highly functioning decentralized health system.

Twubakane's overall strategy focused on improving capacity to offer services at decentralized levels, and selective support for improving health *and* decentralization policies, protocols and strategies guidelines at the central level. Rather than developing Twubakane-branded materials, the program worked closely with ministries and other partners to invest in nationally adopted manuals and programs, and then assist with dissemination, orientation/training on and use of these materials in the partner districts and health facilities.

Twubakane Program Participating Districts

- 1) Nyarugenge, Kigali
- 2) Kicukiro, Kigali
- 3) Gasabo, Kigali
- 4) Ngoma, Eastern Province
- 5) Kayonza, Eastern Province
- 6) Kirehe, Eastern Province
- 7) Rwamagana, Eastern Province
- 8) Kamonyi, Southern Province
- 9) Muhanga, Southern Province
- 10) Nyaruguru, Southern Province
- 11) Nyamagabe, Southern Province
- 12) Ruhango, Southern Province

In January 2005, when USAID's Rwanda Health and Decentralized Project was awarded to IntraHealth and its partners, Rwanda's territory was organized into 12 provinces, 40 health districts and 106 administrative districts. Health districts were defined according to the location of district hospitals, operating fairly independently from administrative districts and reporting directly to the central level MINISANTE. This organization, with separate and discrete administration and health districts, led to little collaboration and coordination among the districts and to a lack of integration in the health sector at both central and decentralized levels. These challenges, acknowledged by the MINISANTE during its first Joint Health Sector Review in 2006, implied the need for greater coordination and a multisectoral approach to health at all levels.

During its first year of implementation, and as planned in the program design, Twubakane worked in four of the country's 12 provinces: Gikongoro, Gitarama, Kibungo and Kigali municipality. Pursuant to

the Government of Rwanda's redistricting and territorial reform in early 2006, the Twubakane Program, in collaboration with USAID and partner ministries, proposed focusing its activities in 12 of the 30 districts in Rwanda (which closely align with the four former provinces).

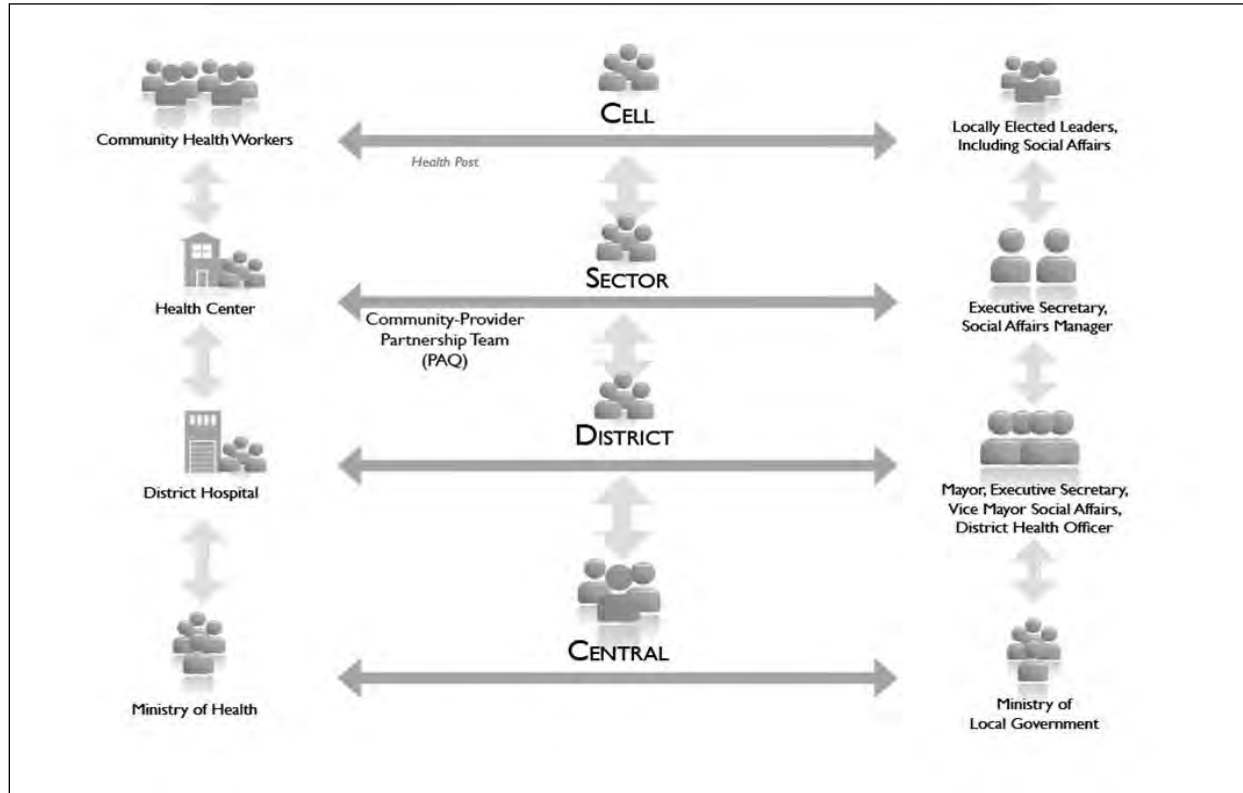
As part of the program's multilevel launch, in 2005, the Twubakane Program organized innovative participatory planning workshops at national, provincial and district levels, bringing together representatives of administrative districts, health districts and civil society organizations to discuss health and decentralization in a new way—generating great enthusiasm (and creating great expectations) not only for the Twubakane Program, but also for the concept of decentralized health. These workshops were innovative in part because Twubakane invested considerable effort into ensuring that Twubakane's action plans were harmonized with those of administrative and health districts, and that the plans aligned with national policies and strategies. The participatory planning workshops helped prepare stakeholders for the new phase of decentralization in Rwanda by bringing together decentralized level health and administrative authorities in a new interactive way.

In 2006, Twubakane had a unique opportunity to offer support to the Government of Rwanda's new phase of decentralization, helping to ensure that it led to improved health care services management and delivery. Immediately following the first district mayoral elections in February 2006, the Twubakane team was on the ground with our district partners, helping them develop the notable first performance-based contracts signed in April 2006 between the mayors and the President of Rwanda—*imihigo*¹. The *imihigo* include approximately 100 indicators, of which about are 15 health-related. These included, and continue to include, such indicators as contraceptive prevalence rate (CPR), births in health facilities, membership in community-based health insurance schemes, use of insecticide-treated nets (ITNs), and construction of latrines to promote good hygiene. The *imihigo* have helped galvanize local support, and encouraged mayors and other district authorities to become advocates for public health, increase their local health budgets and demand additional resources from national health programs that had been previously centralized.

The first two years of the program, 2005 and 2006, represented significant change for the Government of Rwanda (GOR), with the launch of an administrative reform and redistricting process in early July 2005, a process that had a major impact on all levels of government. In addition to territorial reform and redistricting, the new phase of decentralization involved new roles and responsibilities at all levels. The MINISANTE, along with other sectoral ministries, significantly reduced central-level staff as capacity was shifted to decentralized levels. Under the new administrative system, health districts were incorporated into the districts as departments of health and social services, and health officials responsible for district-level service delivery and management reported directly to locally elected district mayors. With the Government of Rwanda embarking on major decentralization and administrative reform, the Twubakane Program has been in a unique position to provide timely assistance not only to initiate and support key health-related interventions but also to provide solicited and timely support to the Government of Rwanda for decentralization and administrative reform. This support included highly appreciated central-level technical assistance for the development of a new fiscal decentralization policy.

¹ *Imihigo*, a traditional Rwandan rite where groups or individuals make public pledges particular accomplishments with failure being associated with shame and dishonor, are the common name for performance-based contracts.

Figure 1. Rwanda Health and Decentralization Diagram



Also in 2006, at the request of the MINISANTE, the Twubakane Program contributed extensively to the coordination of the organizing committee for the Ministry’s first Joint Health Sector Review meeting, organized to review and analyze implementation of Rwanda’s first Health Sector Strategic Plan (HSSP I), 2005—2009, as well as to begin discussions related to a move toward more joint planning and a Sector Wide Approach (SWAp). During this first Joint Health Sector Review meeting, sessions also were held to discuss and clarify roles and responsibilities of districts, health officers and hospital directors in the rapidly evolving and decentralizing health sector.

An important innovation introduced by the Twubakane Program in 2006 was the District Incentive Funds (DIF) grants initiative, through which more than \$5 million in funds were granted directly to Twubakane –supported districts. (Due to inevitable issues, the DIF grants, originally scheduled to begin during the first year of the project, were delayed by a year.) These grants provided funding for each district to strengthen health service delivery at the decentralized level. Each grant (ranging in value from \$75,000 to \$150,000 per year) allowed districts to fund activities related to strengthening their specific health service delivery issues while also receiving technical assistance and capability building support from the Twubakane Program. (See more about the DIF grants in Component 4 below, and in the District Incentive Fund Grants Assessment Report.)

The year 2006 represented a year of major advances in decentralization and health policy and program development at the central level, as well as trainings of both district teams and of health care providers in hospitals and health centers. The newly created districts were beginning to plan for and budget to support and contribute to training and other capacity-building initiatives related to family health, family

planning, maternal health, child health, including malaria and nutrition, *mutuelles* strengthening and health facility management.

By early 2007, the districts, which had been in existence for a full year, demonstrated greater capacity to prioritize local needs and develop and implement District Incentive Fund grants initiatives that had an impact on the health of their populations, with great focus on malaria, community health, and mobilization of local authorities to support family planning. Also in 2007, as Rwanda's government rolled out the national health insurance coverage law, Twubakane's support to the national *mutuelles* management system and technical unit became critical, both in terms of supporting more sustainable approaches to ensuring coverage for indigents and in terms of ensuring sustainable financial viability efficient management.

The Twubakane Program was designed, by USAID and the GOR, to have two distinct phases, and in July 2007, the program held a continuing application workshop and presented a revised strategic proposal to USAID and the GOR. The continuing application document was developed in close communication with a variety of partners and stakeholders. To preparation for the workshop, the Twubakane team held a participatory workshop with representatives from ministries, districts, health facilities and direct beneficiaries to ensure that the program would continue to be responsive to needs at all levels in order to maximize results in a sustainable way. The preparatory workshop, and the continuing application workshop itself, resulted in overwhelmingly positive feedback, with stakeholders appreciating Twubakane's overall responsiveness, flexibility, support of GOR-led priority programs and approach of combined technical and financial assistance. (In response to the Twubakane's Continuing Application submission, USAID/Rwanda raised the overall budget ceiling of the cooperative agreement to \$30,689,199, with additional funding planning for malaria control efforts, family planning and addition field staff.)

In 2008, the Twubakane team continued to work closely with districts and other partners to promote high-quality health services, focusing on sustainability strategies for each program-supported intervention. The program built upon the strides made in the first three years, focusing on the ability of districts to manage and implement the DIF grants and to support the quality of health services, as well as linkages through the community-provider partnership PAQ (*Partenariat pour l'Amélioration de la Qualité*) teams. Twubakane-supported districts demonstrated improved capacity to plan, budget for and manage services, while also recognizing the continued importance and need to build additional capacity of health care providers, health facilities and district authorities. The Twubakane team also began to shift away from conducting direct supervision of providers to supporting supervision and coaching on the part of district hospital supervisors and other local authorities.

In 2008 and 2009, the Twubakane team also continued to participate actively in the Health Sector Cluster Group and Decentralization Sector Cluster Group (or Decentralization, Citizen Empowerment, Participation, Transparency and Accountability, DCEPTA, group). Twubakane also supported the initiation of the newly formed Health Development Partners Group. Through these groups, Twubakane participated actively in the final evaluation of the Rwanda's HSSP I and the development of the country's second HSSP, 2009—2012. These groups also contributed to the development of the health sector's Sector Wide Approach (SWAp), supporting the design and application of the Joint Action Work Plan at central and decentralized levels.

In 2009, during the last year of program implementation, the Twubakane team focused on working closely with teams at the level of districts, hospital, health centers, community-provider partnerships

and communities to ensure sustainability of results beyond the end of the Twubakane Program. In early 2009, the Twubakane team learned that the full anticipated funding from USAID would not be available, and, at the request of USAID, worked closely with the MINISANTE, MINALOC and partner districts to review 2009 workplans accordingly. Although some planned activities were postponed or cancelled this year due to funding shortfalls, for other key activities, the Twubakane Program, with USAID's support, was able to leverage funding from other development partners to ensure that activities were carried out. (A notable example of this was the highly successfully on-the-job training for FP that was co-supported by Family Health International in two districts.) In addition, in several instances, the districts themselves took on funding and technical assistance to ensure that the planned activities took place. This reaction of the districts bodes well for the continuity and sustainability of interventions introduced during the life of the five-year Twubakane Program.

During this last year of program implementation, the Twubakane team also completed several important studies and reviews, including "Good Governance and Health: Assessment Progress in Rwanda," "Community-Providers Partnerships for Quality Improvement in Rwanda: Assessment of the *Partenariat pour l'Amélioration de la Qualité [PAQ]* Approach," and "The Twubakane Program's District Incentive Funds (DIF) Grant Initiative in Rwanda: Final Assessment." In addition, as described below, the Twubakane Program conducted a final rapid facilities assessment in all health centers and hospitals in the program's partner districts.

These final assessments revealed significant progress in health and decentralization indicators in Rwanda, and, specifically, improvements in access to and use of high-quality services in Twubakane Program districts. As the Honorable Minister of Health noted during the Twubakane End-of-Project Workshop, the Twubakane Program successfully demonstrated its capacity and flexibility in responding to the ever-changing needs and demands of supporting health and decentralization in Rwanda, and deserves credit for contributing to the impressive overall results in the health sector since 2005.

Finally, in early December 2009, the Twubakane team held a participatory stakeholders workshop with representatives of USAID, the GOR (MINISANTE, MINALOC and NDIS), other partner organizations, the 12 Twubakane-supported districts, hospitals, health centers, and community-provider partnership teams. During the workshop, participants reviewed key accomplishments and lessons learned during the five-year Twubakane Program, committed themselves to maintaining momentum and devoting resources to ensuring sustainability of results, and outlining important prioritizes or next steps for each Twubakane Program component. During this workshop, the Twubakane Program team and its partners also planned for the Twubakane End-of-Project Ceremony, which was held on December 18, 2009. During the EOP ceremony, the nearly 200 participants heard about the many successes and lessons learned throughout the project. Participants included the Minister of Health, the US Ambassador, the USAID Mission Director, as well as the MINISANTE's Permanent Secretary, the governor of the southern province, mayors, hospital directors, other representatives from the 12 Twubakane-supported districts and a variety of partner organizations. IntraHealth was represented by its President and CEO and well as its Director of MCH and FP. During his remarks, the Minister of Health noted Twubakane's success and credited the program with creating demand for quality and quantity of services. Highlighting the program's flexible approach and its ability to respond to and support the evolution of Rwanda's rapidly changing decentralized health systems, he also noted the excellent relationships that the Twubakane Program staff had with the MINISANTE team. "Whether it was family planning, child health or community services, we called on the team, and they were there," the minister said. "They share in all of these results that the health sector has realized over the past few years." The minister also thanked

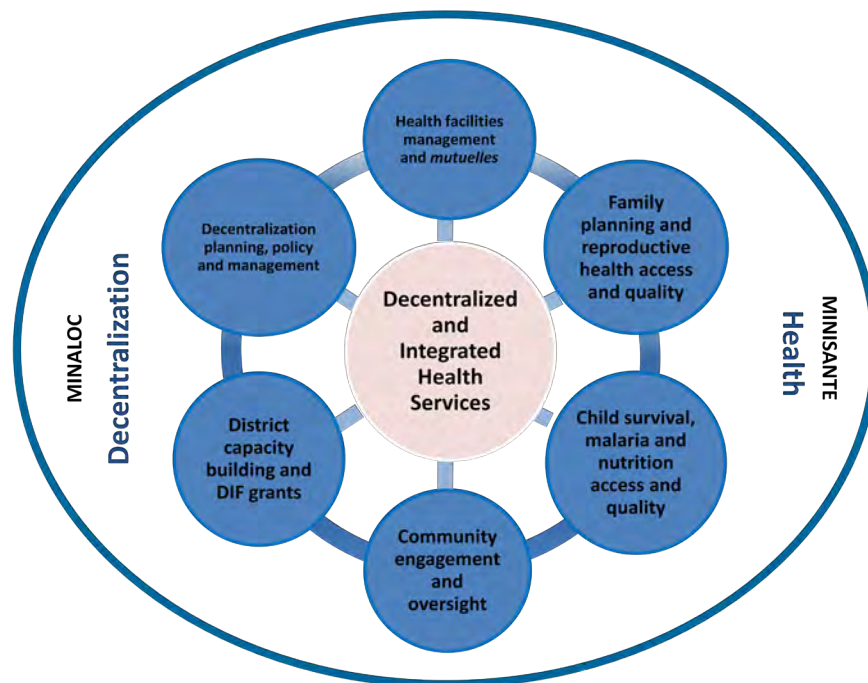
USAID for the technical and financial support the program provided to the districts and to the Ministries of Health and of Local Governance.

PERFORMANCE REVIEW

The Twubakane Program consisted of six integrated components: (1) family planning and reproductive health, (2) child survival, malaria and nutrition, (3) decentralization policy, planning and management, (4) district planning, budgeting and management, (5) health facilities management, and (6) community access to, participation in, and ownership of health services. Twubakane was designed to support decentralization and health simultaneously and synergistically all Twubakane strategies have been systematically integrated across these six project component areas. Three essential cross-cutting elements that have been included in each of the six components: gender equity, communications and human capacity building.

All interventions have been “on program,” consistently aligned with the Government of Rwanda’s policies and programs, and with those interventions supported by other development partners and donors.

Figure 2. Twubakane Program Model



In the following sections, overall accomplishments and results achieved are described for each component. For a list of results by component, please see the Twubakane Program Results Framework in Annex A.

For each component, data related to the Twubakane Program Performance-Monitoring Plan (PMP) is reported for the life of the project. Data were obtained from all health centers and district hospitals receiving Twubakane support, unless otherwise stated. Data were provided from the Rwanda health management information system (HMIS), rapid facility assessments (RFA) in health centers and hospitals Twubakane Program Final Report, January 2010

conducted annually by Twubakane, and district authorities as part of an annual strengths—weaknesses—opportunities—threats (SWOT) exercise. Additional results related to capacity-building activities are documented in the Twubakane Program’s training database.

Component 1: Family Planning and Reproductive Health Access, Quality and Use

Over the past several years, Rwanda’s indicators related to family planning and reproductive have improved significantly, as indicated in the following table:

Table 1. Rwanda’s National Maternal and Child Health Indicators (DHS Surveys)*

INDICATORS	2000	2005	2007-08
Maternal mortality rate /100,000 live births	1071	750	NA
Use of modern contraception	4%	10%	27%
Total Fertility Rate	5.8	6.1	5.5
Use of antenatal care (at least one visit)	92%	94%	96%
Deliveries assisted by trained personnel	31%	39%	52%

* Enquête Démographique et de Santé, Rwanda 2000. Calverton, Maryland; ORC Macro, 2001. Institut National de la Statistique du Rwanda (INSR), ORC Macro. Rwanda Demographic and Health Survey 2005. Calverton, Maryland; INSR and ORC Macro, 2006. National Institute of Statistics (NIS) [Rwanda], Ministry of Health (MOH) [Rwanda], and Macro International Inc. Rwanda Service Provision Assessment Survey 2007. Calverton, Maryland; NISR, MOH, and Macro International Inc., 2008.

Repositioning FP: When the Twubakane Program began in early 2005, the newly formed FP technical working group had two overall objectives: developing Rwanda’s first national FP policy, and promoting high-level government support for family planning and population issues. Twubakane staff contributed actively to achieving both objectives. By late 2005, the national policy had been developed, and starting in 2006, the President of Rwanda declared family planning as a national priority, requesting that all ministries develop their own plans to promote family planning. Throughout five years, the Twubakane Program supported FP repositioning in Rwanda to ensure that advocacy was translated into action through orientation of authorities and local leaders on population and health issues in FP, collaboration with the Ministry of Economic Planning and Finance on the revised National Population Policy, support for mobilization activities through District Incentive Fund (DIF) grants and for implementation of district plans to reach FP objectives laid out in the performance-based contracts between the districts and the President.

Starting in early 2008, in response to Rwanda's successes in prioritizing family planning and population issues, and impressed with successes in USAID-supported FP service delivery, the Hewlett Foundation provided IntraHealth with a grant to support "the solidification of Rwanda's political commitment to population and family planning, and to assist the country in translating that commitment into a comprehensive, evidence-based national program that respects the rights of individuals." This grant, which provided important cost share and support to Twubakane's efforts at repositioning family planning, supported Twubakane's collaboration with the Rwanda Parliamentarians' Network for Population and Development. This resulted in ongoing efforts by parliamentarians to speak directly to their constituents about the important contributions of family planning to their health and development. The Hewlett-supported initiative also allowed Twubakane to support high-level government commitment to population and FP, to train local authorities from all 30 of Rwanda's districts, to train journalists in FP to improve media coverage, and produce a report on Rwanda's experience with FP. This report has been cited in numerous other reports and presentations about family planning in Africa and this Rwanda case study is scheduled to be featured in USAID/Washington's upcoming Repositioning in Action E-Bulletins planned for February 2010.

http://www.intrahealth.org/files/media/5/fp_in_Rwanda.pdf

Increasing Access to and Use of Quality FP Services: The Twubakane Program collaborated with the MINISANTE and other partners, through the FP technical working group, to implement a decentralized approach to the nationwide rollout of FP training, providing trained district-level trainers with the capacity to provide ongoing training and supportive supervision starting in 2005. As part of the FP training, Twubakane supported continued training and post-training follow-up in long-acting methods to ensure that all health centers (HCs) are able to offer a full range of short-term *and* long-acting methods (IUDs and implants). Prior to 2006, FP clients had to go to district hospitals to receive long-acting contraceptive methods. However, training in long-acting methods that began in late 2006 ensured that these methods would be available at all HCs that offered modern contraception. Many HCs requested refresher training and supportive supervision during 2007 and 2008 due to attrition of providers or a desire for enhanced knowledge and skills.

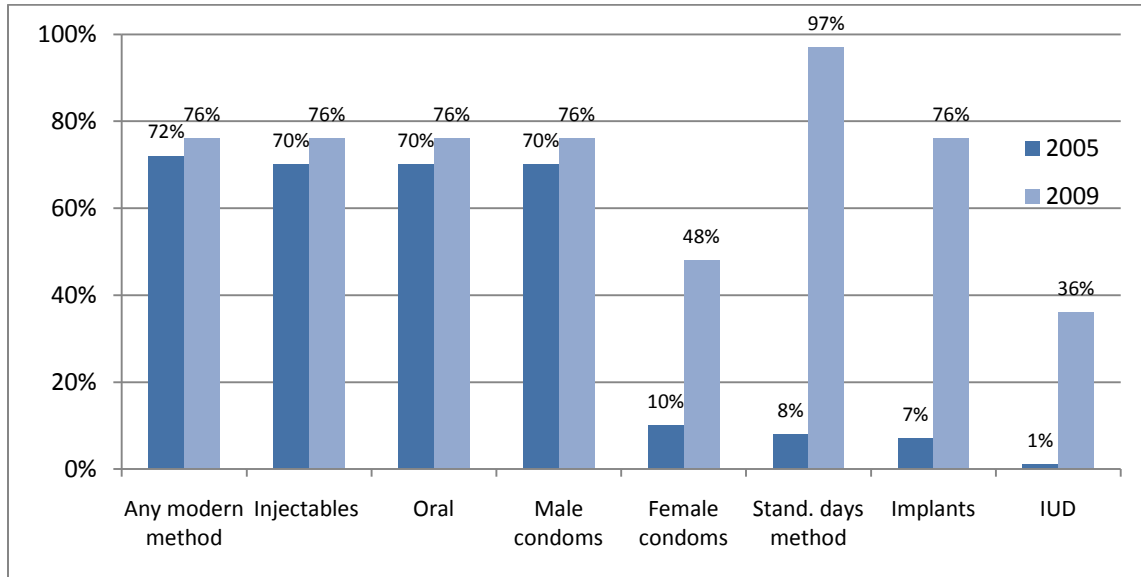
Also starting in 2005, Twubakane collaborated with Georgetown University Institute for Reproductive Health to scale up the Standards Days Method (SDM), making Fertility Awareness-Based Methods (FAM) more widely available in Rwanda. Twubakane procured nearly 20,000 sets of CycleBeads and introduced SDM in the method mix included in FP training modules for health care provider training in FP. CycleBeads are currently available nationwide and systematically included in the range of methods offered in health centers including, but not limited to, Catholic-supported health centers.

The five-year Twubakane Program trained and supported a total of 1256 health care providers offer quality services in family planning. Twubakane collaborated closely with district-level supervisors for supportive supervision of FP services. Twubakane staff members conduct visits monthly to selected sites with district health supervisors, mentoring them in the supportive supervision methodology to increase quality of services. By the end of 2008, all public (non Catholic-supported) HCs in the 12 Twubakane-supported districts were offering modern contraceptive methods including at least one long-acting method.

Data collected for the PMP indicate continued increases in FP availability and utilization. As seen in Figure 3 (below), the percentage of facilities providing modern contraceptives has increased since 2005. While the percentage increase is limited due to the fact that many health centers are Catholic-

supported, there has been a significant increase in the percentage of facilities offering IUDs, implants, and the Standard Days Method.

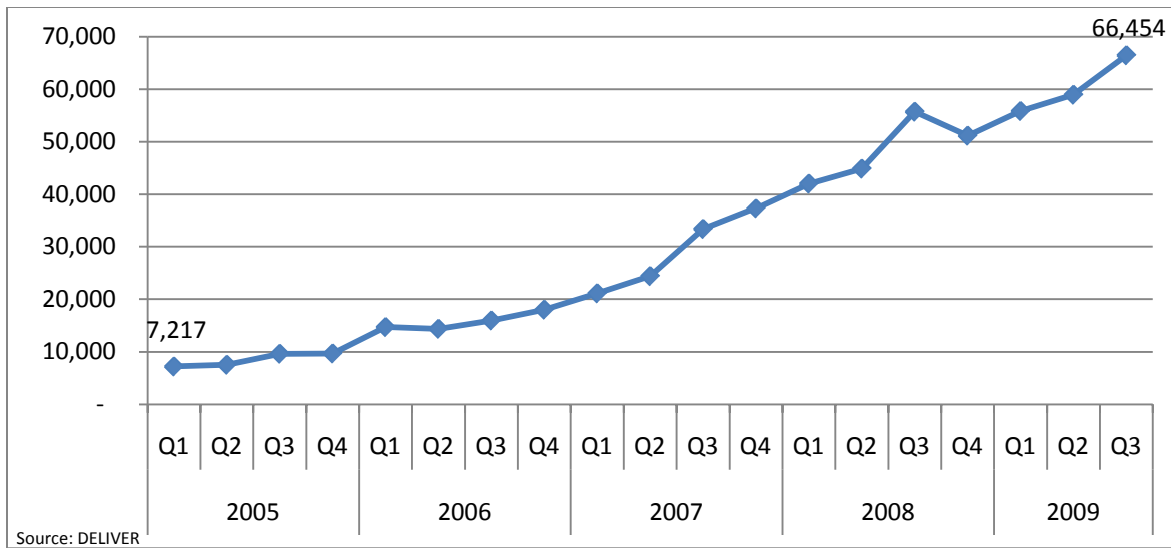
Figure 3. Percentage of Health Centers Offering Modern Contraceptive Methods



In 2005, Twubakane supported 110 HCs and 12 district hospitals and in 2009, 136 HCs and 14 hospitals. For explanations of which facilities provided data for indicators, please see Annex C.

Figure 4 shows a consistent increase in couple years of protection (CYP) in Twubakane-supported districts, with nearly a five-fold increase in CYP since 2005, and a 70% increase between 2007 and 2008. Couple years of protection, a proxy for measuring contraceptive coverage, is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated from routine data collection on contraceptive commodities distributed and administered to clients. CYP is a way to estimate coverage, providing an indication of the volume of program activity, as well as comparison among the different family planning methods

Figure 4. Twubakane Supported Districts—Couple Years of Protection, 2005-2009



On-the-Job Training for Family Planning: To further expand client access to FP services and to facilitate the integration of FP into all health center services, IntraHealth-led projects in Rwanda (Capacity Project and Twubakane Program) embarked on an on-the-job training (OJT) approach starting in 2008 to increase the number of trained and supported health providers at each facility and to build the capacity of health facilities to continually update new providers. In collaboration with the MINISANTE and other FP partners, the national standardized two-week FP workshop curriculum was adapted to an eight-week OJT approach. Using IntraHealth’s *Learning for Performance* methodology, streamlining the content and increasing opportunities for hands-on skills practice, the OJT schedule allows participants to complete individualized exercises and practice sessions on their own time. Group activities are conducted in the clinic during the afternoons when there were few clients. After successfully completing mid-course knowledge and skills assessments, OJT participants get clinical practice with actual clients during the busy morning clinic sessions. An average OJT trainer-trainee ratio of one to six allows for increased discussion, coaching and feedback with the trainer. To receive certification, participants demonstrated knowledge mastery and skills competency in simulated, then actual client interactions.

The Twubakane Program supported OJT for FP in the districts of Ruhango, Nyamagabe and Nyaruguru in the Southern Province, with Family Health International providing extensive support for OJT in Nyamagabe and Nyaruguru. A total of 90 providers in Ruhango, 126 in Nyamagabe and 92 in Nyaruguru successfully completed the 8-week OJT course. Supportive supervision conducted during the OJT course showed that health center staff appreciated the teamwork approach instilled through OJT, and expressed the desire to use these teamwork approach in other areas.

The OJT participants appreciated the fact that the OJT schedule allowed them to complete individualized exercises and practice sessions on their own time. Group activities were conducted in the clinic during the afternoons when there were few clients. After successfully completing mid-course knowledge and skills assessments, OJT participants proceeded to guided clinical practice with actual clients during the busy morning clinic sessions. An average OJT trainer-trainee ratio of one to six allowed for increased discussion, coaching and feedback with the trainer. In order to receive certification, participants demonstrated knowledge mastery and skills competency in simulated, then actual client interactions. A

small financial incentive was provided for high performing participants. Initial results indicate that more health care providers are trained to competency using the OJT approach in a shorter length of time at a much lower cost per participant. In addition, through OJT, there also is less disruption in offering regular clinic services. Finally, OJT participants also served nearly twice as many clients as workshop participants during the usual two-week training, particularly clients requesting long-acting methods such as *Jadelle* implants.

On-the-Job Training—Efficient and Cost-Effective:

“This on-site training in FP was wonderful, and allows us to train a maximum number of providers with minimal financial resources, said Froduard Nyirishema, health director in Ruhango District. “The results I saw in the health centers definitely showed that this was a success. We do need to follow up and support ongoing training and coaching.” Donatha Mujawamaliya, a nurse from Kinazi Health Center, said “The training was very useful. A family planning client can be received by any of our nurses now. I myself feel capable to give accurate information, whether it’s in the maternity ward, during VCT or PMTCT. I can give advice about sides effects, too... in the past, I always sent clients with questions about FP to my colleague; now I don’t have to do that.” And Hilarie Mukamana, a nurse from Mukoma Health Center agreed that, “This training was necessary. Before, I thought that inserting a Jadelle or IUD was some kind of magic. Now, I am capable of doing it myself. I would only ask you to think about organizing this kind of training in other areas, especially in emergency obstetrics and neonatal care.”



OJT participants in all districts recommended that the MINISANTE evaluate the advantages of this new training approach to better support it and extend it to other areas, recommend that other partners in the health sector adopt the OJT approach in the trainings they support, and ensure supervision of the providers trained through OJT to facilitate sustainability of the approach.

Introduction of Permanent Methods—non-scalpel vasectomy: As part of continued expansion of the availability of long-acting and permanent FP methods, the Twubakane Program introduced non-scalpel vasectomy (NSV) in five districts in 2009. Through the introduction of this service, Twubakane trained 49 providers to counsel clients in permanent methods and trained 11 doctors and 10 nurses (as assistants) to perform the non-scalpel vasectomy. A medical team (doctor and nurse) was trained from Gitwe, Rwamagana, Kigeme, Kibungo, Kabgayi and Kaduha hospitals. The practical training took place in selected health centers (Gitarama, Rutobwe and Shyogwe in Muhanga District) and Gitwe Hospital in Ruhango District. As of the end of December 2009, a total of 66 vasectomies had been performed in the six hospitals participating in the vasectomy trainings.



Long-Acting Family Planning Methods Meet the Need: Kinazi Health Center in Ruhango District has led the way in offering IUDs and other long-acting methods. Between August 2008 and September 2009, they registered 169 IUD clients and 158 implant clients—and contraceptive prevalence was estimated at 32.4%. “We are proud to offer a full range of long- and short-acting methods of family planning, our clients are also happy to receive convenient services. We work with community health workers and local leaders to sensitize our population, and integrate FP in other services like HIV/AIDS services and

vaccination. Many clients prefer the long-acting methods; we are very grateful that Twubakane has given us the capacity to offer these methods,” said Marie Claire Harerimana, health center manager.

Family Planning Secondary Posts: Rwanda has a strong tradition of health care provision by faith-based facilities (38% of all public health facilities nationwide are faith-based, primarily Catholic). Most of the faith-based health facilities, and all of those supported by the Catholic Church, do not offer modern methods of FP. Of 136 health centers in the 12 Twubakane-supported districts, 32 do not offer a full package of modern FP methods due to their affiliation with the Catholic Church.

To overcome this obstacle, starting in 2006, the Twubakane Program collaborated with the MINISANTE, districts, and other partners to establish FP secondary posts that ensure that clients have nearby access to a full range of modern methods of FP, even if their primary source of health care services is a Catholic-support facility. The Twubakane team, local district and sector health authorities and Catholic leaders have worked together to establish secondary FP posts; the posts are established by the district, which provides a location where modern methods can be offered, the Catholic facility identifying providers to be trained, and Twubakane (and, starting in 2007, other partners) offering training and support, along with furnishing equipment and supplies. Support to these facilities included provision of equipment (such as exam tables and office furniture), supplies and training and supervision of providers. One challenge facing secondary posts is that many providers are “loaned” from neighboring facilities, meaning that services cannot be offered on a daily basis. However, because of this arrangement, providers are also able to refer and counter-refer clients needing additional services, such as child health care, from the neighboring HC. The secondary posts continue to struggle to have sustained support from local leaders and the continuous stocking of consumable products. Twubakane continued to work closely with the MINISANTE to ensure ongoing support for FP secondary posts, as some Catholic Church authorities have expressed concerns about the same health care providers working in both the Catholic-supported facility and the FP post. During the final year of the Twubakane Program, as part of regular data collection efforts, Twubakane was able to obtain service data from these posts, an improvement over previous years. Twubakane also worked with the MINISANTE to ensure that data from secondary posts is captured in the national HMIS; the program will begin to regularly collect data from these secondary posts in the coming year. The FP secondary posts have measurably increased access to and use of modern contraception in Rwanda. Both supervision visits and the data above have shown that the FP secondary posts are active and succeeding in decreasing unmet needs for FP. While Catholic-

supported health centers provide counseling on natural methods of FP, most are willing to refer clients to the FP secondary post for modern methods of FP now that they are in place.

Table 2. FP Secondary Posts Functioning in December 2009 (Twubakane-supported Districts)

District		FP Secondary Post
Nyaruguru	1	Ruheru
	2	Cyahinda
	3	Cyanyirankora
	4	Kibeho
	5	Ruramba
	6	Kamirabagenzi
Nyamagabe	7	Mbuga
	8	Cyanika
	9	Rugege
Ruhango	10	Muyunzwe
	11	Kizibere (DIF funded)
Kicukiro	12	Masaka
	13	Kicukiro
	14	Gikondo
	15	Rusheshe
Rwamagana	16	Munyaga
Kayonza	17	Rukara
Ngoma	18	Zaza
	19	Rukoma –Sake
	20	Jarama
	21	Gituku
Muhanga	22	Kagarama
	23	Gatenzi
	24	Mushishiro
	25	Nyarusange
	26	Kivumu
	27	Bwilika
	28	Karama
	29	Musange
Nyarugenge	30	Bilyogo
Kamonyi	31	Nyagihamba

FP/RH Integration: Since the beginning of the Twubakane Program, the team worked closely with a variety of partners, technical working groups and MINISANTE departments to support improvement integration of FP services at the health facility level, especially the integration of FP services with HIV services. Through its extensive trainings in contraceptive technology and FP counseling and IEC, Twubakane has worked to promote systematic screening and an “opt-out” approach, whereby every client who comes to a health center receives some kind of counseling or information about FP. Twubakane continued to participate actively in various HIV and FP integration discussions and activities, and provided ongoing support to USG HIV/AIDS clinical partners to develop simplified modules to ensure that providers offering HIV services are able to provide FP counseling. Twubakane and the Capacity Project also continued to include HIV integration in the ongoing training of providers in FP. Through support to secondary FP posts, Twubakane also continued to ensure that individuals and

couples that are clients of Catholic-supported facilities, including those who are HIV-positive, have access to a full range of contraceptive methods and FP services. In addition, through on-the-job training in FP, Twubakane further contributed to the integration of FP services by ensuring that a team of providers in each health center is capable of providing high-quality FP counseling and services.

Improving Access to and Use of High-Quality Safe Motherhood Services: In 2005, access to well-trained providers and high-quality safe motherhood services in health centers and hospitals was extremely limited. Women and families often expressed reluctance to delivering in health centers because any complication during labor or delivery resulted in a long, and often costly, transfer to a district hospital. In addition, pro-active prevention of post-partum hemorrhaging was not routinely practiced as providers in health centers were not allowed to use oxytocin (or other uterotonic) necessary for the practice of the active management of third stage of labor (AMTSL), thus many women suffered hemorrhages.

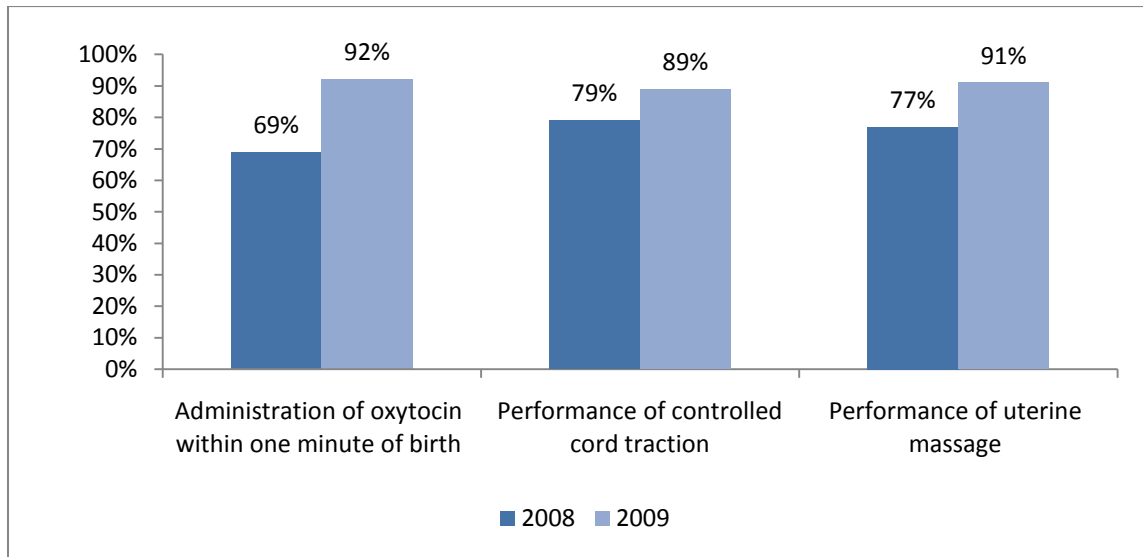
Throughout its five years, Twubakane worked at central and decentralized levels to improve safe motherhood policy, programs and service delivery. Twubakane supported the MINISANTE by serving as the secretariat for the safe motherhood technical working group starting in 2006. In 2005, Twubakane collaborated with the MCH Task Force, the National Integrated Malaria Control Program, TRAC Plus and several partners, including the USAID-funded ACCESS Project, UNICEF, UNFPA and others, to finalize the Focused Antenatal Care (FANC) protocols and training modules. Twubakane also contributed to the national quantification of RH commodities effort organized by the USAID-funded DELIVER Project. Using Pile Line software, this effort projected needs for 2008-2010 and covered items such as oxytocin, magnesium sulfate, iron/folic acid and Vitamin A, among others.

The Twubakane Program, in collaboration with other partners, supported the development of the national safe motherhood roadmap and standardized training manuals in emergency obstetrics and neonatal care (EONC).

By the end of 2009, all 12 Twubakane-supported districts have trained and validated hospital training teams in EONC. Hospital trainers have trained HC maternity ward staff—a total of 450 providers—in basic EONC, including management of obstetric emergencies (e.g. shock, eclampsia), AMTSL, and immediate post-partum and neonatal care. Twubakane also, in collaboration with district hospital supervisors, facilitated supportive supervision to health centers to improve the practice of AMTSL. In 2009, many positive findings were noted during supervision visits, including widespread and systematic use of partographs to track progress and outcomes during labor, and the practice of AMTSL to prevent post-partum hemorrhage. In addition, health providers are using improved infection prevention practices.

An important component of quality labor and delivery services is the ability of providers to practice AMTSL to prevent post-partum hemorrhaging. When Twubakane started, very few providers were practicing AMTSL and those who were, were hospital based. Providers at health centers were unable to practice AMTSL, in part because oxytocin was not officially allowed at the HC level, according to the MINISANTE policies, norms and protocols. With support from Twubakane, the MINISANTE approved use of oxytocin at the HC level pending finalization of the revised policies, norms and protocols (See Figure 5). In 2009, 88% of the deliveries that took place in health facilities had benefited from the practice of active management of the third stage of level, significantly reducing the number of cases of post-partum hemorrhage (complete data available from 106 of the 120 health centers offering AMTSL).

Figure 5: Percentage of Health Centers that Offer Active Management of the Third Stage of Labor (AMTSL)



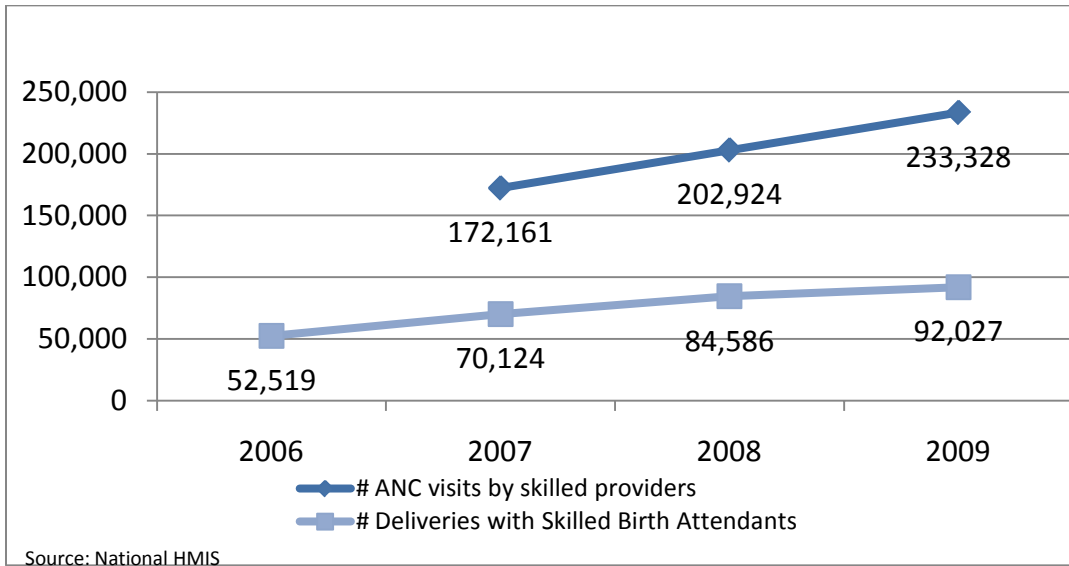
Twubakane also collaborated with the USAID-funded ACCESS Project on the introduction of Kangaroo Mother Care for case management and care of premature and underweight neonates in eight hospitals (Munini, Kigeme, Kaduha, Kibagabaga, Kanombe, Nyanza, Rwamagana and the CHUK of Kigali). In 2008 and 2009, new emphasis was also placed on the prevention of fistula, which has been incorporated into the EONC modules. Twubakane collaborated with EngenderHealth and the Fistula Care Project for improved integration of fistula prevention, repair and integration issues into ongoing activities.

Overall, health facilities supported by Twubakane exceeded the PMP targets for indicators related to antenatal care and deliveries (see Figure 6). The number of antenatal care visits from 2007 to 2009 increased by nearly 36%, and the number of deliveries by a skilled birth attendant increased by 75% from 2006 to 2009. Twubakane also exceeded its training target in maternal and newborn health.



A mother practicing Kangaroo Care.

Figure 6. Maternal Health Service Utilization from 2006 to 2009



Data on the availability of emergency obstetric and neonatal care can be seen in Table 3 and Figure 7, below. The goal in Rwanda is for all HCs with a maternity unit to offer essential emergency obstetrics and neonatal care (EONC) care, composed of six interventions to address complications during deliveries, and for district hospitals to offer comprehensive EONC, the six essential interventions plus cesarean sections and blood transfusions. Twubakane has focused on assisting MINISANTE reach this goal through training and supervision, and supporting and equipping hospitals as well as health centers to be able to provide these services. An important challenge in the future will be ensuring: (1) ongoing refresher training courses to ensure the availability of well-trained providers, and (2) reliable stock of the needed commodities and supplies for EONC. District-level hospitals in Twubakane-supported districts are, for the most part, able to offer high-quality EONC services, but some health centers still face challenges concerning commodities and trained providers (as trained providers often move on or are transferred to other facilities.) In 2007, two new hospitals, Kirehe and Munini, were opened and began offering delivery services; thus, results for hospitals offering comprehensive EONC are not consistent across the years.

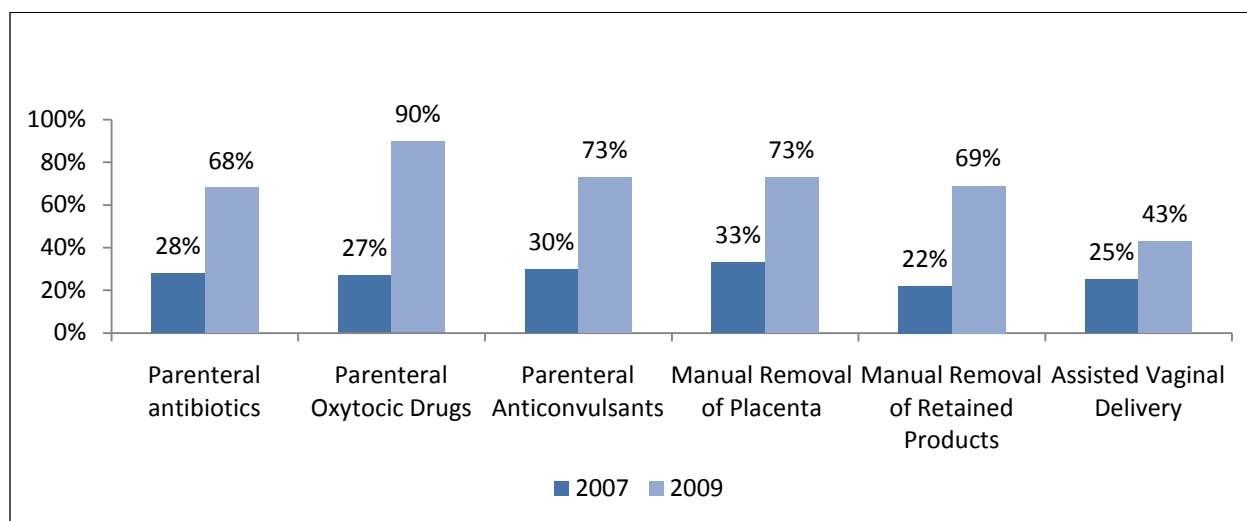
Table 3. Emergency Obstetric and Neonatal Care, Twubakane-supported Districts

Indicator	Results 2007 Random sample 60 HCs	Results 2008 135 HCs	Results 2009 135 HCs	Data Source
% of health centers that offer elements of essential emergency obstetrical and neonatal care [^]	10%	19%	24%	Twubakane RFA
Parenteral antibiotics	28%	74%	68%	
Parenteral Oxytocic Drugs	27%	65%	90%	
Parenteral Anticonvulsants	30%	70%	73%	
Manual Removal of Placenta	33%	58%	73%	
Manual Removal of Retained Products	22%	62%	69%	
Assisted Vaginal Delivery	25%	21%	43%	
	All 12 District Hospitals	All 14 Hospitals	All 14 Hospitals	
% of hospitals that offer comprehensive emergency obstetrical and neonatal care ⁺	83%	71%	86%	Twubakane RFA
Parenteral antibiotics	100%	93%	100%	
Parenteral Oxytocic Drugs	100%	93%	100%	
Parenteral Anticonvulsants	92%	93%	100%	
Manual Removal of Placenta	100%	93%	100%	
Manual Removal of Retained Products	92%	93%	93%	
Assisted Vaginal Delivery	100%	71%	93%	
Blood Transfusion	100%	93%	100%	
Surgery (e.g. Cesarean Section)	100%	86%	100%	

[^] Essential emergency obstetric and neonatal care (EONC) is defined as the availability of six interventions to address complications that arise during deliveries.

⁺ Comprehensive EONC is defined as the availability of eight interventions: the six essential interventions plus Cesarean sections and blood transfusions.

Figure 7. Percentage of Health Centers Offering Elements of Essential Emergency Obstetrical and Neonatal Care



Gender-Based Violence Prevention and Response: In order to support an initiative to improve the quality and utilization of antenatal care and prevention of mother-to-child transmission of HIV (ANC/PMTCT) services through an integrated response to gender-based violence (GBV), Twubakane, in collaboration with USAID, in late 2006 assessed the readiness of the policy environment, the health system and the community to respond to GBV at ANC/PMTCT service sites and in the community. This readiness assessment was conducted in five health facilities in the city of Kigali. Three of them are Catholic-affiliated (Biryogo, Kicukiro and Masaka). The other two are public (Gikomero and Kacyiru). (See full report at: http://www.intrahealth.org/~intrahea/files/media/gender-equality-1/GBV_assessment_report.pdf)

The assessment results were disseminated in 2007. In five service sites in Gasabo, Kicukiro and Nyarugenge districts, results of the study were reviewed with service providers, facilities and the community (focus levels of the assessment). Twubakane also began to develop the GBV/PMTCT training curriculum and clinical protocols for identification and management of GBV. A retreat of legal and political decision makers was organized to define strategies to reinforce the legal and political environment for GBV prevention and care. Twubakane worked in partnership with the Rwandan National Police (RNP) in 2008-09 to support the police with gender-based violence training and response by officers. In 2009, Twubakane worked with the RNP to help update and disseminate the standard operating procedures guide for police officers.

Partnership with Pro-Femmes Twese Hamwe: The Twubakane Program collaborated with Pro-Femmes, assisting them with strengthening the capacity of Pro-Femmes and its member organizations to work efficiently in the context of decentralization. As a result of collaboration greater outreach and mobilization activities related to FP and safe motherhood have occurred by member organizations. Pro-Femmes also worked closely with Twubakane on the program's efforts to improve GBV prevention and response. The active involvement of Pro-Femmes continued through the fourth year of the five-year project.

Future Priorities in Family Planning, Reproductive Health, Maternal Health and Gender-Based Violence

Family Planning

- Some priorities, including introduction of high-quality and widespread post-abortion care, emergency contraception, adolescent reproductive health care, were never supported to the extent necessary and should be national priority for the new few years.
- Expanding the offer of permanent methods through trainings in non-scalpel vasectomy revealed extensive unmet needs for vasectomy. However, misconceptions and rumors are widespread on the part of the population and, in some cases, even health care providers themselves. Experience thus far in Rwanda has shown that clients who have selected this method are excellent ambassadors for raising awareness and mobilizing potential clients. In the future, it will be important to continue to orient both local authorities and community health workers on this method of FP.
- USAID and IntraHealth have expressed the need to conduct a thorough evaluation of the on-the-job training (OJT) approach for FP. This evaluation will provide important lessons learned as well as guidance in how to expand this approach for use in other service delivery priorities, including emergency obstetrics and neonatal care, integrated management of childhood illness, antenatal care and overall integrated service delivery.
- Hospital and health center staff, as well as district authorities, have expressed the need to continue OJT for FP in all of Rwanda's districts to ensure daily availability of all FP methods and to facilitate integration of FP with other services. OJT for FP has been conducted in 12 out of Rwanda's 30 districts (with support from the Twubakane Program and the Capacity Project).
- For community-based family planning services, the MINISANTE and partners should determine how to best include FP counseling and community-based distribution in the CHW package without overwhelming CHWs. Community performance-based financing will help motivate CHWs, but restrictions (especially with USAID funding and the Tiahrt amendment) will need to be respected, and free and informed choice assured for all clients.
- As the use of modern contraception continues to increase, it would be interesting to learn more about how clients make choices about which methods to use and how influential providers are in these choices. This will support long-term contraceptive logistics security.
- The Capacity Project supported initial steps to adapt the emergency obstetrics and neonatal care curriculum for use in on-site training, or OJT. The curriculum, once validated, can be used at the hospital and health center level.

Maternal health services

- Continued attention to correct practice of infection prevention protocols is essential, but an ongoing challenge in many health facilities. The MINISANTE, district supervisors and supporting partners should continue to support facilities in ensuring infection prevention, especially during delivery. Proper use of sterilization equipment for infection prevention is, for example, essential.

- To prevent post-partum hemorrhaging through the practice active management of the third stage of labor (AMTSL), health facilities need a regular and reliable supply of oxytocin.
- Additional attention is needed for outreach communication from health centers to their communities about the improvements in care, regular consultation of training reference guides, and continuous procurement of needed medical supplies.
- Health facilities' maternity wards should be analyzed more closely for overall capacity, patient flow and possibility of expanding maternity wards and the number of trained personnel to ensure that they are ready to receive additional clients.
- Post-partum care and post-delivery services such as immediate insertion of IUDs and planning for postnatal care need additional consideration and focus.

Gender-based violence prevention and response

- Additional trainings of both trainers and providers are necessary to ensure that health facilities, particularly health centers, are well-prepared to respond to gender-based violence.
- Additional IEC/BCC materials and strategies are needed to prevent and respond to cases of GBV.
- The Rwanda National Police has expressed the need for additional training, especially in counseling of GBV survivors.
- In general, there are many actors in the prevention and control of GBV in Rwanda; the effort would be much more efficient if there were a more effective mechanism to coordinate the various efforts and stakeholders.

Component 2: Child Survival, Malaria and Nutrition Access and Quality

The Twubakane Program has helped the MINISANTE to improve the quality of integrated pediatric care at facility and community levels by supporting the rollout of clinical and community integrated management of childhood illness (IMCI), including prevention and control of malaria and malnutrition, starting in 2005. Much of this effort dovetailed with those of the MINISANTE's Community Health Desk as the national integrated community health policy was developed and the strategy rolled out. Twubakane also continued to provide technical and financial support for community-based nutrition activities. Nationwide, Rwanda has realized important achievements in improving child health over the past several years, as noted in Table 4.

Table 4. Key Maternal and Child Health Indicators (DHS Surveys)*

INDICATORS	2000	2005	2007-08
Infant mortality rate/1000 live births	107	86	62
Under-five mortality rate/1000 live births	196	152	103

*Demographic and Health Survey, 2000. Calverton, Maryland; ORC Macro, 2001. Institut National de la Statistique du Rwanda (INSR), ORC Macro. Rwanda Demographic and Health Survey 2005. Calverton, Maryland; INSR and ORC Macro, 2006. National Institute of Statistics (NIS) [Rwanda], Ministry of Health (MOH) [Rwanda], and Macro International Inc. Rwanda Service Provision Assessment Survey 2007. Calverton, Maryland; NISR, MOH, and Macro International Inc., 2008.

Prevention and Control of Malaria: From the onset, the Twubakane Program worked closely with the National Integrated Malaria Control Program (*Programme National Intégré de Lutte contre le Paludisme*, or PNILP) on national treatment protocols and training modules for malaria case management and for prevention and treatment of malaria in pregnancy. In 2005, Twubakane supported the PNILP in the development of new focused antenatal care (FANC) guidelines, including intermittent preventive treatment (IPT) or malaria during pregnancy. In collaboration with the WHO, Twubakane supported the PNILP in training 456 providers nationwide in FANC and IPT. In late 2007, Twubakane worked with the USAID-funded ACCESS Project to organize the national Malaria in Pregnancy/Focused Antenatal Care training of trainers. Trainings in 2008 included the treatment and prevention of malaria in pregnancy, as a part of focused antenatal care, and the overall management of anti-malaria drugs and supervision.

In late 2006, Rwanda became a partner in the USG’s Presidential Malaria Initiative (PMI), and Twubakane participated actively in contributing to development of integrated strategies, agreeing upon intervention areas and zones, and developing collaborative workplans.

Through additional PMI funding, the Twubakane Program supported the home-based management of malaria (HBM) fever in a total of five districts (Gasabo, Kicukiro, Nyarugenge, Ruhango and one district out of Twubakane’s zone, Bugesera). In 2008, Twubakane further expanded the number of communities implementing home-based management of fever and assisted PNILP with the introduction of Coartem at the community level. This introduction required community orientations and trainings to ensure proper use of the new drug. Upon completion of their training, community health workers receive “kits” which includes items such as boots, flashlights, umbrellas, bags and wooden boxes to store records and medicines. At the end of the Program, 3619 CHWs were offering home-based management of malaria or community integrated management of childhood illness.

A total of 86,458 children were treated for malaria fever at the community level in 2009 alone, and it is estimated that more than 115,060 have been treated for malaria fever in the five districts since HBM began.

Sister Scolastique, a nurse in charge of childhood illness, credits health agents from the Home Based Management of Fever Program for considerably reducing the number of serious malaria cases registered at the center.

Therese M. is 54 years old and works as a health agent in the Kicukiro District of Rwanda. She is one of the 85 volunteers supervised by the Masaka Health Center. Without fail, Therese can be seen making the 15-kilometer trip to the center to obtain medical supplies for her community. She also provides health

center authorities with a regular report of malaria cases in her area. Despite the long journey, Therese travels to Masaka Health Center at least twice a month. She and other workers in Kicukiro are well known for their contributions to the community. “If we could find a partner to give us bicycles to facilitate transport, we would be very content,” she says.

Verena M., a 30-year-old mother of four, praises Therese, whom they call their “Muganga” (doctor), Therese treated two of Verena’s children at the community level. “Before our neighbor began giving medicine to our children in the home,” says Verena, “I always had trouble finding the money I needed for consultation fees to bring [them] to the health center. I was forced to drive to the hospital, where I had to pay so much that I was forced to sell my goats. Thanks to our “Muganga”, I’ve taken my two young children to her, and I paid only 50 Rwandan Francs [nine cents] per child [for medicine], and they have all been cured.” Verena and other parents are proud to see their children treated by their neighbors at a cost affordable to everyone.



Integrated Management of Childhood Illness (IMCI): Rwanda’s MINISANTE officially adopted IMCI as its approach to reducing child mortality in 1999, and validated its national strategy in 2000, but strategic implementation was delayed until 2005. In 2005, Twubakane provided technical and financial assistance to the MINISANTE to hold a workshop focusing on tools elaboration and training modules adaptation for clinical IMCI. In addition to addressing the five major causes of childhood illness and death in Rwanda—pneumonia, diarrhea, malaria, measles and malnutrition—the workshop participants also integrated HIV/AIDS prevention, care and treatment into the tools and training manuals developed. From 2006 onwards, Twubakane assisted districts with the rollout of clinical IMCI at the HC level by training and supporting 411 health care providers. At the end of 2009, 75% of health centers were actively implementing clinical IMCI. Health centers continue to face challenges with lack of personnel or transfers of providers between facilities. An important consideration for future implementation of child health services is that, currently, IMCI services are not considered part of the performance-based financing system. Therefore, sufficient emphasis on delivery of quality services may not occur consistently at all health centers.

In addition to clinical IMCI, Twubakane continued to assist with introduction of community IMCI in selected districts. Twubakane has supported MINISANTE with adaptation of training materials for CHWs,

the providers of IMCI at the community level. Nationally, Twubakane continued to support the Maternal and Child Health (MCH) Task Force's IMCI technical working group in collaboration with USAID-funded BASICS Project, WHO, the USAID-funded Child Survival Expanded Impact Project and UNICEF. Led by BASICS, this group revised materials for community-level IMCI, including training modules, case management tools and IEC materials.

An assessment conducted in early 2008 revealed deficiencies in cold chain management related to refrigerator maintenance and temperature control, vaccine management (spacing in the refrigerator and storing expired vaccines instead of returning them to the district) and proper use of forms to document vaccine administration. During 2008, Twubakane supported 273 technicians in 11 of the 12 supported districts to improve cold chain management. (Nyarugenge District technicians were not available to participate in the training.)

Nutrition: One of the early efforts of Twubakane in nutrition was national level advocacy to bring attention to the serious state of nutritional status in Rwanda. In 2005, Twubakane was an active member of the PROFILES technical committee and began participating in national Vitamin A and mebendazole outreach campaigns as part of national and eventually district-level advocacy efforts (immunizations are also offered). Other efforts included contributions to the production of the National Nutrition Strategic Plan and a community nutrition guide in Kinyarwanda. From 2006-2009, Twubakane supported implementation of the nationally approved community-based nutrition program. All districts now offer this service and 861 community health workers have been trained using nationally approved materials; each trained CHW has materials to conduct growth monitoring in their kits. To complement this service at the health center level, facilities received equipment including weighing scales, growth monitoring cards and registers.

Since July 2008, the Nutrition Desk of the MINISANTE and district-level health authorities have supported a Positive Deviance Model/HEARTH nutrition program in the health centers of Muyumbu and Karengwe Sectors in Rwamagana District. Peer educators, or *maman lumières*, were identified based on their positive feeding practices with their own children. After one year of implementation, the intervention was evaluated. Out of 179 moderately or severely malnourished children who participated in the program, 107 (61%) of the participating children showed no signs of malnutrition 24 days after enrollment and 177 (99%) had gained weight within 24 days of entering the program. The two children who did not gain weight during the program were referred to local health facilities for further investigation and, in both cases, these children were diagnosed with other illnesses that impeded progress. Children who remained moderately or severely malnourished after 24 days also received intensive follow-up from community health workers and health facility staff.

Twubakane Program results for child health, malaria and nutrition are presented in the following table. Results for these indicators continue to show improvement. The number of diarrhea cases treated by community health workers increased significantly through implementation of the integrated community health package. More children are receiving DPT3 immunizations and vitamin A.

Table 5. Child Health Indicators

Indicator	Results 2005~	Results 2006~	Results 2007~	Results 2008~	Results 2009~	Data Source
CHILD SURVIVAL						
# Diarrhea cases treated	n/a	n/a	39,869	55,229	89,920	HMIS
# Children <12 months who received DPT3 immunizations	105,401	107,176	113,126	112,814	121,162	HMIS
# People trained in child health and nutrition	n/a	2,030	3,221	5,808	2,842	Twubakane records
Female	n/a	n/a	1,657	3,051	1,450	
Male	n/a	n/a	1,564	2,757	1,392	
# (%) of health centers with a functional cold chain (during 3 months prior to survey)§	60%	n/a	n/a	n/a	95 (70%)	Twubakane RFA
# (%) of health centers with a functional cold chain (at time of survey)§	n/a	n/a	n/a	n/a	108 (80%)	
NUTRITION						
# Children <5 who received vitamin A ⁺	n/a	n/a	526,134	1,029,724	592,007	UNICEF, HMIS
# Children reached by nutrition programs	n/a	n/a	658,461	799,642	837,351	HMIS
MALARIA						
# People trained in treatment or prevention of malaria	n/a	1,724	2,591	5,112	2,576	Twubakane records
Female	n/a	n/a	1,397	2,623	1,297	
Male	n/a	n/a	1,194	2,489	1,279	
# Children <5 diagnosed with simple malaria in health centers (Twubakane's 12 Districts)	n/a	n/a	n/a	n/a	236,427	HMIS
# Children <5 treated for malaria through HBM (Twubakane's 5 HBM Districts [^])	n/a	n/a	n/a	n/a	86,458	PNILP reporting forms and HMIS

~In 2005, Twubakane supported 110 HCs and 12 district hospitals; in 2006, 127 HCs and 12 district hospitals; in 2007, 131 HCs and 12 district hospitals; and in 2008 and 2009, 136 HCs and 14 hospitals. For explanations of which facilities provided data for indicators, please see Annex 3.

§ Functional cold chain: working refrigerator or refrigerator/freezer, cold box, ice packs, working thermometer, up to date temperature tracking form, and refrigerator temperature maintained from 0-8 degrees Celsius.

⁺ Includes doses of Vitamin A given in growth monitoring in the facility and in the community and during the biannual mass campaign. There is likely to be double counting of children who received Vitamin A more than once.

[^] Twubakane supports home-based management of malaria and other community health activities in Ruhango, Bugesera, Nyarugenge, Kicukiro, and Gasabo.

Future Priorities in Child Health, Nutrition and Malaria

- As with FP/RH, it is recommended that health care providers be trained in IMCI through on-the-job training, or OJT. This would be the training of more providers in IMCI, but also would foster teamwork among the trained providers, especially important in the integration of services. This would require adapting the curriculum to this training approach.
- According to health center managers, IMCI is not practiced systematically in all health centers because the IMCI protocol is not financially compensated for through the performance-based finance system. The MINISANTE either has to: (1) determine how to include IMCI in the PBF approach as these indicators are currently not included and thus, providers do not exhibit the same priority for offering these services as for those included in PBF, or (2) change the protocol for integrated pediatric care at the health center level.
- One of Rwanda's national priorities is eradicating malnutrition and recuperating children and others who are malnourished. There is concern, however, within some health facilities that more attention is paid to responding to and curing malnutrition than to preventing the illness in the first case. However, adopting the same preventative approach as has been done with family planning would have longer lasting results. Advocacy must continue within the GOR, ministries, parliament and technical working groups to ensure that the prevention of malnutrition is addressed in a widespread, multisectoral and sustainable manner.
- Given Rwanda's dramatic successes in malaria prevention and control over the past few years, it is important that attention continue to be paid to the most proven intervention—widespread distribution and use of long-life ITNs, continued and expanded implementation of home-based management of fever, including moving towards greater use of rapid diagnostic testing, and inclusion of malaria preventative services within the community PBF approach. As with nutrition, focusing more on the preventative elements versus curative needs to continue to be a priority, a community PBF needs to reward preventive actions.

Component 3: Decentralization Planning, Policy, and Management

The Twubakane Program's partnership with and support to the central level government, especially during the intense phase of decentralization in later 2005/early 2006, has contributed to improved capacity to develop and disseminate policies, programs and procedures. Twubakane has worked closely with MINALOC and the MINISANTE to build capacity and national systems, and to put in place numerous policies and procedures necessary for effective decentralization—with an emphasis on health services. In addition to the ministries, Twubakane has collaborated with the Rwanda Association of Local Government Associations (RALGA) to improve planning and management of decentralization, emphasizing health services.

Ministry of Local Administration (MINALOC): Starting in 2005, the Twubakane Program provided technical assistance to the MINALOC to prepare for the second phase of decentralization. Refining and redefining the Rwanda fiscal decentralization policies and strategies became increasingly important during the transition period to the new administrative and territorial reform. Expanding districts' resource base, resource mobilization mechanisms, debt relief, local tax schemes and laws, and

establishing a sustainable local finance system are key in assuring successful implementation of the entire decentralization strategy. In response to requests from the MINALOC to support the decentralization policies and programs, in December 2005, Twubakane provided technical assistance to the MINALOC's Local Government Finance Unit to refine and redefine Rwanda's fiscal decentralization policies, strategies and procedures manuals. A draft of the revised fiscal decentralization policy was presented to MINALOC, MINECOFIN, the Rwanda Revenue Authority and development partners. The policy was finalized in 2006 and Twubakane supported dissemination and implementation through its contributions to district-level workshops and orientation sessions.

Throughout the program, Twubakane continued to work in partnership with the MINALOC and the National Decentralization Implementation Secretariat (NDIS), contributing to many important policies, plans and guidelines. In 2008, Twubakane supported the rollout of the Rwanda Decentralization Strategic Framework (RDSF), the Decentralization Implementation Program (DIP), and the Economic Development and Poverty Reduction Strategy (EDPRS). These policy documents guide local government authorities and development partners in supporting implementation of decentralization policies of the central government as well as provide indicators on good governance and decentralization. In 2009 (as well as in past years), Twubakane collaborated with MINALOC to support the Decentralization Joint Sector Review. Twubakane has promoted and reinforced cluster work groups and partner coordination, supporting the government as it prepares for its next upcoming third phase of decentralization. The Twubakane Program, also in collaboration with other partners, has supported the development and dissemination of guidelines and evaluation criteria for evaluating district performance contracts (*imihigo*), dissemination of the Joint Action Development Forums (JADF) Ministerial Decree and developing operations tools for the effective functioning of JADFs; disseminated the guidelines for Mini-budget preparations from January –June 2009 for the Districts and alignment of budget and planning cycle to the East African Community.

Ministry of Health (MINISANTE): Twubakane has worked with the various departments, desks, divisions within the ministry in an effort to support overall improved capacity for planning, better coordination within the ministry and among development partners and management of health services from the central to the lowest level of service. Through its MINISANTE focal point from January 2005 through December 2008 (the director of the capacity-building and policy development unit), the Twubakane Program was requested to participate in a variety of ad hoc working groups on a variety of issues, including health sector transparency and accountability, health care financing, role and responsibilities and improved overall integration of services. At various times throughout the program, Twubakane has participated in international meetings/conferences to review Rwanda's experience with various elements of its health care system; the Twubakane Program presented results at the 2006, 2007 and American Public Health Association Annual Meetings, the Global Health Council Annual Meeting in 2007, 2008 and 2009, and the International Conference on AIDS and STIs in Africa in 2008 and the International Conference on Family Planning in 2009. Other recent examples include the Rwanda's Maternal and Neonatal Care International Conference in May 2008, and the early 2009 review meeting on performance and resource-based financing. Participation in such efforts offers the ministry technical assistance on the topics and an opportunity to hear from the district perspective, often brought by Twubakane staff. Important national efforts include the Joint Sector Reviews (Twubakane was often asked to help coordinate and finance the meeting) and development of the Joint Action Work Plan. In 2009, Twubakane supported initiation of a Decentralization Technical Working Group, aligning all the various actors in decentralization and health.

Health Sector Costing Study: At the request of the MINISANTE, the Twubakane Program collaborated with the National University of Rwanda's School of Public Health and the MINISANTE to analyze costs of the minimum package of health services (MPA) provided at the health center level and the complementary package of health services (CPA) delivered at the district hospital level. This national health sector costing study, conducted in 2007. The results of the study, officially disseminated in May 2008, contributed to setting service tariffs for 2009. The results of the costing study also are being used to further examine health care financing issues in Rwanda, including examining both expenditure and revenue data in order to develop financing targets (proportions shared by payer), as a large proportion—approximately 20%—of financing of health centers still comes from the population; and to further explore the concept of economies of scale and scope within Rwanda health service provision.

National Health Accounts (NHA): Rwanda is one of a few countries with multiple years of NHA data. The completion of the most recent 2006 NHA exercise (which was presented in 2008) allowed policymakers and stakeholder's insight into Rwanda's complex health financing system in its entirety and, along with the four past NHA exercises, an opportunity to observe trends. To institutionalize the NHAs, the MINISANTE has decided to address the larger issue of health financing by establishing a health financing desk within the ministry. This will assist with sustainability and will allow MINISANTE to institutionalize NHA once there is more health financing capacity within the ministry. To contribute to this process, Twubakane worked closely with MINISANTE and the World Bank to establish the terms of reference for a health financing technical working group; these were approved during the Joint Health Sector Review in November 2008. Another priority activity in 2008 was supporting the finalization of a draft of Rwanda's first health financing policy. This policy will contribute to the Economic Development and Poverty Reduction Strategy (EDPRS) and the Health Sector Strategic Plan (HSSP) II.

Health Management Information System: At the request of MINISANTE and USAID, Twubakane conducted a multi-level assessment of the HMIS in 2006. The assessment analyzed information systems supporting MINISANTE and its dependent institutions, decentralized HIV/AIDS coordination entities and non-facility based HIV/AIDS activities and decentralized health structures such as health centers and hospitals and related health donor projects. Following the assessment, MINISANTE prioritized improvements to the HMIS and, starting in 2007, begin to implement some of the proposed recommendations. Remaining challenges related to the national HMIS focus on the need to support systems that that communicate with each other, including the health facilities HMIS, the PBF information system, the *mutuelle* information system, and the community health workers and community BF information systems. .

Support to Rwanda Association of Local Government Authorities (RALGA): The mandate of RALGA is to strengthen its member organizations, local governments. Twubakane's overall support to and partnership with RALGA focused on preparing RALGA to adjust to the new phase of decentralization. Twubakane partner VNG provided distance and in-country support to RALGA's capacity-building program officer throughout the project. Results of this support include development of a capacity-building strategy for RALGA members and local government authorities. This work allows RALGA to expand its role as a broker to meet members' capacity-building needs by liaising with institutions and development partners. Another form of support to RALGA was the 2007-08 anti-corruption initiative (ACI). This \$140,000 grant covered production of weekly radio programs, development of training materials, training of local officials and a national poster campaign. As a service to RALGA's stakeholders, a CD-rom of all the ACI activities and materials was created and distributed. In addition, a useful tool for local authorities was created this year in Kinyarwanda on corruption, accountability,

transparency and good governance. With Twubakane’s assistance, copies were distributed to all 30 districts.

Table 6 (below) shows the number of policies Twubakane supported through their development and the number of policies, plus guidelines and manuals Twubakane helped disseminate.

Table 6. Policy Development Supported by Twubakane, 2005-2009

Indicator	Results 2005	Results 2006	Results 2007	Results 2008	Results 2009	Data Source
# of policies drafted or revised with USG support	13	11	14	22	16	Twubakane records
# of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA, health facilities, and other relevant stakeholders with USG support	2	7	9	9	8	Twubakane records

The lists below provide a sample of the range of policies developed with Twubakane assistance and those disseminated, along with guidelines and other supportive documents.

Illustrative policies initiated, developed or revised with Twubakane Program support, 2005-2009

- National Nutrition Strategic Plan
- National Health Accounts
- Health Services Costing Study
- District Accountant Training Manual and Guidelines
- Anti-Corruption Guidelines for Local Government and RALGA members
- Decentralization Implementation Plan
- National Community Health Policy National Policies, Norms and Protocols for Family Health
- National Behavior Change Communication Policy
- MINISANTE Joint Health Sector Review and work plan recommendations
- Fiscal decentralization policy and equalization formula
- Decentralization Implementation Plan
- Rwanda Decentralization Strategic Framework
- Transparency and Accountability Framework
- Good governance and leadership workshops for district and sector authorities
- GESIS / HMIS technical reviews and revision of health indicators
- *Mutuelles* (Policy, Management Manual, Capitation Payment Guide for Implementation)
- M&E framework and Management Information Systems (MIS) systems and modules for Local Government, with 17 indicators for tracking health service delivery
- District Auditor training manual and guidelines
- Health Corruption vulnerability assessment
- Economic Development and Poverty Reduction Strategy
- Health Sector Strategic Plan (HSSP 2 draft)
- Adaptation of Ubudehe process for management of “indigents” benefitting from *Mutuelles* subscriptions
- Health Care Services Norms, Standards, Protocols - formatting of the final versions and production of the documents on CD Rom
- Input and production of the draft Hospital Management manual
- District Auditor training manual and guidelines
- Continued work and input provided on the Health Financing Policy (Health financing TWG, and workshops of WHO and World Bank)

Good Governance and Health—Assessing Progress in Rwanda: In early 2009, the Twubakane Program, with technical assistance from RTI International and IntraHealth home offices, undertook a review of how Twubakane’s efforts to support the decentralization of Rwanda’s health system and to build the

capacity of local governments to plan, budget for and deliver health services have enhanced health governance and contributed to improved health outcomes. This analytic exercise examined two key research questions:

- 1) How and in what ways have Rwanda's governance and decentralization reforms changed the relationships, accountability and incentives between government and citizens regarding health services?
- 2) Have the governance reforms and innovations that decentralization has introduced, and Twubakane has supported, led to increased capacity and performance of government institutions in the areas associated with good health governance?

The study reviewed Rwanda's health governance reforms and challenges over the past several years, including decentralization, service delivery and performance and citizen participation. In general, the team documented some important facilitating conditions for good health governance in Rwanda, including strong political will from the president and senior officials, a strong commitment to decentralization and to fighting corruption, the synergy between Twubakane's efforts in the government-wide emphasis on performance, embodied in the *imihigo* process, the government's desire to identify and replicate best practices throughout the country and the availability of donor resources. These are important in terms of identifying the features that contribute to the successes in decentralization and health realized by the Twubakane Program. These facilitating conditions also come with their own risks, which are described in greater detail in the assessment report, "Good Governance and Health: Assessing Progress in Rwanda". In general, the study noted that Rwanda has a conducive environment for governance improvement, and decentralization has had a positive impact on health governance. The innovations supported by Twubakane have led to demonstrable health governance outcomes, most clearly related to accountability, responsiveness, and efficiency and effectiveness. These health governance outcomes have contributed to improved health results. These include, for example: increases in service utilization, increases in insurance coverage at the community level, and mobilization of communities around health issues and for the utilization of services. Respondents noted, for instance, increases in immunization rates, contraceptive prevalence rates, and increases in the number of births taking place in health facilities as opposed to homes. (See full report: <http://www.intrahealth.org/~intrahea/files/media/good-governance-and-healthassessing-progress-in-rwanda/goodgovandhealth.pdf>)

Future Priorities in Decentralization Planning, Policy, and Management

- As national programs administrated by the MINISANTE because stronger and better financed, there is an increasing risk of over-centralizing some priorities with the health center. The MINISANTE, MINALOC, MINECOFIN and other GOR entities, including the district themselves, should diligently ensure that resources for health program implementation are available at the level of districts, hospitals, sectors, health centers and communities themselves to encourage that the health sectors' excellent results are maintained.
- RALGA has expressed the need to continuing capacity-building and support if it is to continue to play the key role of assessing capacity-building needs and assisting to meet those needs.
- Additional assistance will be needed for the sector level as the next phase of decentralization moves down and out. Identifying sufficient human resources and capacity at the central level to support lower levels of government will be important to maintain the momentum established by Twubakane Program and other partners supporting decentralized capacity building.

- It is vital that the MINISANTE and other ministries seek continued improvements in the national Health Management Information System and other information systems to ensure that districts (and then sectors) are able to input and extract up-to-date data for reporting and for analyzing ongoing progress as well as challenges. Better performing and more integrated management information systems with reduce the need to duplicate systems.
- Policies, norms and protocols are intended to be guides for quality service delivery but can quickly become outdated when new evidence is published changing international standards for service delivery. MINISANTE needs to establish an ongoing mechanism for periodic review and revision (as needed) of the policies, norms and protocols, as well as the composition and delivery of the MPA and CPA.
- It is essential that the health sector (the MINISANTE and its partners) develop and maintain a health finances database.

Component 4: District-Level Capacity Building

As noted in the introduction and context section, above, the Twubakane Program was well-positioned and ready to support Rwanda's districts from their creation in early 2006. In each of the 12 Twubakane-supported districts a selection of capacity building activities were supported, including:

- District SWOT analyses
- Good governance and leadership workshops
- Joint Action Development Forums (JADFs)
- District resource mobilization (fiscal census, market privatization)
- District accounting and auditing
- District planning and reviews associated with the *imihigos* (performance-based contracts).

Twubakane technical staff and field coordinators have noted improvement in the capacity of the district, sector and health facility staff and officials to lead and direct their own budget and planning exercises. District authorities also noted that the location of Twubakane field coordinators within the district offices facilitated capacity-building activities and fostered greater sustainability. Twubakane's ongoing support in the form of coaching and mentoring was much appreciated as evidenced by the numerous public recognitions, calls, emails and testimonials of Twubakane support.

In addition, as noted in Component 3, Twubakane continued support for participatory district capacity building at the national level, in collaboration with RALGA. Twubakane also supported ongoing contributions to District capacity mapping and resource allocation, FormaDis, and cataloguing of training modules for local government authorities.

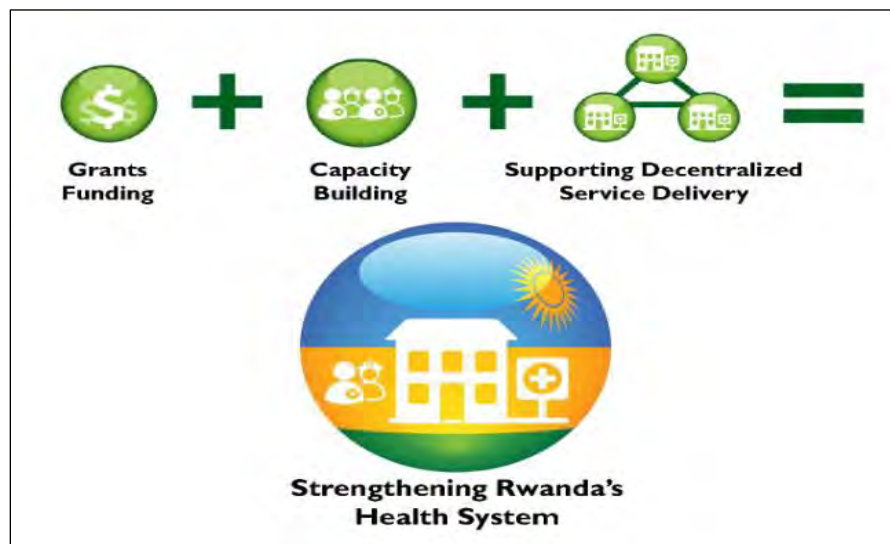
District Incentive Fund (DIF) Grants: The DIF grants, originally scheduled to begin during the first year of the Twubakane Program in 2005, were delayed due to the extensive redistricting and new phase of decentralization ambitiously launched by the GOR in late 2005 and early 2006. Through this key innovation of the Twubakane Program each district, and (for the last two years) the City of Kigali, received financial and technical assistance to support activities that addressed local priority needs in

health and decentralization. More than one sixth of the overall Twubakane Program budget was awarded directly to the districts through DIF grants.

Districts implemented a wide range of activities, ranging from income-generating activities for indigents to support *mutuelles* membership fees, outreach health education, renovation and equipping of health facilities, and improved good governance and leadership through improved planning, budgeting, management and overall service delivery. Over the course of the four years of grants, districts made progress managing, implementing and reporting on the DIF activities and funding received. By 2008, the districts were including discussion of DIF grant activity status during weekly district meetings, consulting with ministries regarding activity implementation, improving their overall tender process for procurement, and executive secretaries regularly monitor sector-level activities. In addition, the activities prioritized by the districts and funded through the DIF grants increasingly contributed directly to the goals of the Twubakane Program—and the GOR—to improve access to, and use and quality of key family health services.

As noted in Figure 8, below, the DIF grants helped to strengthen Rwanda’s health system through the combination of funding, capacity building and supporting decentralization service delivery.

Figure 8. DIF Impact on Rwanda’s Health System



Ministers of MINALOC and MINISANTE supported this initiative of Twubakane and actively communicating directly with the district mayors about the importance of expeditiously using and reporting on the DIF grant monies. Despite improvements in implementation and reporting, many districts, however, still faced challenges concerning their absorptive capacity for funds and the timely implementation of activities. Each year some districts had their DIF contracts extended, facilitating completion of activities but somewhat delaying initiation of the following year grant.

The table below shows the number of DIF activities per year, according to category of activity. Districts selected the greatest number of activities relating to Improvements to health and hygiene infrastructure and supplies, followed by district capacity building.

Table 7. District Incentive Fund Grant Activities by Category

Indicator	2006 Results	2007 Results	2008 Results	2009 Results	Total for all 4 Years	Data Source
# of DIF grant activities that improved local government authorities, district, and sector level capacity to provide services, especially health services, to population	52	56	57	47	212	Twubakane Records
District administrative level capacity building	13	19	22	17	71	Twubakane Records
Support to sustainability of <i>mutuelle</i> payments for indigents	8	2	2	3	15	Twubakane Records
Improvements to health/hygiene infrastructure and equipment/supplies	25	24	20	17	86	Twubakane Records
Community mobilization and communication	4	10	12	8	34	Twubakane Records
Health -related training of local authorities	2	1	1	2	6	Twubakane Records

In late 2009, an assessment of the DIF grants was undertaken to examine the DIF grant initiative’s contributions to the Twubakane Program’s efforts to strengthen decentralized health systems and improve health outcomes. Results showed that that the District Incentive Funds (DIF) were broadly appreciated and praised as an effective approach. The assessment results indicate that, in synergy with multiple other local health initiatives, the DIF grants mechanism contributed to progress in health services, district capacity, and participation and collaboration. For more detailed information on the District Incentive Fund (DIF) grant initiative and assessment, including lessons learned and recommendations for the future, please consult the assessment report, “The Twubakane Decentralization and Health Program Rwanda District Incentive Fund Grant Initiative Final Assessment, January 2010.” (web link: <http://www.intrahealth.org/~intrahea/files/media/district-incentive-fund-dif-grant-initiative-final-assessment/final-dif-assessment.pdf>)

Improved access to clean drinking water – DIF

“I was born in this village of Kabatasi, we were using the swamp water for all our home needs, resulting in different illnesses,” said Rusumbabahizi Alphonse, one of Rubona sector residents in Rwamagana District in the Eastern Province of Rwanda. “Now that we have cleaner water, we are no longer having cases of illnesses like diarrhea at home.” Alphonse, 48, is one of the beneficiaries of the clean water from the storm water drainage canals which were renovated through the DIF.



Access to clean water was one of the main problems faced by the population of Rwamagana District. According to district statistics, three years ago over 48% of the households were a distance of more than 500 meters away from where they could access water. With different projects, including the Twubakane-funded renovation of the storm-water drainage canals, that percentage has been reduced to 35%, and the district target is to reduce that percentage to 0% within three more years.

“With this project, we have reduced problems related to the lack of clean water. People are no longer using stagnant water to drink, cook or wash dishes and clothes. The renovation of the storm water drainage canals is one of our successful projects with Twubakane program, which has a direct impact on the life of our population,” said Valens Ntezirembo, Rwamagana district mayor.

With the DIF, Twubakane supported the renovation of 32 storm water drainage canals in Rwamagana district. The project cost the equivalent of \$23,000 (US), and more than 2,000 households now benefit from that water drainage system.

“The project is very cost effective: we don’t spend much on the maintenance, and people fetch water free of charge,” said Ntezirembo. “Since this water comes from its source, it doesn’t dry up during the dry season; it’s very sustainable.”

Joint Action Development Forums (JADF): Since the creation of the district-level JADF in 2007, the Twubakane team provided assistance for the JADF in all program-supported districts. This mechanism assists district government administration and its stakeholders to discuss and coordinate development planning, budgeting, monitoring and evaluation. Twubakane staff provided districts assistance with harmonization of partner interventions and reporting requirements, resource mobilization for the long-term sustainability of JADFs and in Ruhango, an evaluation of field activities implemented by members of the forum. This evaluation form is available for use in other districts and provinces throughout Rwanda. Because of their important role in initial support to JADF meetings, some Twubakane staff members have been elected as officials of the JADF committees.

District Auditors’ Training and Orientation: Strengthening the audit process in districts was identified as a need to improve decentralization and overall district functioning. The District Capacity-Building Needs Assessment noted that the few reports produced by auditors were not analyzed by District Council members, and the offices of the Auditor General and the Ombudsman also both recommended reinforcement of the districts’ audit process. In addition, Twubakane field coordinators and the DIF grants management team both noted that more regular, thorough and accurate audits would have a positive impact on the implementation of the Twubakane Program and on decentralization.

To respond to this need, starting in 2008, the Twubakane Program collaborated with the Ministry of Finance and Economic Planning (MINECOFIN), the German Development Service (DED) and the Rwandan Institute of Administration and Management (RIAM) to develop a training module for district auditors. Through this training, Twubakane and the districts were able to orient and/or train approximately 100 participants throughout the 12 districts. Tools for improving the accuracy and transparency of the accounting and audit reporting functions were provided to participants and a check list of best practices of internal controls at the sector offices and at local health centers and schools was developed and distributed. These activities, particularly at the sector level, demonstrated the capacity that has been built of district auditors, and the transfer of their skills and knowledge, boding well for sustainability of these interventions

Participatory Assessments of Districts’ Strengths-Opportunities-Weaknesses-Threats (SWOT):

Engaging with public officials to contribute to improved district level planning, budgeting and management is an important aspect of Twubakane’s support to districts. To measure progress in this regard, SWOT assessments with district and sector officials were conducted by Twubakane in October 2006, in December 2007, February 2009 (for 2008) and in November 2009 (see methodology section of Annex C for a description of the methodology). The table below presents results from each of the SWOT exercises and shows overall improvement in the indicators.

Table 8. District-Level Planning, Budgeting and Managing Indicators, 2006-2009

Indicator	2006 Results	2007 Results	2008 Results	2009 Results	Data Source
% Districts that have mechanisms in place for public reporting on health sector activities ⁺	58%	100%	100%	100%	SWOT
Public Meetings		100%	100%	100%	
Radio Messages		83%	92%	83%	
Newsletters		8%	50%	25%	
Pamphlets		17%	25%	42%	
Information Boards		100%	100%	100%	
% Districts that have mechanisms in place for public reporting on their financial performance ⁺	8%	33%	42%	42%	SWOT
Public Meetings		83%	100%	92%	
Radio Messages		33%	17%	25%	
Newsletters		0%	17%	8%	
Pamphlets		8%	8%	0%	
Information Boards		33%	33%	33%	
FINANCIAL PLANS AND BUDGETS					
% Districts with annual plans and a Medium term Expenditure Framework (MTEF) that include a full range of health activities	100%	100%	100%	100%	SWOT
% Districts that have plans and budgets documented to reflect citizen input	92%	100%	100%	100%	SWOT

⁺Districts must have both an oral and written mechanism to be counted in these public reporting results.

Twubakane supported capacity building of district entities and individual public sector officials in order to strengthen districts' financial management and planning practices, throughout the five years. Results are mostly consistent across indicators. Due to the funding situation in 2009, the number of individuals trained decreased (Table 9).

Table 9. Public Sector Capacity Building, 2006-2009

Indicator	Results 2006	Results 2007	Results 2008	Results 2009	Data source
# Sub-national government entities receiving USG assistance to improve their performance	12	12	13	13	Twubakane records
# Sub-national governments receiving USG assistance to increase their annual own-source revenues	12	12	13	13	Twubakane records
# of local non-governmental and public sector associations supported with USG assistance	101	144	144	147	Twubakane records
PAQ teams	99	130	130	133	
RALGA	1	1	1	1	
Pro-femmes	1	1	1	1	
JADFs	n/a	12	12	12	
# Individuals who received USG-assisted training, including management skills and fiscal management, to strengthen local government and/or decentralization.	2,114	4,450	1859	986	Twubakane records and RALGA
Female		1,018	1097	382	
Male		3,432	762	604	
# of USG-supported anti-corruption measures implemented	6	10	14	0	RALGA
# of government officials receiving USG-supported anti-corruption training	n/a	216	250	0	RALGA
Female		52	125		
Male		164	125		

Future Priorities in District-Level Capacity Building

- The MINALOC and the GOR, in general, have expressed the need for support of capacity building at the sector level. However, as Twubakane has noted in various reports, districts also still request and require capacity-building support for planning, budgeting and management as well as responding to the needs of local populations.
- Based on the positive feedback received and successful results of the assessment of the Twubakane Program's District Incentive Fund grants, it is highly recommended that the USG and other development partners work with the GOR to try to implement similar grants mechanisms in the future
- The MINALOC, NDIS and the districts themselves also have requested continued support to ensure the proper and effective functioning of Joint Action Development Forums at the district level, and greater attentive to support these forums as the sector level.

- District partners have requested ongoing assistance for continue training in good governance, transparency, leadership, accounting and auditing, as well as training, refresher training and supervision.

Component 5: Health Facilities Management and *Mutuelles*

The Twubakane Program’s support to health facilities management has focused on ensuring that *mutuelles* are functional and effectively leading to increased access to services, including supporting *mutuelles* management structures and collaborating with the MINISANTE and other partners to adapt the *mutuelles* program to a changing environment. The Program has focused on strengthening the framework for health financing and management through technical assistance at the national level as well as working at the hospital and health center level to build their management capacity.

Revision of Health Care Policies, Norms and Standards: A significant undertaking of the MINISANTE, which began in 2006, is the revision and updating of policies, norms and protocols for health care services and the minimum and complementary packages of activities. Twubakane has provided both local and international technical assistance since the process began, and has collaborated with many development partners to ensure consensus on the documents’ content. In 2008, this exercise continued to face challenges, particularly concerning follow-up to finalize the process and ensure buy-in of stakeholders. An initial draft of the document was reviewed in early 2008, and workshop was held in July 2008, during which MINISANTE desks and partners reviewed content. Following this workshop and review, content was added to address concerns about task-shifting and school health. During the last six months of 2009, Twubakane worked very closely with the quality assurance desk of the MINISANTE to finalize these documents, and by the end of 2009, a final review by the MINISANTE and partners is pending.

Table 10. Twubakane-Supported Service Delivery Points, 2005-2009

Indicator	Results 2005	Results 2006	Results 2007	Results 2008	Results 2009	Data Source
# Service Delivery Points (SDP) with USG support	139	143	164	210	215	Twubakane Records and Twubakane RFA
Hospitals	12	12	12	14	14	
Health Centers	110	127	131	136	136	
Dispensaries & Health Posts	17	4	7	34	34	
FP Secondary Posts	0	0	14	26	31	

As Table 10, above, reveals, the number of service delivery points supported by Twubakane increased over the five years. Two new hospitals were established (one with DIF grant funds), health centers were built, health posts at the cell level were established and, as described in Component 1, FP secondary posts were established. The addition of these facilities served to directly increase access opportunities for Rwandans.

Another element of access to care is the number of HCs providing services included in the MPA for Family Health. Rwanda has a defined set of services for the minimum and comprehensive package of services offered at facilities. In conjunction with the expansion offered through the revision of the policies, norms and protocols, Twubakane worked with facilities to support providers through training,

provision of equipment and supplies and ongoing supervision to ensure that the MPA and CPA were available. It is important to note that according to the indicator definition, a facility must offer the full package of services routinely to be considered “offering the MPA (or CPA)”. With the ongoing movement of health care providers and non-regular supply of materials and equipment, facilities in Twubakane-supported districts have been challenged to observe an overall and consistent increase in full offering of the MPA/CPA. Despite these challenges, consistent improvements have occurred when examining the individual services (see Table 11 below).

Table 11. Health Centers Providing Services in Minimum Package of Activities (MPA) for Family Health, 2005 and 2009

Indicator	2005 Results <i>All 110 HCs</i>	2009 Results <i>135 HCs</i>	Data Source
% health centers providing:			
Prenuptial consultations	9%	16%	Twubakane RFA
Prenatal consultations	93%	89%	Twubakane RFA
Delivery services	83%	92%	Twubakane RFA
Post-natal consultations	45%	59%	Twubakane RFA
Post-abortion Care	60%	52%	Twubakane RFA
Family Planning	72%	76%	Twubakane RFA
Vaccinations	91%	100%	Twubakane RFA
Growth Monitoring	81%	100%	Twubakane RFA
VCT	n/a	98%	Twubakane RFA
Clinical IMCI	n/a	75%	Twubakane RFA
Epidemiological surveillance	n/a	96%	Twubakane RFA
Hygiene	n/a	96%	Twubakane RFA

Health Care Financing—*Mutuelles*: At the national level, Twubakane supported the *mutuelles* system through close collaboration with the MINISANTE’s *Mutuelles* Technical Support Unit, or *Cellule d’Appui Technique aux Mutuelles de Santé*. Twubakane, with collaborators GTZ, BIT-STEP, Belgian Technical Cooperation (BTC), the Global Fund and the British Department for International Development (DFID), met regularly in a technical working group to discuss national-level implementation and share experiences. Aspects of the system addressed included harmonizing the subscription (open season) period; review the critical factors that affect *mutuelles* subscription fees and quality of health care services; examine how health care prevention programs can be beneficial to *mutuelles* members and health centers; and review the cost implications of including HIV/AIDS patients in *mutuelles* programs.

In each of the districts, Twubakane supported *mutuelles* managers and management committees conducted supervision visits designed to improve management capacity of *mutuelles* managers through on-the-job training and advice. Supervision visits revealed financial management problems and, in 2008, potential embezzlement of funds in several *mutuelles* sections. In some of the *mutuelles* sections, managers were interrogated by the police to report on financial management and discrepancies. In November and December 2008, the GOR undertook a nationwide audit of the *mutuelles* program; results of the audit are scheduled to be presented in early 2009.

In 2008, Twubakane also conducted an assessment of the financial viability of *mutuelles*, which showed that about 70% of the *mutuelles* sections in the Twubakane-supported districts risked bankruptcy in 2008 due to management problems or insufficient funding to pay health facilities’ bills. The assessment

was presented during a national *mutuelles* workshop in Rubavu in September 2008. During this workshop, the MINISANTE and development partners called for a nationwide audit of *mutuelles*.

An important step in the *mutuelles* program was the web-based database which Twubakane support in design and roll out to the district level. This system allows for multiple points of verification of data, ease of tracking members and generation of reports.

Table 12. *Mutuelles* Membership, 2007-2009

Indicator	Results 2007	Results 2008	Results 2009	Data source
# People covered with health financing arrangements (in Twubakane Districts)	2,376,986	2,320,493	2,380,514	Districts' <i>mutuelles</i> units and Twubakane RFA
% Population in the districts supported by Twubakane that are enrolled in <i>mutuelles</i> (Pop=3,494,937+)	72%+	68%	68%	Districts' <i>mutuelles</i> units and Twubakane RFA

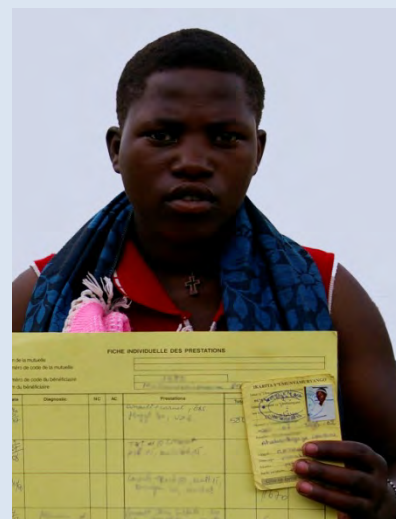
+ Population estimates for the districts are GOR estimates based on the 2002 census figures and a population growth rate estimate of 2.8% annually as used by MINISANTE.

The Muhima Hospital, in the city center of Kigali, is one of the most visited hospitals, particularly the maternity ward. With the promotion of *mutuelles*, the hospital no longer knows of cases severe enough to provoke death.

According to Clarisse Utamuliza, the nurse in charge of the neonatology service, of 200 people who she deals with every day, between 100 and 150 are members of *mutuelles*. *Mutuelles* members each pay 1,000 FRW, or 2USD, to benefit from services all year long.

“Among the health insurances that we have available in Rwanda, the *mutuelles* are the only one that pay in a timely manner, which allows us to cover our expenses. I think it’s because the *mutuelles* are decentralized, and so it’s the local district that pays us directly.”

“The *mutuelles* are very important to us, I am no longer afraid to come seek care for me and my children, because with my *mutuelle* card, I know that I can benefit from any kind of care,” explains Chantal Murebwayire, a 24 year-old whose premature baby is in the hospital. “If I weren’t a *mutuelle* member, I would have difficulty paying the bill for such a long stay of my baby at the hospital.” According to Clarisse, the nurse, babies born before term typically spend between 30 and 60 days at the hospitals, and care for them can cost as much as 200,000FRW or 370USD. *Mutuelles* members only pay 10% of the total amount.



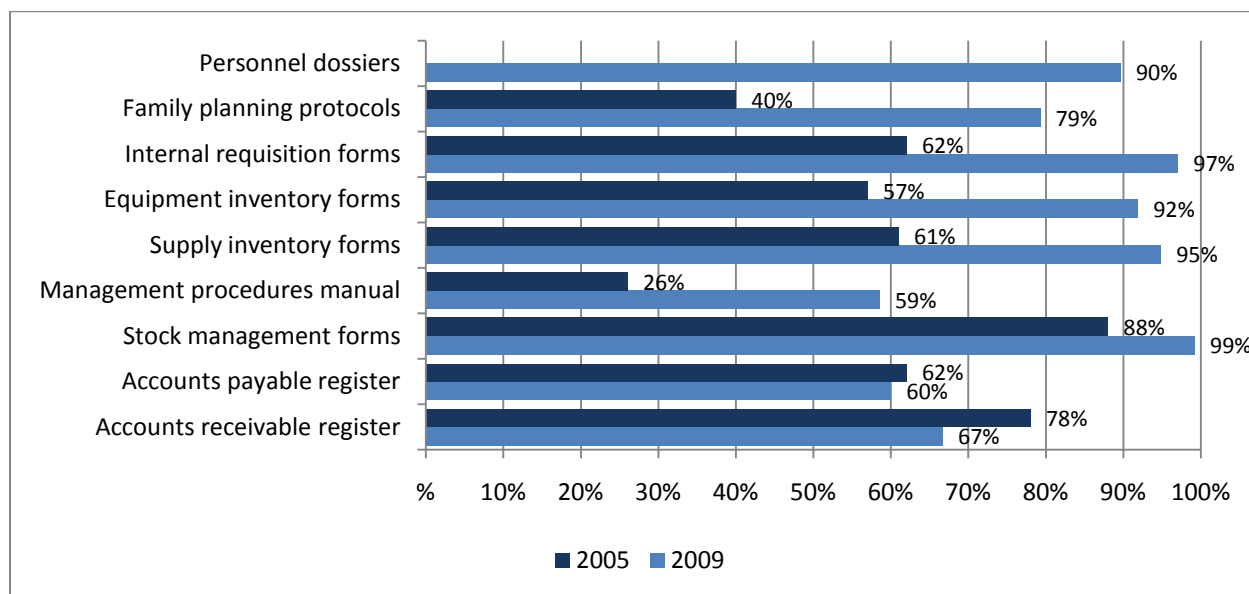
Health Facilities Management: Through its management support to hospitals and health centers, Twubakane has supported the increased capacity of health facilities to better manage their resources and to provide high-quality health services. The MINISANTE and partners collaborated closely on health facility strengthening initiatives, and worked together to develop health facility management manuals,

one for hospitals and another for health centers. In 2008, the manuals were revised and finalized to ensure that they are practical and well-adapted to the Rwandan context. The manuals focus on key health facility management areas, including financial management and accounting, resource and equipment management, drugs, maintenance and human resource management.

Twubakane initiated support for development of strategic plans at the hospital level and by 2008 began to assist health centers to develop their own strategic plans. Several tools were used to support the health facility strategic planning process, including participatory SWOT analyses, review of basic package of indicators and forms to collect information on personnel, materials, services and budgeting. Hospital and health center personnel prioritized activities and budgets based on key objectives and through participative discussions and consensus to determine their main activities. Emphasis was being placed on producing simple and realistic plans, focusing on benefits to the population served, and feasibility given available and often limited resources. An important element of the plan is that it aligns with the DDPs, national goals outlined through the Economic Development and Poverty Reduction Strategy, Vision 2020 and performance-based contract targets set on an annual basis.

Situation analyses at the facilities identified priority areas for strategic planning, including quality of care, human resource management, overall equipment needs, improvements in infrastructure, hygiene, general communication about services and community outreach. Following development of strategic plans by each of the hospitals and HCs, Twubakane provided support to develop operational plans (all facilities) and business plans (hospitals only). In 2004 (data collected in 2005), only 57% of health centers in the Twubakane intervention area had full cost-recovery (receipts equal to or greater than expenses) while in 2008 (data collected in 2009), 79% of health centers had full cost-recovery. On the other hand, among hospitals, all but one had full cost recovery in 2004 but only 33% did so in 2008. Since 2005, there has been significant improvement in the availability of management tools in health facilities. The following chart presents results on the availability of tools in health centers for which data were collected in 2005 and 2009. Hospitals have similar results.

Figure 9. Availability of Management Tools in Health Centers



Future Priorities in Health Facilities Management and *Mutuelles*

- Supervision of *mutuelles* committees is an ongoing priority to support continued access to care by Rwandans. Financial viability of facilities is challenged when *mutuelles* do not function according to recommended procedures and members are not able to seek services.
 - The MINISANTE and its partners need to work with districts and other representatives of decentralized levels to develop standardized health facility management manuals for hospitals and health centers, including standardized accounting system and administrative procedures for human resources. This must be carefully coordinated a central level.
 - As described above, the management information system for *mutuelles* and for health facilities management needs to be able to communicate with other management information systems.
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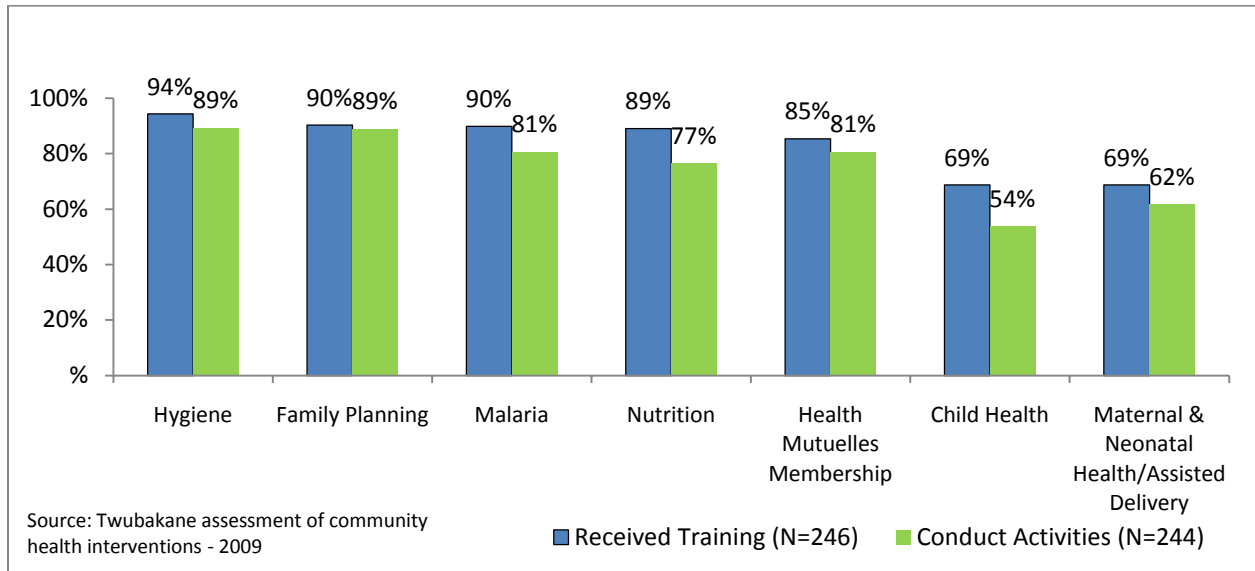
Component 6: Community Engagement and Oversight

From 2005 to mid-2007, the Twubakane Program, in collaboration with other partners, supported the MINISANTE in the development of the national policy on community health and training materials for community health workers. These documents reflect the integrated approach to services at the community level adopted by the GOR. Although Twubakane recognized challenges in supporting an integrated package of services in communities, particularly in terms of fears of overloading CHWs, ensuring high-quality services, and assuring fair compensation for CHWs, Twubakane has worked with the MINISANTE's Community Health Desk and other partners to support the approach. Since 2008 when this policy began to be rolled out, Twubakane has focused support at the national level to finalize management tools, to integrate CHIS indicators into the community PBF system and to conduct a national training on the CHW Trainers' Guide. In the five districts of Ruhango, Kicukiro, Gasabo, Nyarugenge, and Bugesera, Twubakane has concentrated its efforts (following guidance from MINISANTE), on building the capacity of CHWs by training them first in home-based management of fever, then Community IMCI, and then in the full integrated package of services. Twubakane also provided supportive supervision as they began offering a wide range of services in their communities.

The encouragement of community health activities and community participation in health has been important in the 12 districts to accompany and support the decentralization process, as well as improved community-level health services in Rwanda. The existence of PAQ teams throughout the Twubakane-supported districts, the increasingly large number of trained and active CHWs, and the engagement of local authorities, hospital and districts supervisors, are all milestones in increased community participation.

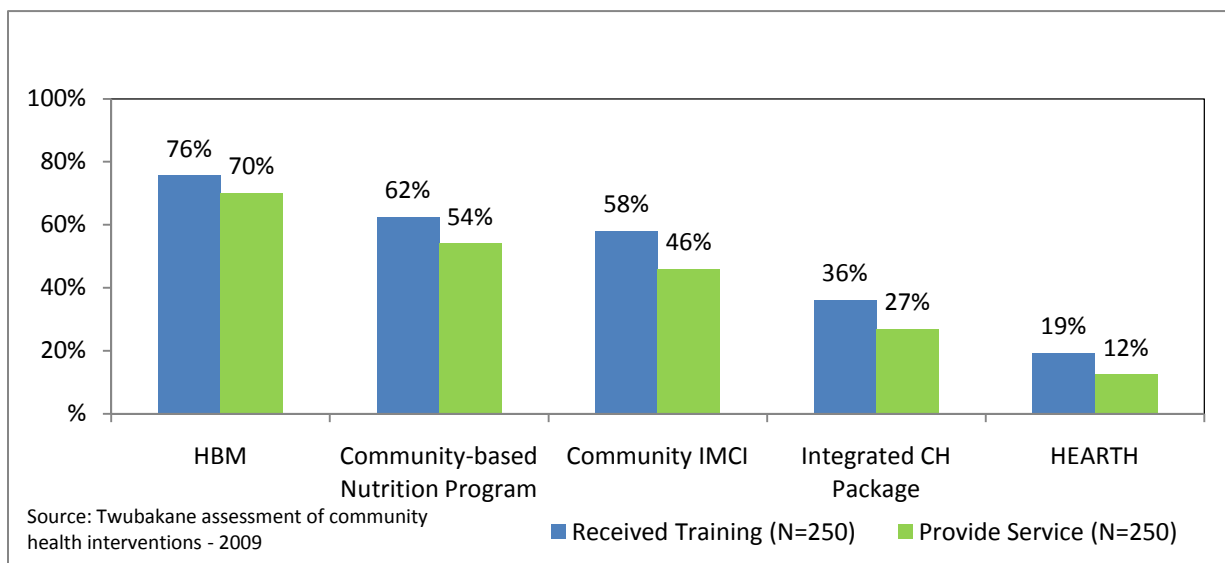
CHWs have responsibilities for providing treatment services (e.g., for malaria, diarrhea) and mobilizing the community around various health issues through health education efforts. As the figure below shows, CHWs are generally conducting mobilization efforts on health topics in which they have been trained and which are priorities in their communities.

Figure 10. Community Health Workers' Participation in Community Health Mobilization



The initial capacity building efforts for CHWs was to offer home-based management of fever (HBM) for malaria. Following the introduction of malaria management to CHW responsibilities, Community IMCI was introduced in Twubakane's community health districts and the integrated package of community health services was introduced in Ruhango. The table below includes data from Twubakane's 12 districts and illustrates that the training process is still on-going but that HBM implementation is widespread. A portion of CHWs at all health centers in the Twubakane zone have been trained in the community based nutrition program, and a smaller portion in the newly introduced HEARTH model for malnutrition recuperation. The community-based nutrition program, while implemented by smaller numbers of CHWs, has been a successful tool for outreach and the identification of malnourished children.

Figure 11. Community Health Workers' Participation in Community Health Services



An assessment conducted by Twubakane in 2009 of CHWs in program districts indicated that 99% of CHWs were elected by their communities. They have high confidence and pride in their work, with at least 96% believing that the populations they serve are satisfied with the services they provide and 98% believing they make a positive difference in the lives of the people in their communities. There is strong support of community health workers from the formal health system, with 88% reporting that they receive supportive supervision from an associated health center. Of those who receive supervision, 94% reported that a health center-based supervisor visits them at their homes. This was confirmed from a separate questionnaire administered to staff at health centers, with 94% of them saying they conduct supervision visits of community health workers at their homes.

Partenariat pour l'Amélioration de la Qualité (PAQ): PAQ, or community-provider partnership teams is approach used by Twubakane since 2005 to bring together HC managers and health care providers with local leaders and community representatives in an effort to identify and address barriers to quality and to use of services. Starting with 11 PAQ teams that had been established 2002 and 2003 by IntraHealth's USAID-funded PRIME II project, there are now 133 teams throughout the 12 Twubakane-supported districts. This approach is an important mechanism to improve service quality and increase community participation in planning and management of health care and health care facilities at the local level. Since 2006, the PAQ approach has been officially identified by the MINISANTE as a best practice in quality assurance, and in 2008 the PAQ approach was included in the ministry's national quality assurance policy and strategy.

Having established teams in almost all of the health centers, Twubakane transitioned in 2008 from establishing teams to building capacity of PAQ supervisors (based at health centers) to institutionalize the teams and foster sustainability. PAQ supervisors from the district and hospital are now in place and providing advice and support to the PAQ teams.

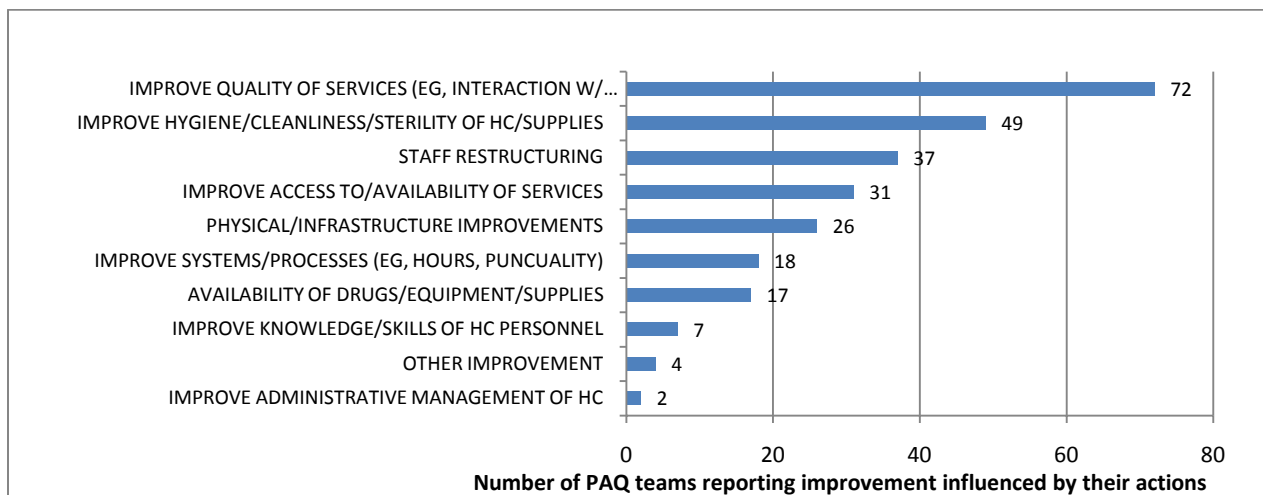
As shown in Table 13, below, as of October 2009, 98% of the 136 health centers in the Twubakane intervention zone have a PAQ team. Indicative of their active functioning, 85% of the HCs had a PAQ that reported having met at least once in the previous six months and 71% of the HCs had a PAQ that had met in the past three months.

Table 13. Community Engagement in Health Centers through PAQs

Indicator	2005 Results All 110 HCs	2007 Results Random Sample of 60 HCs	2008 Results All 136 HCs	2009 Results All 136 HCs	Data Source
% of health centers that have established a mechanism for communities to provide input on quality of services (PAQ)	10%	100%	96%	98%	Twubakane RFA
% of health centers with an active mechanism for communities to provide input on quality of services <u>Most recent PAQ meeting:</u> In the last 3 months 4-6 months ago More than six months ago Never/No PAQ team	n/a	80%	86%	85%	Twubakane RFA
		68%	79%	71%	
		12%	7%	13%	
		20%	9%	13%	
		n/a	5%	3%	
% of health centers with a PAQ that has influenced at least on change in the health center in the previous year	n/a	n/a	71%	84%	Twubakane RFA
% of health centers with a PAQ that has undertaken community mobilization activities in the previous year	n/a	n/a	76%	94%	Twubakane RFA

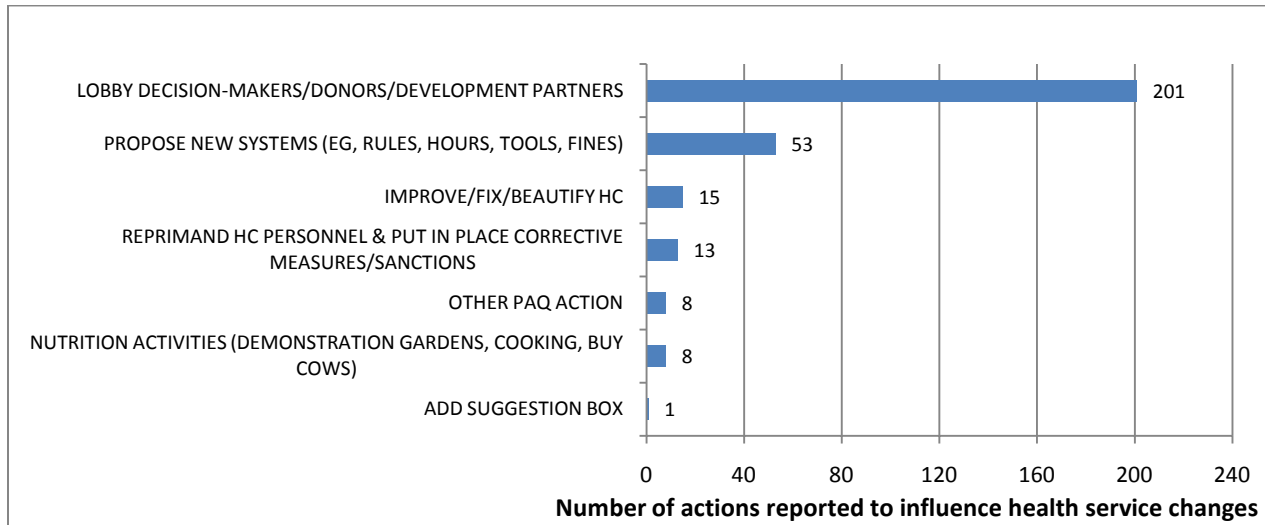
An important role of PAQ teams has been their ability to influence changes at the health centers based on input from PAQ team members and negotiations with HC management. A total of 114 of the PAQ teams (86%) have influenced some kind of change to health services or infrastructure. Of those, 64 teams influenced improvements to the quality of services (e.g., interaction with clients, respect of health care norms, etc.); 49 influenced improvements to hygiene and sanitation within health centers; and 37 influenced the restructuring of staff (e.g., recruitment, removing of ineffectual personnel, etc.).

Figure 12. Improvements to Health Services Influenced by PAQ Teams, 2009



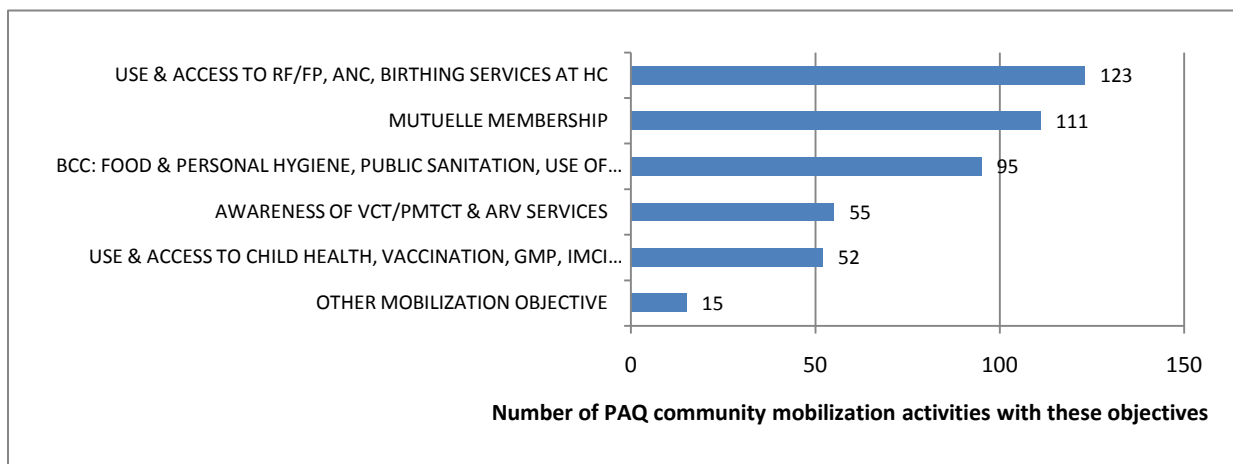
The specific actions undertaken by the PAQ teams to influence these changes include lobbying for directives or advocating for funds from administrative decision-makers, donors, and other development partners; making specific proposals to implement new rules and systems; and putting in place corrective systems, including reprimands of personnel in violation of health facility regulations and guidelines.

Figure 13. Actions Taken by PAQ Teams to Improve Health Care Services, 2009



Many of the actions undertaken by PAQ teams during 2009 to mobilize the community were focused on increasing use of health services for FP and safe motherhood (e.g., delivery at a HC vs. at home), enrollment in mutuelles and education about personal and food hygiene. In order to mobilize community members, PAQ teams mostly relied on group sensitization activities, household visits, and team members serving as good examples to the community.

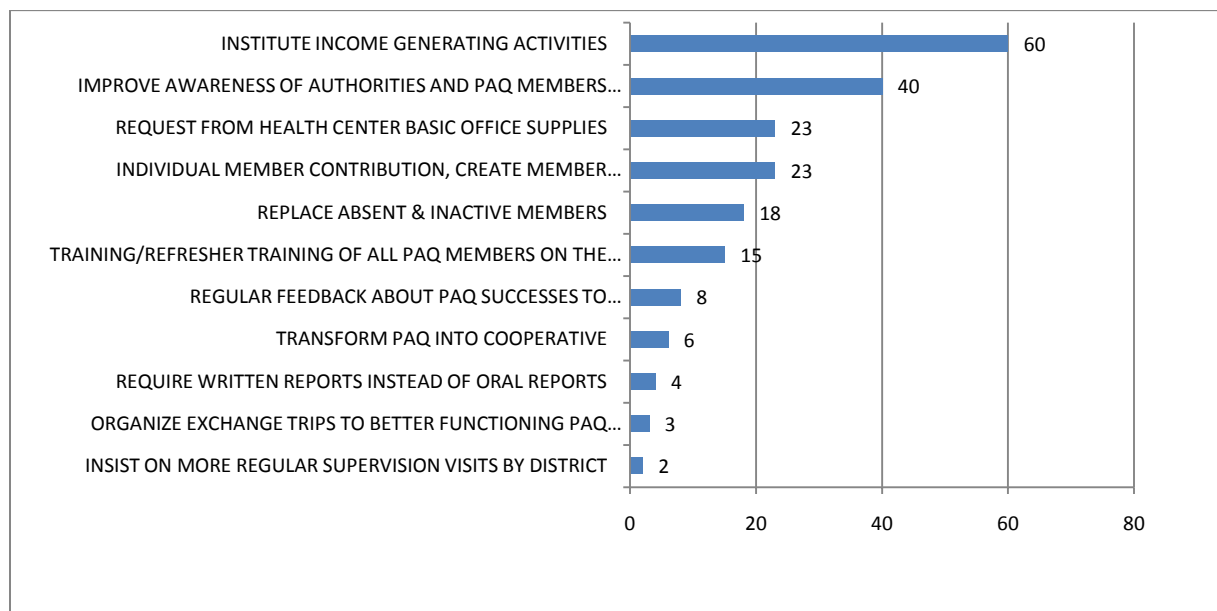
Figure 14. Types of PAQ Community Mobilization Objectives, 2009



Most PAQ teams said they encountered important challenges and obstacles to their efforts. Lack of financial means and meeting space were by far the most frequently mentioned, followed by limited

member participation, motivation, or time, and lack of knowledge of the PAQ strategy and community health policies. To address these challenges, some actions that PAQ teams undertook were to set up income-generating activities, request individual member contributions and set up member support funds, and replace absent or inactive members.

Figure 15. PAQ Actions in face of Challenges/Obstacles, 2009



Fostering sustainability of the PAQ approach

The president of the PAQ team of the Musambira Health Center in Kamonyi District, proudly proclaimed: “We have really influenced the way the health center runs, including asking for an audit of the center. Now, the management is ‘clean’ and they have even hired more personnel, all thanks to the PAQ team’s work!” To her right in the photo is Celestin Munyankindi, the mutuelles manager for Kamonyi District, and also president of the district-level PAQ team—an innovation the district made possible. “The best way to make the PAQ approach sustainable,” he said, “is to have a PAQ team at the level of the district hospital. That is what we have been able to create in Kamonyi, and the district authorities are truly realizing that the PAQ plays a huge role not only in improving the quality of care, but also in making health care providers more conscious of the important role that they play in the lives of the community members.”



An evaluation of PAQ teams in late 2008/early 2009 provided valuable information for further implementation of this Twubakane component as well as for MINISANTE. The qualitative evaluation of the PAQ approach included in-depth interviews and focus groups of national authorities, local authorities, health center staff, PAQ team members, and community members. Assessment results showed high levels of both community and government awareness of the PAQ committees and their activities. More than four-fifths (84%) of community respondents had heard of the committees, and most sector and district representatives spoke favorably of the PAQ committees' role within the local health care system. All of the committees' executive boards had met at least once in the last quarter, indicating a high level of commitment on the part of the PAQ committees' key members. The assessment findings also suggested that most PAQ committees had contributed to improved service quality at their health centers. Stakeholder perceptions regarding PAQ achievements focused on two health center outcomes, physical infrastructure and environment, and service delivery, as well as two community outcomes, community partnerships and community outreach. Community members indicated that they care about the quality of services—and are willing to volunteer their time to improve quality—and health providers acknowledged that listening to communities can make their work easier and more efficient. Overall, the successes highlighted by this assessment suggested that the PAQ approach should be scaled up nationally in Rwanda.

To sustain the PAQ committees' momentum and deepen community engagement with local health facilities, it will be important that the MINISANTE develop a strategy to ensure that the PAQ approach, officially listed as one mechanism for assuring and improving the quality of services, be supported and rolled out. The MINISANTE and partners also will need to work with district and sector leadership to begin to address issues such as PAQ member turnover, training needs, and mechanisms for covering operating expenses. Although health centers will continue to be affected by deeper structural problems such as human resource shortages, this assessment's findings indicate that community-based entities such as the PAQ committees have the potential to strengthen health care quality and client satisfaction.

Community-Based Health Information System (CHIS): In 2007, at the request of the MINISANTE, Twubakane began the pilot test of the community-based health information system in selected sectors in two districts: Kicukiro and Kirehe. The CHIS has since evolved, and will be merged with the community performance-based financing information system. During 2008, Twubakane trained 187 CHWs in these two districts in use of the CHIS. The sectors in these districts where the CHIS was piloted, are still using and appreciating the system.

Table 14. Strategic Information Management*

Indicator	2005 Results <i>All 110 HCs</i>	2007 Results <i>Random Sample of 60 HCs</i>	2008 Results <i>All 136 HCs</i>	Data Source
# People trained in Strategic Information Management (Community Health Information System)	100	30	317	Twubakane records
Male	n/a	9	171	
Female	n/a	21	146	

*No trainings were conducted in 2009

Future Priorities in Community Engagement and Oversight

- One of the often-cited reasons for appreciation of CHWs relates to their ability to treat illnesses quickly and near to the person's home. Without a reliable supply of commodities for CHWs, however, they can risk lost trust by community residents. MINISANTE and others partners need to work together to determine how best to quantify and assure ongoing supply of these commodities.
- Much of the initial investment of resources for the CHW program has been identifying, training and equipping the workers to allow them to provided much needed services. We know however, that health workers of all skills levels also need ongoing supportive supervision to ensure and enable them to provide quality services to expected standards. MINISANTE and its partners need to determine how to implement a reliable and sustainable system of supervision for the many CHWs.
- Community PBF is relatively new, as is the CHW initiative. There are still many issues to work through as the community PBF and CHWs are scaled up nationally. It will be critical, for example, that CHWs be rewarded for those indicators that reward both preventive and curative services and that have the greatest impact on the health of the population they serve.
- In order to provide income to the CHWs, as they devote time to delivering health services and not other employment, the national policy says cooperatives will be formed. Since many of these cooperatives are new, it will be important to review how they are functioning and provide support in cooperative management and organization. Helping CHWs balance their obligations to community residents for health services and obligations to the cooperatives will be needed.
- The PAQ approach has been adopted in the National Quality Assurance Policy and teams are functional in the 12 Twubakane-supported districts. In order to make this program truly national, MINISANTE Community Health Desk, districts, and health facilities will need assistance to introduce and support PAQ teams in other districts.
- In addition to national scale up, as a voice for the community, PAQ teams need to establish strong and solid relationships with the local CHWs. As a quality assurance mechanism, the PAQ teams will benefit from information shared with CHWs (by community residents) about services at the health facilities. PAQ teams and CHWs will need assistance to establish formal relationships.

CHALLENGES AND LESSONS LEARNED IN DECENTRALIZATION AND HEALTH

The most salient lessons learned in implementing the Twubakane Program were related to the importance of integrating decentralization and health at all levels, and of ensuring partnership and local ownership. The greatest challenge faced in implementing the Twubakane Decentralization and Health Program was responding to an ever-changing and rapidly decentralizing environment. Supporting decentralization through an empowering, bottom-up approach has been challenging. Early on, some stakeholders saw decentralization as a top-down mandate, not fully understanding the benefits of true decentralization and of shifting decision making authority to decentralized levels. Over the past several years, with the full implementation of decentralization, many stakeholders at all levels have realized that, for decentralization to be truly effective, finance must follow function, with districts and other decentralized entities having the resources necessary to support service delivery.

The Twubakane Program's successes, as well as the challenges, have been related to Rwanda's rapidly changing environment. Launching the program in a time of widespread reform necessitated implementing activities at both the central and decentralized levels while, at the same time, responding to and supporting the changes as they occurred at all levels.

The Twubakane staff members have worked as a team in close collaboration with our GOR counterparts, and a variety of other partners, at all levels in fostering an integrated approach, both within the health sector, and among health, decentralization and good governance, and overall social and economic development.

Other key challenges and lessons learned include:

- Community health workers offer vital—and often urgent—services to the communities in which they serve; *in addition*, in close collaboration with the PAQ teams, CHWs have become empowered community representatives with a voice in health management and governance issues at the local level. Furthermore, as many beneficiaries have noted, the availability of health services at the community level has saved time and money for community members. An important remaining challenge for the GOR and its partners will be to ensure that CHWs are fairly compensated for their work, either through fully functional cooperatives, through community performance-based financing or both. The MINISANTE also must figure out how to ensure ongoing supportive supervision of CHWs.
- Strengthening the management of health facilities and *mutuelles* has contributed to more cost-effective use of resources; *in addition*, district authorities better understand the investments needed for quality health care services and the role *mutuelles* play in allowing citizen access to these health care services. In continuing to improve health facility management and the functioning of *mutuelles*, the GOR and the MINISANTE need to ensure the involvement of and ownership by local authorities.
- Decentralization policies and programs have contributed to increased availability of resources at the local level and empowered local government authorities; *in addition*, the successful implementation of the decentralization plan is contributing to local leadership and services, including health services that are more responsive to the needs of the population.
- The Twubakane Program staffing, including technical staff based in the Kigali program office and field coordinators based with the district teams has been a productive structure for the program and GOR partners. Throughout the five years, it has been extremely important to have program-based technical staff available to support central level policy/program work and relate to GOR central level staff and to act as liaisons with district level staff as policies are disseminated. Staff located in the district offices who served as a member of the district team (both field coordinators and assistants) allowed for easier better coordination of activities with district authorities and other development partners, timely technical and financial support for districts as their capacity was built to implement programs/activities, and translation of central level policies. The only thing that might have been more effective would have been to increase the number of field staff in the district offices from the beginning of the program, but this may have presented its own challenges.
- The Twubakane Program National Steering Committee, composed of the Permanent Secretaries of the MINALOC and of the MINISANTE, USAID health and demography/governance officers, the Twubakane Chief of Party, and provincial authorities, had an important role to play during the

first year of project, but dissolved as decentralization became more important. In addition, with the continued decentralization process, the limited central level staff had multiple commitments and were challenged to have available time on the same date and time of day. Instead, the program sought guidance from the ministry-designated point persons and invited representatives to events at both the central and district levels, and all authorities accepted the gradual dissolution of the steering committee. (Note—starting in 2007, the MINECOFIN apparently requested that individual bilaterally funded projects NOT have their own steering committees.)

- In order for the Twubakane Program to work most effectively, the program team needed to receive integrated support from USAID (the health team, democracy and governance team and the program team) as well as the GOR (the MINISANTE, MINALOC and MINECOFIN). This integrated support and review of the Twubakane Program (including reading quarterly and annual reports on a regular basis) was more effective during the first two years of project implementation.
- District Incentive Funds provide much-needed resources to the districts and promote good governance and capacity building; *in addition*, DIF grants impact the quality of services through investments in medical equipment and supplies, health facility renovations, PAQ teams and community mobilization.
- Family planning and reproductive health efforts have had an impact on the health of women, as well as their children and families; *in addition*, attention to family planning and reproductive health has galvanized district authorities and other local leaders to care about health as a social and economic development issue—and to direct local resources to promote health and ensure high-quality services.
- Continuing application—provided a good opportunity to review results, re-strategize (new staff, etc.): In July 2007, the Twubakane Program presented its continuing application for the second half of the program to the GOR and USAID. This presentation involved stakeholders from central and district levels and included district authorities, providers and citizens as presenters as well as Twubakane staff. Feedback was positive, emphasizing the overall responsiveness of Twubakane to GOR needs at all levels and the participatory and empowering approach used by program staff. The mid-point of the program allowed Twubakane to take stock of progress to date, through June 2007. Following the continuing application, the total program ceiling was increased to \$30,689,199, specifically to support additional work in malaria, family planning and additional field staff.
- Final partners' review meeting: provided opportunity to review follow on work with district stakeholders, fostering sustainability as they understood they were capable of continuing the work, as well as that other development partners and donors are interested in and available to provide support and funding.
- Community-provider partnership (PAQ) teams not only encourage community participation and ownership; *in addition*, the work of the PAQ teams has had positive influences on good governance, community health and improved maternal, child and reproductive health.
- Decentralization policies and programs have contributed to increased availability of resources at the local level and empowered local government authorities; *in addition*, the successful implementation of the decentralization plan is contributing to local leadership and services, including health services that are more responsive to the needs of the population.

- Supporting participatory processes at all levels, including planning and assisting in developing work plans, has been time-consuming and laborious. However, the Twubakane team has learned that Joint Action Work Plans must be developed from a bottoms-up approach in order to be truly meaningful to local actors and to have any chance of actually being implemented.



ANNEXES

ANNEX A: TWUBAKANE DECENTRALIZATION AND HEALTH PROGRAM GOALS, COMPONENTS, OBJECTIVES AND RESULTS

Goal	Components/ Objectives	Planned Results	Results Achieved
<p>To increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels</p> <p><i>(package of family health services includes FP/RH and child survival/malaria and nutrition services)</i></p>	<p>Component 1: Family Planning and Reproductive Health</p> <p>Increase access to and the quality and utilization of FP and RH services in health facilities and communities</p>	<ol style="list-style-type: none"> 1. Norms and protocols (MPA and CPA) for FP/RH revised to expand package of services offered at health centers 2. Increased use of modern FP 3. Quality of FP services improved in health facilities 4. Quality of RH services, including safe delivery and management of obstetrical emergencies, improved in health facilities 5. Health care providers follow norms for referral/counter-referral for FP/RH 6. Functional rapid response system for obstetrical emergencies exists at community level 7. Utilization of antenatal services increased 	<ol style="list-style-type: none"> 1. Norms and protocols revised. Expansion includes allowing oxytocin at HC level; long-acting FP methods at HC level; also CBD for injectables 2. Modern FP prevalence increased from 10% in 2005 to 27% in 2007/08 (ref: RIDHS 2007/08) 3. Increased range of methods in health facilities has contributed to improved quality of services 4. Percentages of health facilities offering essential (HC) and comprehensive (hospital) EmONC has increased contributed to improved quality of services; move women are delivering at facilities indicating their satisfaction with services 5. Following decision of MINISANTE, the project focused on building an integrated system to reduce the need for referral and increase access to FP services. 6. By the end of the project 90% of health facilities used partograms systematically to improve response time to obstetrical emergencies, compare to baseline in 2005 when only 26% of facilities did. 7. Use of ANC increased (measured in # of visits) from 52,519 in 2006 to 92,027 in 2009

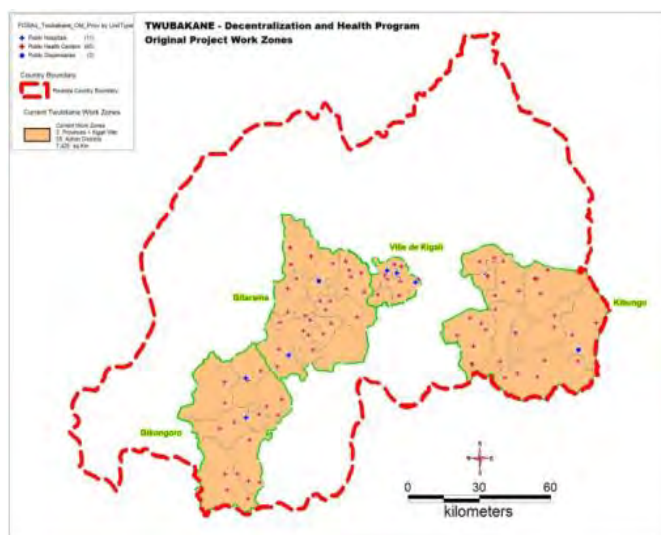
Goal	Components/ Objectives	Planned Results	Results Achieved
<p>To increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels</p> <p><i>(package of family health services includes FP/RH and child survival/malaria and nutrition services)</i></p>	<p>Component 2: Child Survival, Malaria and Nutrition</p> <p>Increase access to and the quality and utilization of child health, malaria and nutrition services in health facilities and communities</p>	<ol style="list-style-type: none"> 1. Norms and protocols for IMCI, malaria and nutrition to expand package of services offered at health centers 2. Quality of CS/malaria/nutrition services improved in health facilities 3. Community-based nutritional surveillance and community-based case management of moderate malnutrition improves 4. Capacity for case management of severe malnutrition in health facilities improved 5. Increased use of insecticide-treated nets 6. Improved home-based case management of malaria and other childhood illnesses 7. Increased immunization coverage (DPT3) 	<ol style="list-style-type: none"> 1. Norms/protocols expanded implementation of IMCI, IPT for malaria and micronutrients for nutrition 2. Expanded services of IMCI and community-IMCI, updated malaria treatment practices and, along with improved capacity in cold chain management have contributed to improved quality of services at facilities 3. Improved linkages between community and facilities through Community-based Nutrition (268 health providers, 861 CHWs trained) to increase early diagnosis of malnutrition; surveillance addressed to CBHIS (see Component 6 below) 4. Case management for severely malnourished children improved through introduction of IMCI. 5. ITN use not measured by Twubakane PMP (per negotiations with USAID); however, PMI and PNILP data indicated increased use nationwide 6. HBM improved – was not offered in 2004, now offered in 5 districts; in 2009 alone, 86,458 children <5 treated via HBM 7. Number of children <12 months receiving DPT3 increased from 105,401 in 2005 to 121,162 in 2009

Goal	Components/ Objectives	Planned Results	Results Achieved
<p>To increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels</p> <p><i>(package of family health services includes FP/RH and child survival/malaria and nutrition services)</i></p>	<p>Component 3: Decentralization Policy, Planning and Management</p> <p>Strengthen central-level capacity to develop, support and monitor decentralization policies and programs, with an emphasis on health services</p>	<ol style="list-style-type: none"> 1. Increased capacity of central level (MINALOC and MINISANTE) to support local governments to plan, finance and monitor health service delivery 2. Improved policies for effective implementation of decentralization, especially fiscal decentralization, developed 3. National Health Accounts institutionalized and used as planning and monitoring tools 4. National HMIS assessment conducted 5. RALGA's capacity for supporting good governance at local levels improved 	<ol style="list-style-type: none"> 1. Capacity of both MINALOC and MINISANTE increased as evidenced by policies in place including Rwanda Decentralization Strategic Framework (RDSF), the Decentralization Implementation Program (DIP), and the Economic Development and Poverty Reduction Strategy (EDPRS) and completed revised Health Policies, Norms and Protocols 2. Policies such as fiscal decentralization and equalization formula developed and implemented 3. NHA institutionalized at national level via the NURSPH 4. RALGA has increased capacity and is offering support to districts nationwide; able to directly fund staff and activities and to seek external funding as needed
	<p>Component 4: District-Level Capacity Building</p> <p>Strengthen capacity of districts to plan, budget, mobilize resources and manage services, with an emphasis on health services</p>	<ol style="list-style-type: none"> 1. Local government capacity for integrated planning strengthened, including health sector planning 2. Local government capacity for mobilizing and managing resources strengthened 3. Community participation strengthened in planning and budget decisions, including ongoing review of service delivery and other expenditures and attention to building citizen oversight to mitigate corruption 	<ol style="list-style-type: none"> 1. Using DIF grants, local governments better able to plan for services, including health 2. Districts able to mobilize resources using JADFs and MTEF to identify planned resources 3. All districts have mechanism for involving community members in planning and budgeting decisions for health sector and general district financial status; also through PAQ teams

Goal	Components/ Objectives	Planned Results	Results Achieved
<p>To increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels</p> <p><i>(package of family health services includes FP/RH and child survival/malaria and nutrition services)</i></p>	<p>Component 5: Health Facilities Management</p> <p>Strengthen capacity of health facilities, including health centers and hospitals, to better manage resources and promote and improve the functioning of <i>mutuelles</i></p>	<ol style="list-style-type: none"> 1. Capacity of health facilities (district hospitals and health centers) to effectively mobilize and manage diverse resources strengthened 2. Improved HMIS data collection, analysis and use (in Twubakane-supported zones) 3. Health committees effectively functioning to strengthen health facility management 4. Increased rate of membership in <i>mutuelles</i> 5. Capacity of <i>mutuelles</i> to manage and ensure quality of services strengthened 6. Participation of <i>mutuelles</i> in the prevention and promotion increased 	<ol style="list-style-type: none"> 1. Capacity of health facilities to mobilize and manage improved through DIFs (types of health facility projects financed), creation of strategic plans and contributions to JAWP. 2. HMIS as data collection system has had limited improvement only 3. Functioning of health committees was not measured by Twubakane PMP (per negotiations with USAID) 4. Membership in <i>mutuelles</i> increased in 2007 when participation was required and has stayed constant at 68% in Twubakane districts 5. Some improvement of <i>mutuelles</i> to manage; ongoing challenges exist and financial viability ongoing threat. 6. Participation of <i>mutuelles</i> in the prevention and promotion not measured in Twubakane PMP (per negotiations with USAID)
	<p>Component 6: Community Engagement and Oversight</p> <p>Increase community access to, participation in, and ownership of health services</p>	<ol style="list-style-type: none"> 1. Community-based health agents capable of providing information and advice related to FP/RH and Child Survival/Malaria/Nutrition 2. Community-based services delivery system, supported by districts/sectors, effectively functional and providing a variety of commodities and services 3. Community-provider partnership committees active in evaluating and solving problems related to health service delivery (in health facilities and communities) 4. System of community-based surveillance of morbidity/mortality functioning to track illnesses/death and to mobilize community responses 	<ol style="list-style-type: none"> 1. CHWs in 5 focus districts (selected by MINISANTE) offering services, particularly Child Survival/Malaria/Nutrition 2. System functional in 5 focus districts; each CHW received service delivery kit; HCs involved in procurement of replacement supplies; database of existing CHWs created 3. By 2009, 133 PAQ partnership teams exist (133/135 HCs); 84% of health centers have PAQ team improving health services 4. Community-based Health Information System tested in two districts; later merged into national community-PBF system

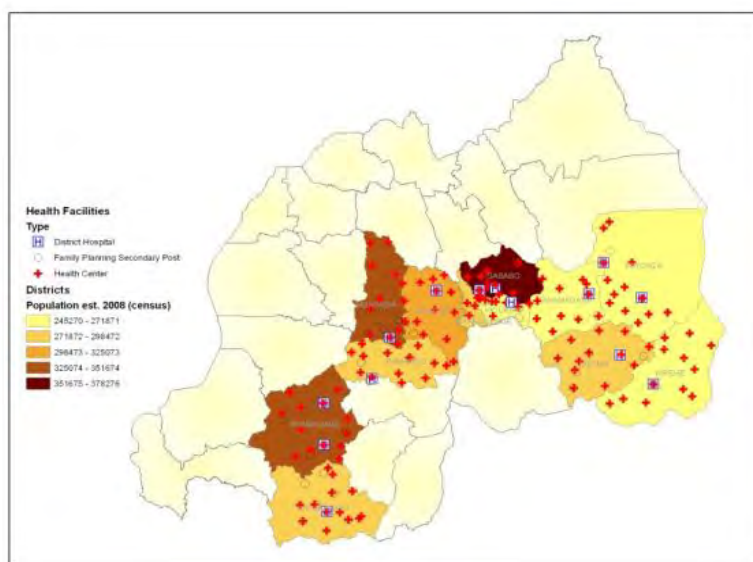
ANNEX B: TWUBAKANE'S INTERVENTION ZONE—ORIGINAL (2005) AND REVISED (2006)

Province	District	Population	
		Year: 2002	Year: 2006
KIGALI		765,325	852,572
	NYARUGENGE	236,990	264,007
	GASABO	320,516	357,055
	KICUKIRO	207,819	231,510
SOUTH		1,308,585	1,457,764
	NYARUGURU	234,190	260,888
	NYAMAGABE	280,007	311,928
	RUHANGO	245,833	273,858
	MUHANGA	287,219	319,962
EAST		894,802	996,809
	RWAMAGANA	220,502	245,639
	KAYONZA	209,723	233,631
	KIREHE	229,468	255,627
	NGOMA	235,109	261,911
Total population		2,968,712	3,307,145



Population of New Districts in Rwanda (Note:
Population growth rate = 2.85 % per annum)
Source: MINALOC and Rwanda Census Data, March 2006.

Original intervention zone covering four provinces:
Gikongoro, Gitarama, City of Kigali and Kibungo



Revised intervention zone covering 12 districts: Nyarugenge, Kicukiro, Gasabo, Ngoma, Kayonza, Kirehe, Rwamagana, Kamonyi, Muhanga, Nyaruguru, Nyamagabe, and Ruhango.

ANNEX C: MONITORING AND EVALUATION METHODOLOGY AND INDICATOR DEFINITIONS

Throughout the life of the Twubakane Program, M&E activities focused on the ongoing data collection and analysis needed for reports of quarterly and annual program performance as well as data to inform planning and implementation decision-making. Twubakane primarily uses indicators set in January 2007, when the PMP indicators were changed in accordance with the USG's 'Investing in People' indicators and additional indicators were added for program monitoring.

The reporting period for most indicators is the calendar year (January-December), however, HMIS indicators are reported for USAID's fiscal year (October-September). The sources of data were all HCs and district hospitals receiving Twubakane support unless otherwise stated. At the end of 2005, there were 110 HCs (plus 7 dispensaries and 4 private clinics which were included with the 110 HCs in the RFA's reported results) and 12 district hospitals. By the end of 2006, there were 127 HCs and 12 district hospitals. By the end of 2007, there were 131 HCs and 12 district hospitals, and at the end of 2008 and 2009 there were 136 HCs and 14 district hospitals.

It should be noted that due to administrative restructuring in Rwanda in 2006, a small number of the HCs in the Twubakane intervention zone changed.

METHODOLOGY

Data Collection

The main data sources for program performance have been the national HMIS (monthly health facility data), an annual rapid facility assessment (RFA) in HCs and hospitals and a district survey (SWOT). In addition, data were collected from Twubakane program records (training and workshops) and from partners (RALGA, DELIVER, and UNICEF).

HMIS data for both HCs and hospitals is collected quarterly from the district hospitals. The sample for the majority of HMIS indicators is the 136 HCs in the 12 Twubakane districts. However for the indicators on assisted deliveries, postpartum visits, and diarrhea cases treated, the sample includes the 14 district hospitals as well.

A comprehensive RFA of all health facilities was conducted by Twubakane at the end of 2005. However, due to a change in indicators in 2007, very little of that RFA information can be used as baseline data for current indicators. Hence, in the fall 2006, a mini-RFA with a small number of indicators was conducted in a sample of 40 HCs in Twubakane's intervention zone. This survey collected data on clinical indicators unavailable through the HMIS as well as on indicators pertaining to community engagement in HC management. The centers were selected through a purposive sampling strategy that—while not random—strove to be representative of the HCs in the Twubakane zone.

In February 2008, the M&E team repeated this mini-RFA, with additional indicators with a random sample of 60 HCs. The purpose was to obtain this data using a sampling method that would ensure a representative sample of all the health facilities in the Twubakane zone. It was stratified by district with the number of HCs sampled per district proportionate to the number of HCs in the district. Random selection was achieved through a random numbers generator. A full RFA was completed in December 2008 in all 136 HCs and all 14 hospitals. However, one health center (Kaduha) refused to participate;

therefore, results for many indicators are based on 135 HCs. A final RFA was conducted with the same 136 HCs and 14 hospitals, again, without the participation of Kaduha. The 2007, 2008, and 2009 RFAs included a qualitative focus group with PAQ committee members. The 2009 RFA also included interviews with CHWs working with the HCs.

At the district level, an annual survey of districts was conducted with district officials to obtain data for several indicators about district-level planning, budgeting and managing. This SWOT self-assessment was first conducted in October 2006 in all Twubakane districts with the participation of district and sector officials. These were district mayors, executive secretaries, vice mayors, directors and sector executive secretaries. In 2007, the data collection tool was shortened and simplified to limit the time required for the officials to implement the assessment. The same data collection tool was used in March 2008. In 2008 and 2009, as in previous years, all 12 districts were included in the assessment, and in each district a group of district officials was asked to rate district performance in public reporting of health sector activities and financial performance and to demonstrate that they engage the population in preparing district plans and activities.

Data Analysis

The data analysis for the PMP indicators is descriptive (percentages and numerical counts). In this report, except for where indicated, aggregate results for the 12 districts are presented. Since Twubakane supports 5 districts with PMI funds, the malaria indicators are reported for these 5 districts separately. This aggregation of data contrasts with the quarterly reports in which results were disaggregated to provide district-level results. Details about indicator definitions, methods of calculations, and reporting period and data source are provided for each indicator in the following section.

For a few indicators which have remained constant in the project from 2005 to 2009, there is baseline data from 2005. However, comparisons between 2005 and 2009 need to be made cautiously as the administrative restructuring in Rwanda in 2006 slightly changed Twubakane's intervention zone.

Indicators: Definitions and Means of Calculation

FAMILY PLANNING/ REPRODUCTIVE HEALTH

Couple Years of Protection Offered by Public Facilities: The estimated protection (CYP) provided by family planning services during a one-year period based upon the volume of all contraceptives provided to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. Reporting period: Fiscal Year (October-September). Data Source: The DELIVER project.

People Trained in Family Planning/Reproductive Health: # people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) Twubakane has trained in FP/RH. FP/RH includes FP, Focused ANC, and the integrated community health package and training includes training courses, workshops and on-the-job training. Reporting period: Calendar Year. Data source: Twubakane project records.

of new family planning users by method: # of new family planning users at hospitals, health centers, and FP secondary posts disaggregated by family planning method. Reporting period: Fiscal Year (October-September) Data source: HMIS monthly forms and Twubakane RFA.

% of health centers providing modern contraceptive methods: # of health centers that offer modern contraceptive methods/# of health centers visited. This indicator is aggregated by method. Reporting period: Calendar Year. Data source: RFA.

Deliveries with Skilled Birth Attendants: # deliveries with a skilled birth attendant. This includes medically trained doctor, nurse, or midwife. It does not include traditional birth attendants. It is calculated by adding the # of deliveries at health centers and hospitals. Reporting period: Fiscal Year (October-September). Data source: HMIS monthly forms.

ANC Visits by Skilled Providers: # ANC visits at health centers assisted by Twubakane. It is calculated by adding: # standard visits in 1st trimester + # standard visits in 2nd trimester + # standard visits in 7th or 8th month + # standard visits in 9th month. Reporting period: Fiscal Year (October-September). Data source: HMIS monthly forms from health centers.

People Trained in Maternal/Newborn Health: # people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal and/or newborn health and nutrition care. Maternal/Newborn Health includes Focused ANC, EONC, Kangaroo Care, and the integrated package for community health. Reporting period: Calendar Year. Data source: Twubakane project records.

% of health centers that offer essential emergency obstetrical and neonatal care: # of health centers that offer the 6 necessary interventions for essential EONC/# of health centers visited. This indicator is disaggregated by intervention. Reporting period: Calendar Year. Data source: RFA.

% of hospitals that offer comprehensive emergency obstetrical and neonatal care: # of hospitals that offer the 8 necessary interventions for comprehensive EONC/# of hospitals visited. This indicator is disaggregated by intervention. Reporting period: Calendar Year. Data source: RFA.

% of health facilities that offer Active Management of the Third Stage of Labor: # of health facilities that systematically perform all three interventions that make up AMSTL/# of health facilities visited. This indicator is disaggregated by intervention. Reporting period: Calendar Year. Data source: RFA.

CHILD SURVIVAL

Diarrhea Cases Treated: # cases of child diarrhea treated with oral rehydration therapy (zinc is not used in Rwanda). All cases of diarrhea in children <5 treated at health centers and hospitals are counted as they would typically include ORT. If data was available on cases were treated through community based distribution of ORT that would also be included. Reporting period: Fiscal Year (October-September). Data source: HMIS monthly forms.

Children <12 months who received DPT3 Immunizations: # children less than 12 months who received DPT3 in a given year. Reporting period: Fiscal Year (October-September). Data Source: HMIS monthly forms.

People Trained in Child Health and Nutrition: # people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in child health care and child nutrition including the Community-based nutrition program, Community IMCI, and Clinical IMCI . Reporting period: Calendar Year. Data source: Twubakane project records.

NUTRITION

Children <5 Who Received Vitamin A: While this indicator is intended to include # children under 5 years of age who received Vitamin A from USG-supported programs, in fact it is really # of doses of Vitamin A dispensed to children under 5 by USG-supported programs. Includes: # doses of Vitamin A received by children <5 in each mass campaign + # children <5 who received Vitamin A at health centers or in the community as part of growth monitoring. As the mass campaigns are biannual some children may receive Vitamin A in both campaigns. Hence the indicator necessarily refers to # doses rather than # children. Reporting period: Fiscal Year (October-September). Data source: UNICEF or EPI program data on mass campaign and HMIS monthly reports.

Children Reached by Nutrition Programs: # children < 5 years reached by programs that promote good infant and young child feeding and/or growth promotion programs. Includes: # children < 5 years old treated for malnutrition at health centers + # children <5 in growth promotion programs at health centers. In order to avoid duplicate counting, the number of children in growth monitoring programs is taken for the month with the highest number of participants for the year. Reporting period: Fiscal Year (October-September). Data source: HMIS monthly reports.

MALARIA

People trained in treatment or prevention of malaria: # people (medical personnel, health workers, community health workers, etc.) trained in malaria treatment or prevention including Clinical IMCI, Community IMCI, and HBM. Reporting period: Calendar Year. Data source: Twubakane project records.

children <5 years diagnosed with simple malaria: # children <5 years who are diagnosed with simple malaria in health centers. This indicator is reported for all 12 Twubakane funded districts and for Twubakane's 5 HBM districts (Ruhango, Nyarugenge, Kicukiro, Gasabo, and Bugesera). Reporting period: Fiscal Year (October-September). Data Source: HMIS.

children <5 treated for malaria through HBM: # children <5 treated for malaria through home based management of fever by community health workers. This indicator is reported solely for Twubakane's 5 HBM districts (Ruhango, Nyarugenge, Kicukiro, Gasabo, and Bugesera). Reporting period: Fiscal Year (October-September). Data Source: HMIS and PNILP reports.

DECENTRALIZATION, POLICY PLANNING AND MANAGEMENT

of policies drafted or revised with USG support: # of laws, policies, regulations, or guidelines related to improved access to and use of health services drafted or revised with assistance from Twubakane. Reporting period: Calendar Year. Data Source: Quarterly reports and other documentation.

of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA, health facilities, and other relevant stakeholders with USG support: # of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA (local government authorities), technical civil

servants, health facilities, and other relevant stakeholders with assistance from Twubakane. Reporting period: Calendar Year. Data Source: Quarterly reports and other documentation.

DISTRICT LEVEL PLANNING, BUDGETING, AND MANAGING

% Districts that have mechanisms in place for public reporting on health sector activities: % of districts in which both oral and written mechanisms for public reporting on health sector activities are in use and can be verified. Mechanisms include public meetings, newsletters, pamphlets, information boards, posters, etc. Reporting period: Calendar Year. Data source: SWOT.

% Districts that have mechanisms in place for public reporting on their financial performance: % districts in which both oral and written mechanisms for public reporting on health sector finances are in use and can be verified. Mechanisms could include public meetings, newsletters, pamphlets, information boards, posters, etc. Reporting period: Calendar Year. Data source: SWOT.

% Districts with annual plans and an MTEF that include a full range of health activities: % districts that have an annual work plan and an MTEF (3-year plan) that include plans for all of the following types of health activities: prevention, treatment, infrastructure, equipment and staffing. Reporting period: Calendar Year. Data source: SWOT.

% Districts that have plans and budgets documented to reflect citizen input: % districts that demonstrate through documentation that there was citizen input in the process of developing a district work plan or budget. Reporting period: Calendar Year. Data source: SWOT.

USG ASSISTANCE FOR CAPACITY BUILDING IN PUBLIC SECTOR

of Sub-national Government Entities receiving USG assistance to improve their performance: # sub-national entities (refers to 'local governments' and their departments and divisions) receiving USG financial or technical assistance. In Twubakane entities refer to districts. Annually this number should be all 12 because all 12 receive DIFs. Quarterly would be all districts receiving any technical or other financial assistance. Reporting period: Calendar Year. Data Source: Twubakane records.

of Sub-national Governments Receiving USG Assistance to increase their Annual Own-source Revenues: # sub-national governments receiving USG financial or technical assistance to increase annual own-source revenues. Twubakane's 12 districts and Kigali City are included in this indicator. Reporting period: Calendar Year. Data Source: Twubakane records.

of local non-governmental and public sector associations supported with USG assistance: # of local non-governmental and public sector associations supported by Twubakane. This includes local Civil Society Organization networks and associations (e.g. health, business) and public sector associations (e.g. prosecutorial, police /investigatory) and for Twubakane includes PAQ teams, JADFs, RALGA, and others. Reporting period: Calendar Year. Data Source: Twubakane records.

of Individuals who received USG-Assisted training, including management skills and Fiscal Management, to Strengthen Local Government and/or Decentralization: # individuals who participated in any training or education event, whether short-term or long-term, in-country or abroad. Educational events include any activity that has specific learning objectives with knowledge, skills and

competencies to be gained by the individual participants. Reporting period: Calendar Year. Data source: Twubakane project records.

of USG-supported anti-corruption measures implemented: Anticorruption measures supported by USG. May include new laws, regulations, procedures, consultative mechanisms, oversight mechanisms, investigative/prosecutorial initiatives, public information initiatives, civil society initiatives, and other measures taken (in any sector) with the objective of increasing transparency about public decision making, conflict of interest, resource allocation, decreasing impunity for corrupt acts; increasing demand for reform or awareness of the problem; increasing knowledge about corruption and its costs; and reducing opportunities for corruption. Implementation requires that the measure be adopted, that organizational arrangements are put in place, financial and human resources allocated, & that observable steps are taken to initiate implementation and repeated, continued or/& expanded to demonstrate that implementation is continuing. Reporting period: Calendar Year. Data Source: RALGA.

of Government Officials Receiving USG-Supported Anti-corruption Training: # government officials in training or education events, whether short-term or long-term, in-country or abroad. Educational events include any activity that has specific learning objectives with knowledge, skills and competencies to be gained by the individual participants. Reporting period: Calendar Year. Data Source: RALGA.

of DIF grant supported activities that were implemented to improve the local government authorities, Administrative District, and Sector level capacity to provide services, with an emphasis on health services, to its population: This indicator will be disaggregated by district and by category of activity: District administrative level capacity building, Activities to support sustainability of *mutuelle* payments for indigents, Improvements to health and public hygiene infrastructure and health equipment supplies, Community mobilization and communication activities, and Health related training of local authorities. Reporting period: Calendar Year. Data Source: Twubakane Records.

HEALTH FACILITIES MANAGEMENT AND MUTUELLES

service Delivery Points (SDP) with USG Support: Sum of all the hospitals, health centers, Health Posts and secondary family planning posts receiving financial or technical support from Twubakane. Reporting period: Calendar Year. Data source: Twubakane project records and Twubakane RFA.

% health centers providing the minimum package of activities (MPA) in family health: # of health centers offering the 12 services included in the Minimum Package of Activities/ the # of health centers visited. This indicator is aggregated by health service including growth monitoring, family planning, post-abortion care, post-natal consultation, delivery, prenatal care, pre-marital counseling, vaccination, VCT, hygiene and sanitation, Epidemiological surveillance, and Clinical IMCI. Reporting period: Calendar Year. Data Source: RFA.

People covered with health financing arrangements: # of people covered by USG-supported health insurance (*mutuelles*) for all twelve Twubakane-supported districts. Reporting period: Calendar Year. Data Source: RFA.

% Population in the districts supported by Twubakane that are enrolled in *mutuelles*: # of people covered by USG-supported health insurance (*mutuelles*) for all twelve Twubakane-supported districts/the estimated population for all twelve Twubakane-supported districts. Reporting period: Calendar Year. Data Source: RFA.

COMMUNITY ENGAGEMENT AND OVERSIGHT

people trained in Strategic Information Management with USG funds: # people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in Strategic Information Management (including HMIS tools/management and Community HMIS).
Reporting period: Calendar Year. Data Source: Twubakane Records.

% health centers that have established a mechanism for communities to provide input on quality of services (PAQ): # health centers with an established PAQ team /Total # of health centers visited.
Established means that they have had a launching meeting and a management committee was formed.
Reporting period: Calendar Year. Data source: RFA.

% health centers with an active mechanism for communities to provide input on quality of services (PAQ): # health centers with a PAQ that met and discussed service delivery issues in the community during the previous 6 months/Total # of health centers visited. Reporting period: Calendar Year. Data source: RFA.

% of health centers with a PAQ that has influenced at least one change in the health center in the previous year: % of health centers with a PAQ that can demonstrate it has influenced at least one change at the health center in the previous year. Reporting period: Calendar Year. Data source: RFA.

% of health centers with a PAQ that has undertaken community mobilization activities in the previous year: % of health centers with a PAQ that have undertaken community mobilization activities in the previous year. Reporting period: Calendar Year. Data source: RFA.

Twubakane Decentralization and Health Program
IntraHealth International/Rwanda
Former BCDI Building (near CHUK)
B.P. 4585
Kigali, Rwanda
Office tel: 00-250-504-056
Office fax: 00-250-504-058