



# Twubakane

## Decentralization and Health Program

# Twubakane Third Year Annual Report

*...Let's Build Together*



# *“Abishyize hamwe nta kibananira”*

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## ACRONYMS

ACI	Anti-Corruption Initiative	M&E	Monitoring and Evaluation
AMTSL	Active Management of Third Stage of Labor	MIFOTRA	Ministry of Finance
ANC	Antenatal Care	MINALOC	Ministry of Local Administration
BCC	Behavior Change Communications	MINECOFIN	Ministry of Finance and Economic Planning
CBIS	Community-Based (Health) Information System	MINISANTE	Ministry of Health
CHW	Community Health Worker	MPA	Minimum Package of Activities
CNLS	<i>Commission Nationale de lutte contre le SIDA</i>	MTEF	Medium Term Expenditure Framework
CPA	Complementary Package of Activities	NGO	Nongovernmental Organization
CPI	Client Provider Interaction	NHA	National Health Accounts
CPR	Contraceptive Prevalence Rate	NSI	National Statistic Institute
CS	Child Survival	PAQ	<i>Partenariat pour l'Amélioration de la Qualité</i>
DDP	District Development Plan	PMI	President's Malaria Initiative
DHS	Demographic and Health Survey	PMP	Performance-Monitoring Plan
DIF	District Incentive Fund	PMTCT	Prevention of Mother-to-Child Transmission
DIP	Decentralization Implementation Program	PNBC	<i>Programme de Nutrition au Base Communautaire</i>
EONC	Emergency Obstetric and Neonatal Care	PNILP	<i>Programme National Intégré de Lutte Contre le Paludisme</i>
ESP	<i>Ecole de Santé Publique</i>	RALGA	Rwandese Association of Local Government Authorities
FBO	Faith-Based Organization	RDSF	Rwanda Decentralization Strategic Framework
FP	Family Planning	RFA	Rapid Facility Assessment
GBV	Gender-Based Violence	RH	Reproductive Health
GOR	Government of Rwanda	RTI	Research Triangle Institute
HBM	Home-Based Management	SBA	Skilled Birth Attendant
HC	Health Center	SDP	Service Delivery Point
HIV	Human Immunodeficiency Virus	SPH	School of Public Health
HMIS	Health Management Information System	SRA	Systems Research and Applications
HS2020	Health Systems 2020	SWOT	Strengths, Weaknesses, Opportunities, Threats
IEC	Information, Education and Communication	TA	Technical Assistance
IMCI	Integrated Management of Childhood Illness	TBA	Traditional Birth Attendant
IPT	Intermittent Presumptive Treatment	TRAC	Rwanda Treatment and Research AIDS Centre
IUD	Intrauterine Device	USAID	United States Agency for International Development
JADF	Joint Action Development Forum	USG	United States Government
LTM	Long-Term Methods	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)**

**RTI International**

**Tulane University**

**EngenderHealth**

**VNG**

**RALGA**

**Pro-Femmes Twese Hamwe**

**Government of Rwanda**

**Ministry of Local Government**

**Ministry of Health**

## INTRODUCTION

The Twubakane Decentralization and Health Program, funded by USAID and implemented by IntraHealth International, RTI International, and Tulane University's Payson Center and other partners, is a five-year program built on fostering strong decentralized local government that is responsive to local needs and promoting sustainable use of high-quality health services. The Twubakane Program's overall goal is 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. The Program is a partnership between the Government of the United States of America (USG), represented by USAID, and the Government of Rwanda (GOR), represented by the Ministry of Local Government and the Ministry of Health. Twubakane also works in partnership with the Rwandese Association of Local Government Authorities (RALGA), EngenderHealth, VNG (Netherlands International Cooperation Agency) and Pro-Femmes.

Launched in March 2005, the Twubakane Program has strived to learn from and apply lessons, responding to a rapidly changing environment to ensure sustainable results. Working in close partnership with the GOR at all levels, the Twubakane team has learned that fostering political engagement at all levels, especially decentralized levels, is key to ensuring the availability and use of high-quality services. Twubakane, with its unique approach to improving health by supporting decentralization, has demonstrated that high-level and district-level political commitment facilitates sustainable results. Among other factors, the program has noted that the district performance-based contracts (*imihigo*), signed by the district mayors and the president of Rwanda, have had a positive impact on health, contributing to both improved health resources and to visible district-level leadership in health. The program has continued to combine central-level policy and technical support with hands-on district capacity building to assist in a smooth transition to a highly functioning decentralized system.

The Rwandan Ministry of Health (MINISANTE) has adopted an integrated approach for all health services, to the extent possible, and at all levels of service. In its support to the GOR, Twubakane works closely with the MINISANTE and other government ministries (Ministry of Local Administration—MINALOC—and the Ministry of Finance and Economic Planning—MINECOFIN) and with districts, health facilities and providers. Our approach supports integration not only within health services, at facilities and in communities, but also across sectors. Twubakane's support for an integrated package of services is based on our belief that we are in Rwanda to support the GOR's national policies and programs and to help districts, sectors, health facilities and communities in implementing the national priorities. Over the past years, the GOR has made great progress in developing policies and programs that facilitate an integrated and comprehensive package of services. USAID has made resources available to support health system strengthening and not just discrete health issues.

During Twubakane's third year, the team focused on consolidating efforts made in years one and two and organized specific interventions to ensure sustainable impact. Much of years one and two was devoted to supporting capacity building and to strengthening infrastructure and systems at the central

### 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

and decentralized level. The third year was able to capitalize on this investment—through achievements such as improved functioning of the District Incentive Funds (DIFs) and more autonomous sector-supported community-provider partnership PAQ (*Partenariat pour l'Amelioration de la Qualité*) teams—while continuing to build capacity of health care providers, health facilities and district authorities.

The mid-point of the program allowed Twubakane to take stock of progress to date, through June 2007. On July 10, 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.

This year, Twubakane support to the GOR to reach the Millennium Development Goals is producing results as Twubakane-supported districts have seen progress towards greater use of family planning and improvements in maternal health and child survival. Such innovations as ensuring a full range of contraceptive methods, supporting secondary posts, rolling out high-quality obstetrics care, supporting home-based management of malaria, and contributing to high-quality services by supporting community-provider partnership teams have had a positive impact on the health of children, their mothers and communities.

Initial results of the interim Demographic and Health Survey show dramatic improvement in utilization of modern contraceptive methods; these results corroborate findings from Twubakane-supported districts. In these districts, couple years of protection for modern contraception doubled from fiscal year 2006 (48,883) to fiscal year 2007 (96,368). The percentage of deliveries managed by skilled providers also has increased. The number of children under five successfully treated for malaria in communities also has increased this year, as has the number of children participating in nutritional programs.

## PERFORMANCE REVIEW BY COMPONENT

In each component section, data is reported that pertains to the Twubakane Program Performance-Monitoring Plan (PMP). The reporting period for this annual report was October 2006 – September 2007, except when otherwise stated, so that results might be compared with previous years' results and with the 2007 targets. The results were obtained from all health centers (HCs) and district hospitals receiving Twubakane support unless otherwise stated. Data is provided from the Rwanda health management information system (HMIS), a rapid facility assessment (RFA) in HCs and hospitals, and district authorities as part of a strengths, weakness, opportunities and threats (SWOT) exercise. Some results (trainings and workshops) are reported from Twubakane program records.

### Component 1: Family Planning (FP) and Reproductive Health (RH) Access and Quality

**Repositioning FP:** The Twubakane Program continues to support repositioning of FP in Rwanda. Efforts at the district, sector and community levels have included orientation of authorities and local leaders on population and health issues in FP, support for mobilization activities through 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.

The Twubakane team participated in the National Workshop on Reproductive Health organized by the Rwanda Parliamentarians Network for Population and Development. One of the workshop's recommendations was legislation to encourage Rwandans to limit family size to three children. A renewed interest in promoting FP has been demonstrated at all government levels, and the Twubakane Program and other members of the FP technical working group continue to support the concept of a national campaign highlighted by public statements from the president of Rwanda.

Twubakane also successfully solicited additional FP funding from the Hewlett Foundation, which will build on high-level government commitment to population and FP. Activities will be launched in early 2008.

Twubakane's participation in the FP technical working group continued, with Twubakane leading in the preparation of a joint national training of trainers based on revised training modules and procurement of revised information, education and communication/behavior change communications (IEC/BCC) materials. Twubakane financed the distribution of 800 flipcharts (in Kinyarwanda), two per HC, for counseling and other health education activities.

**Increasing Access to, Use and Quality of FP:** In 2007, the Twubakane Program continued to support a decentralized approach to the rollout of national-level FP training. With the Capacity Project and the United Nations Population Fund, Twubakane supported performance-based training of two trainers for each of Rwanda's 30 districts; the trained trainers ensure ongoing training in their districts, and district-

#### **Radio Show Increases FP Awareness**

Twubakane RH team participated in a radio show, broadcast in the Southern Province (Radio Salus), on population growth in Rwanda and the impact on the economy. FP was presented as one response to the population growth, and the benefits to the family and the influence on maternal and child health were discussed. Reasons for not using FP—myths, rumors and religious beliefs—were also discussed. Twubakane has participated with CHAMP and PSI on Radio Contact FM to discuss adolescent health (FP and HIV). These radio shows increase awareness about and encourage use of FP services.

Attaining proficiency in skills has been hampered by a continual shortage of Jadelle implants, a very popular FP method in Rwanda. Twubakane and other FP partners continue to work closely with the DELIVER Project to ameliorate the supply issues of Jadelle. At the end of 2007, all public HCs in 10 of 12 Twubakane districts were able to and were offering the full range of FP methods, including LTM. (HC staff from the remaining two districts were trained in January 2008.)

#### **World Health Day**

In April, in celebration of World Health Day (the theme was promoting FP), Twubakane supported the Rwandan Center for Communication to host an event, during which prizes were given to districts having the highest rates of couple years of protection in the first quarter of 2007. Two of the 12 Twubakane-supported districts were rewarded for their high rates of FP use: Nyarugenge and Ngoma. Other event activities included displays highlighting successes with FP; Twubakane's display shared tools and mannequins used in performance-based trainings.

level training has already begun to build capacity of providers at each HC (public or private) to offer FP methods.

As part of the FP training, Twubakane supported continued training and post-training follow-up in long-term methods (LTMs) to ensure that all HCs are able to offer a full range of short- **and** LTMs (IUDs and implants). While training in LTMs began in late 2006, many HCs requested refresher training and supportive supervision during 2007 due to attrition of providers or a desire for enhancement of knowledge and skills.

Working with the Capacity Project, Twubakane is moving toward an on-the-job training approach. Capacity has initiated this approach in 11 districts, and Twubakane will as well by mid-2008. Twubakane continues to transfer responsibility to district staff for supportive supervision of FP services. Twubakane staff conducts visits monthly to selected sites together with district health supervisors, thereby mentoring them in the methodology of supportive supervision and helping to increase quality of services.

Data collected for the PMP supports observations and reports of increased FP utilization. From data collected in the 2005 and 2007 RFA, it appears that the increase in number of HCs offering long-term contraceptive methods (implants, IUDs) was likely a key factor in the tripling of couple years of protection (see Table 1). Unfortunately, the number of facilities experiencing stockouts was higher than expected; this was mostly due to unanticipated high demand for Jadelle implants, and inadequate forecasting for this method.

**Popularity of Jadelle Implants**  
 Twubakane worked closely with the MINISANTE and other partners to spearhead the re-introduction of LTMs, including implants, into the package of services offered at HCs starting in 2005. As noted in past reports, the demand and uptake for Jadelle implants exceeded all expectations. As trainings in these LTMs rolled out, long lines of women formed at HCs during the trainings. From July through December 2007, a total of 3,645 women received Jadelle implants in Twubakane-supported districts, with Muhanga District leading with 962 women receiving this popular method during this six-month period. Political support of implants was evident at all levels, from the mayors supporting them to the minister of health declaring that the expansion in the use of implants would have a measurable impact on maternal and child health.

**Table 1: Family Planning Indicators**

Indicator	Results 2005~	Results 2006~	Results 2007~	Target 2007	Data Source
Couple years of protection offered by public facilities*	31,277	48,883	96,368	53,600	DELIVER
# people who have seen or heard a specific USG-supported FP message	n/a	n/a	541,387	349,862	HMIS
# service delivery points (SDPs) reporting stock-outs of any contraceptive commodity	n/a	n/a	20	9	DELIVER
# people trained in FP/RH	63	1,538	2,116	1,200	Twubakane records
Female	n/a	n/a	1,106	600	
Male	n/a	n/a	1,010	600	

	All 110 HCs		Random Sample 60 HCs+		
% HCs providing modern contraceptive methods	72%		72%		RFA
IUD	1%	n/a	20%	n/a	RFA
Implants <sup>^</sup>	Norplant 7%		Jadelle 67%		RFA
Injectables	70%		72%		RFA
Oral contraceptives	70%		72%		RFA
Male condoms	70%		72%		RFA
Female condoms	10%		23%		RFA
Fixed day method	8%		68%		RFA

~ In 2005, Twubakane supported 110 HCs and 12 district hospitals; in 2006, 127 HCs and 12 district hospitals; and in 2007, 131 HCs and 12 district hospitals. For explanations of which facilities provided data for indicators, see definitions in Annex Four.

\* Protection offered by contraceptive methods.

<sup>^</sup> The main implants used in HCs have changed from Norplant to Jadelle.

+These data on contraceptive methods offered were obtained from the RFA conducted in 2005 in all HCs supported by Twubakane, and in 2007 in a stratified random sample of 60 of those HCs.

**Secondary Posts:** Twubakane continued to roll out its inventive approach of working with districts and sectors to establish secondary FP posts for clients of Catholic-based facilities, where modern methods of contraception are not offered. (In the sample of 60 HCs in Table 1 above, 17 Catholic facilities are not offering modern contraceptive methods and of those 17, eight had a secondary post in 2007.) These locations are staffed with a FP provider and the frequency of service provision ranges from once per week to daily, with some services integrated to include vaccinations and/or antenatal care/prevention of mother-to-child transmission (ANC/PMTCT) of HIV. Since many providers working at the secondary post are “loaned” from larger HCs (public and faith-based), they can refer and counter-refer clients needing additional services from a HC, such as PMTCT. Twubakane has supported these posts with provision of equipment and supplies as well as training the providers.

Demand creation for use of secondary posts is addressed through different strategies including advocacy with local authorities to encourage use of sites, involvement of community health workers (CHWs, or *agents de santé communautaire* in French) to accompany clients, and outreach to males to accompany their wives/partners to secondary posts. At each secondary post, women receive services whether or not accompanied by their partner/spouse. This is an important aspect of service delivery and, although GOR policy dictates that it should be the case for all health facilities, some facilities insist on the spouse’s approval and/or presence.



*Clients listen to an explanation on the different FP methods available.*

**Table 2: Secondary Posts Functioning in December 2007, Listed by District**

District	FP Secondary Post
Nyaruguru	Ruheru
	Muganza
	Kibeho
	Ruramba
Nyamagabe	Mbuga
	Cyanika
	Rugege
Ruhango	Kirwa
Kicukiro	Masaka
	Kicukiro
	Gikondo
	Rusheshe
Rwamagana	Munyaga

Twubakane also worked with the MINISANTE to ensure that data from secondary posts is captured in the national HMIS; the program will begin to collect data from these secondary posts in the coming year. Twubakane continues 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.

**HIV – FP/RH Integration:** This year, Twubakane also participated actively in various HIV and FP integration discussions and activities. Twubakane, with the Capacity Project, provided two FP updates workshops to all USAID HIV cooperating agencies. Twubakane also assisted with training the technical staff from each of the USG HIV cooperating agencies on FP to allow them to support service integration in their sites. In addition, the FP training modules updated by Twubakane and Capacity Project have a chapter on integration of the two services. At HCs, Twubakane has supported facilities with integration of pre-nuptial counseling in FP with voluntary counseling and testing (VCT). At secondary posts, Twubakane has ensured that FP providers offer FP services to HIV-positive couples and that they receive appropriate referrals for ongoing HIV care at HCs.

**Improving Access to Safe Motherhood Services:** In 2007, Twubakane continued to participate actively in and help organize the safe motherhood technical working group. In collaboration with the National Malaria Control Program, the Maternal and Child Health Task Force, TRAC Plus, the USAID-funded ACCESS Project, UNICEF and other partners, the Twubakane Program supported the revision of focused ANC protocols and training modules. These modules were pre-tested during 2007 and are being validated by MINISANTE in early 2008. Twubakane also has collaborated with the ACCESS Project in emergency obstetric and neonatal care (EONC) trainings and supervisions and in introducing Kangaroo Care, a resourceful approach to case management and care of underweight and premature neonates.

Other support to improve obstetrical and neonatal care has included improvements in overall infection prevention, procurement of basic equipment, improving supply chain of oxytocin for prevention of post-partum hemorrhages, and rehabilitation of some health facilities to allow for better flow of services and improved confidentiality for clients (funded through the DIF grants).

As illustrated below in Table 3, facilities supported by Twubakane exceeded the PMP targets for RH indicators pertaining to the birthing process. Twubakane also exceeded its training target by a considerable margin.

An additional indicator of quality RH services which Twubakane had intended to report on in this annual report was the percent of women delivering at facilities who receive Active Management of Third Stage Labor (AMTSL). However, as this data is not currently being collected in the HMIS, it has not been possible to include this year. It is anticipated that next year this data will be available in the delivery registers at HCs.

**Table 3: Reproductive Health Indicators**

Indicator	Results 2005~	Results 2006~	Results 2007~	Target 2007	Data Source
# ANC visits by skilled providers	n/a	n/a	172,161	101,438	HMIS
# deliveries with skilled birth attendants (SBAs)	n/a	n/a	70,124	63,399	HMIS
# postpartum/newborn visits within three days of birth^	n/a	n/a	70,124	50,212	HMIS
# SDPs with USG support	139	143	164	163	Twubakane records
# people trained in maternal/newborn health	546	127	1,983	1,200	Twubakane records
Female	n/a	n/a	1,008	600	
Male	n/a	n/a	975	600	

~ In 2005, Twubakane supported 110 HCs and 12 district hospitals; in 2006, 127 HCs and 12 district hospitals; and in 2007, 131 HCs and 12 district hospitals. For explanation s of which facilities provided data for indicators, see definitions in Annex Four.

^Due to difficulty in obtaining data on this indicator, we have only included data on the # of SBA deliveries (per the definition in the “Investing in People” guidelines). There is currently no formal postpartum visit protocol or data recording if women do come to a HC within three days of delivery.

Measuring progress on this intervention was a new indicator added in 2007 (Table 4): the availability of emergency obstetric and neonatal care (EONC). The goal in Rwanda is for all HCs with a maternity unit to offer essential EONC care (six interventions to address complications during deliveries) and for district hospitals to offer comprehensive EONC (the six interventions plus cesarean sections and blood transfusions). Twubakane has been focusing on assisting MINISANTE reach this goal through training, supporting and equipping hospitals, and now HCs, to be able to provide EONC.

All 12 districts in which the Twubakane Program works now have trained and validated hospital training teams in EONC. In three districts (Rwamagana, Ruhango, Kamonyi), trained hospital providers have trained HC maternity ward staff in basic EONC, including management of obstetric emergencies (e.g., shock, eclampsia), AMTSL, immediate post-partum and neonatal care. However, as Table 4 shows, many of the HCs sampled are not offering EONC services; bringing this service to the HC level will be a focus for Twubakane during 2008. The Twubakane Program also has organized advocacy activities throughout the 12 districts, encouraging local authorities to get involved in promoting facility-based deliveries. In addition, the influence of performance-based financing contracts with HCs has health facilities providing

higher-quality delivery services and encouraging traditional birth attendants (TBAs) to accompany women to HCs for deliveries. As the skill level is increasing at the maternities, more women are coming to facilities to deliver their babies.

**Table 4: Emergency Obstetric and Neonatal Care**

Indicator	Results 2007 <i>Random sample of 60 HCs</i>	Data Source
% of HCs that offer essential EONC <sup>^</sup>	10%	RFA
Parenteral antibiotics	28%	
Parenteral oxytocic drugs	27%	
Parenteral anticonvulsants	30%	
Manual removal of placenta	33%	
Manual removal of retained products	22%	
Assisted vaginal delivery	25%	
	<b><i>All 12 district hospitals</i></b>	
% of hospitals that offer comprehensive EONC <sup>+</sup>	83%	RFA
Parenteral antibiotics	100%	
Parenteral oxytocic drugs	100%	
Parenteral anticonvulsants	92%	
Manual removal of placenta	100%	
Manual removal of retained products	92%	
Assisted vaginal delivery	100%	
Surgery (e.g. cesarean section)	100%	
Blood transfusion	100%	

<sup>^</sup> Essential EONC is defined as the availability of six interventions to address complications that arise during deliveries.

<sup>+</sup> Comprehensive EONC is defined as the availability of eight interventions: the six essential interventions plus cesarean sections and blood transfusions.

**Gender-Based Violence Prevention and Response:** This year, the Twubakane Program’s initiative to improve prevention and management of gender-based violence (GBV) in the context of ANC/PMTCT services was launched with a readiness assessment of service providers, facilities, the community and the overall policy environment to respond to GBV. Five service sites in Nyarugenge, Kicukiro and Gasabo districts in Kigali were assessed. A full report will be available by June 2008. After assessment dissemination, Twubakane will initiate the response phase, including development of a GBV/PMTCT training curriculum, policies and clinic protocols for identification and management of GBV, and referral and educational materials.

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

This year, the Twubakane Program focused on integration of pediatric care at the facility and community levels by supporting rollout of clinical and community integrated management of childhood illness (IMCI), including malaria and malnutrition. Twubakane also provided extensive technical and financial

support to the MINISANTE to supervise nutrition activities at the health-center and community level in pilot districts of Kirehe and Kayonza.

**Malaria – Improving Prevention and Treatment (President’s Malaria Initiative):** At a central level, Twubakane continued to assist the US President’s Malaria Initiative (PMI) by supporting the National Integrated Malaria Control Program (or PNILP in French) with implementation of PMI activities and participation in numerous meetings with PMI partners. These meetings served to devise work plans, agree upon intervention areas and discuss constraints to implementation.

During 2007, Twubakane continued to expand the number of communities implementing home-based management of fever (HBM) as well as update 2006 communities on use of the new drug, Coartem. This involved revising training materials and training communities and providers on Coartem use and assisting HBM partners with packaging issues. HBM management tools were also revised. Twubakane is now supporting implementation of HBM in five districts: Gasabo, Kicukiro, Nyarugenge, Bugesera<sup>1</sup> and Nyagatare through the PNILP. At the close of 2007, Twubakane had trained 1,469 CHWs in HBM in these five districts. HBM components include educating local authorities, training CHW trainers and CHWs, supervision of services and collaboration with HCs to accept HBM referrals as well as provide treatment with Coartem when needed. Supervision and overall data quality have been challenges during the expansion and introduction of a new drug. Twubakane has helped PNILP clarify expectations for supervision visits and submission of monthly reports. Since this clarification was made in the first quarter, timeliness and quality of reports and visits has improved. At the health facility level, Twubakane has trained 57 providers at hospitals in Kayonza District in the use of Coartem. (Twubakane has trained providers at other HCs in use of Coartem as part of Twubakane support for IMCI in Rwanda.)

The training includes the treatment and prevention of malaria in pregnancy and the overall management of anti-malaria drugs and supervision. In late 2007, Twubakane supported the ACCESS Project in the national Malaria in Pregnancy/Focused Antenatal Care training of trainers.

**Integrated Management of Childhood Illness:** Twubakane supported continued rollout of IMCI at the HC level and assisted with introduction of community IMCI in selected districts. For clinical IMCI, trainers, providers and supervisors have been trained throughout 2007 in seven Twubakane partner districts (Gasabo, Ngoma, Rwamagana, Nyaruguru, Nyamagabe, Kirehe and Ruhango); in Gasabo, training was conducted in partnership with the Elizabeth Glaser Pediatric AIDS Foundation. As supervision visits were conducted in these districts, results revealed that 90% of HC providers have started activities but need more intensive supervision to support continued IMCI service delivery. For community IMCI, two districts—Kirehe and Ruhango—were selected, in part due to their success with HBM and clinical IMCI at facilities. Twubakane has supported MINISANTE with adaptation of training materials for CHWs, the providers of IMCI at the community level.

On the national level, Twubakane supported the Maternal and Child Health (MCH) Task Force’s IMCI technical working group in collaboration with BASICS, WHO, the USAID-funded Child Survival Expanded Impact Project and UNICEF. This is the group (led by BASICS) that revised materials for community-level IMCI, including training modules, case management tools and IEC materials.

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<sup>1</sup> This is a district in which Twubakane, through PMI funding, was requested to support HBM. No other Twubakane activities are conducted in this district.

**Nutrition:** In 2007, Twubakane conducted training in Community-Based Nutrition Programming for 147 health care providers and 434 CHWs in the districts of Kayonza, Kirehe, Ngoma, Rwamagana, Gasabo and Ruhango. Associated HCs have reported increases in the number of children under five undergoing growth monitoring and malnutrition screening, and the staffs of these centers have demonstrated improved competency in nutrition programming, as documented during supervision visits. In addition, Twubakane continues to mobilize communities to take direct action against malnutrition. In 144 communities, Twubakane staff led nutrition workshops for local leaders and then collaborated with these influential decision makers as they worked with their neighbors in analyzing and developing solutions for nutrition problems. Through its 12 districts, Twubakane actively promotes discussion of malnutrition and helps communities find appropriate local solutions through PAQ teams organized at the sector level.

Twubakane has been an active participant and technical adviser on the development of Rwanda's National Community Nutrition Strategy. In 2007, Twubakane was a key MINISANTE partner in the development of Rwanda's Community-Based Nutrition training program. Twubakane provided technical and financial support to two national campaigns to provide vitamin A supplements and de-worming treatments, and the campaign achieved 99% coverage for vitamin A supplements and 105%<sup>2</sup> coverage for de-worming treatments in the Twubakane intervention zone.

PMP results for child health, malaria and nutrition are presented in the following table. As most of the indicators in Component Two were new to Twubakane in 2007, baseline data were not available. It is notable that Twubakane exceeded its training targets in Component Two by considerable margins. Further, the HCs supported by the program exceeded the target for children <12 months receiving DPT3 immunizations by 37% (see Table 5 on the following page).

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<sup>2</sup> A result greater than 100% is due to an underestimation of the number of children under five and mothers bringing children older than five for de-worming treatment. Supplies are sufficient to allow this practice.

**Table 5: Child Health Indicators**

Indicator	Results 2005~	Results 2006~	Results 2007~	Targets 2007	Data Source
<b>CHILD SURVIVAL</b>					
# diarrhea cases treated	n/a	n/a	39,869	44,280	HMIS
# children <12 months who received DPT3 immunizations	105,401	107,176	113,126	70,916	HMIS
# people trained in child health and nutrition	n/a	285	1,537	800	Twubakane records
Female	n/a	n/a	695	400	
Male	n/a	n/a	843	400	
<b>NUTRITION</b>					
# children <5 who received vitamin A <sup>+</sup>	n/a	n/a	526,134	472,774	UNICEF, HMIS
# children reached by nutrition programs*	n/a	n/a	606,253	60,000 <sup>^</sup>	HMIS
<b>MALARIA</b>					
# people trained in treatment or prevention of malaria	n/a	1,167	3,415	2,000	Twubakane records
Female	n/a	n/a	1,561	1,000	
Male	n/a	n/a	1,854	1,000	

~In 2005, Twubakane supported 110 HCs and 12 district hospitals; in 2006, 127 HCs and 12 district hospitals; and in 2007, 131 HCs and 12 district hospitals. For explanation s of which facilities provided data for indicators, see definitions in Annex Four.

<sup>+</sup> Includes doses of vitamin A given in growth monitoring and during the biannual mass campaign. There is likely to be double counting of children who received vitamin A more than once.

\* The method of calculating the # of children reached by nutrition programs in this report differs from the method used in the quarterly reports in order to avoid multiple counting of the same individuals (see Annex Four for details).

<sup>^</sup> The disparity between the target and the result for # of children reached by nutrition programs is attributable to the fact that the target was initially set with a much more limited scope. For the current definition of this indicator, see Annex Four.

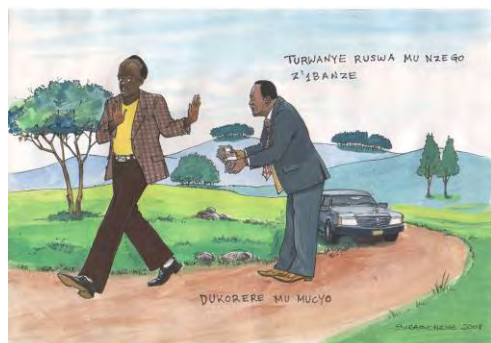
### Component 3: Decentralization Planning, Policy, and Management

**MINALOC and MIFOTRA:** In 2007, Twubakane continued to work in partnership with the MINALOC, providing technical assistance to finalize the Rwanda Decentralization Strategic Framework (RDSF), the Decentralization Implementation Program (DIP), and the Economic Development and Poverty Reduction Strategy. 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. Some districts elected to use their DIF for completion of their five-year District Development Plans (DDPs), especially concerning health-related issues. A second important focus of Twubakane support at the ministry level was collaboration with MINALOC and other partners on district capacity building needs assessment, which will inform district capacity building plans and become part of the DDPs.

**Support to Rwandese Association of Local Government Authorities (RALGA):** Strengthening its member organizations—local governments—is RALGA’s mandate. Twubakane has supported RALGA’s efforts to help district executive secretaries understand their roles and responsibilities and to identify best practices through a competition among districts (Gasabo won first place; Ngoma second place). This year, Twubakane, with partner VNG’s support, conducted an organizational review of RALGA, assessing

its advocacy work and the anti-corruption activities (see winning poster and information). In addition, Twubakane helped RALGA develop a self-evaluation capacity tool which was applied through the SWOT analyses.

*"We recognize that corruption exists in Rwanda in different forms. We thank all the partners that assist in this arena, including Twubakane." --Minister of Local Government Portais Musoni, during award ceremony for the anti-corruption posters*



A new anti-corruption initiative (ACI) with RALGA was launched in January 2007. RALGA received a \$140,000 grant to implement the initiative, which included weekly radio programs, development of training materials, training of local officials and a national poster campaign. At the end of 2007, Twubakane provided assistance to develop a strategy for extending the ACI and communications activities through RALGA. [Winning poster is pictured to the left.]

**Costing Study:** Together with the National University of Rwanda's School of Public Health (SPH), and in collaboration with MINISANTE, Twubakane staff and consultants conducted a national health costing study. Twubakane staff and consultants assisted with financing activities, adapting the costing tool, supporting the data collection and conducting the analysis. The costing analysis provides key health financing information, including unit costs, human resources costs and the effect of staff movements. This study will provide the "fully loaded economic costs" by intervention, service and department. The study, completed at the end of 2007, will be disseminated in 2008. Based on study results, Twubakane is supporting the development and use of a costing tool for six districts in 2008.

**National Health Accounts (NHA):** Twubakane worked closely with the USAID project Health Systems 2020 to support the 2006 exercise. In-depth analyses were conducted on *mutuelles*, employer insurances, donors, nongovernmental organizations (NGOs), HCs and hospitals as well as specific sub-analyses of malaria, FP/RH and HIV/AIDS. A major challenge for both projects is institutionalization of the process and ensuring long-term commitment from MINISANTE by dedicating ministry staff to be responsible for the process. To encourage ownership by MINISANTE, Twubakane has helped to create an NHA steering committee that met throughout the data collection and analysis periods, regularly involved staff and students from the SPH, involved MINISANTE staff at every step of the process, including having the sub-accounts head desk officers present during the dissemination, created an archive of all historical data and is encouraging MINISTANTE to set up and maintain a health finance database. In addition, Twubakane regularly updated health cluster members and development partners on the status of the NHA, thus all are informed, know what to expect from the process and know how to use the information.

The results for the program PMP pertaining to these two activities are listed in Table 6. They illustrate the progress that has been made to date in developing and implementing the costing tool and NHAs.

**Table 6: Process Results in Decentralization, Policy Planning and Management**

Process Results	Results 2007	Targets 2007
<b>Development and Dissemination of a Costing Tool of Minimum and Complementary Activity Packages by MINISANTE</b>		
Develop costing tool for the national level (survey of costs) for the minimum package of activities (MPA) and complementary package of activities (CPA)	Completed in 2007	Completed
Implement costing tool May-July 07 by conducting survey of costs	Completed in 2007	Completed
Technical team analyzes survey results and disseminates them to MINISANTE and its partners (NGOs, multilaterals, bilaterals etc.).	Completed in 2007	Completed
MINISANTE uses survey results to set costs of products and services.		Rescheduled for 2008
MINISANTE adjusts tariffs for clients on the basis of those costs, as needed.		Rescheduled for 2008
Field test a health services costing tool in up to six districts		Rescheduled for 2008
If new tariffs are established, MINISANTE will require hospitals and HCs to apply them.		Rescheduled for 2008
New tariffs are implemented by MINISANTE, private sector, health insurers ( <i>mutuelles</i> and private insurance companies) and others.		Rescheduled for 2008
<b>Timely Production, Completion and Dissemination of National Health Accounts</b>		
Steering committee is created and a memorandum of understanding is signed by stakeholders.	Completed in 2007	Completed
Technical team is trained to conduct the NHA process.	Completed in 2007	Completed
Technical team developed the NHA survey design and tools (with pre-testing).	Completed in 2007	Completed
The data collectors are trained to conduct the survey.	Completed in 2007	Completed
The survey is conducted.	Completed in 2007	Completed
The survey results are analyzed and written up in an NHA report.	Completed in 2007	Completed
Survey results are disseminated in various ways to stakeholders with recommendations for how to institutionalize the NHA.	Drafts disseminated	Completed
Recommendations on how to use NHA (e.g. for planning, for advocacy etc.) are implemented.	On-going	Rescheduled for 2008
<b>National Health Accounts (NHA) Courses Started in Rwandan Training Institutions</b>		
Identify appropriate training institutions: e.g. School of Public Health, and School of Finance and Banking	Completed in 2007	Completed
Introduce curriculum on NHA and adapt to Rwandan context and requirements		Rescheduled for 2008

Process Results	Results 2007	Targets 2007
Train trainers in NHA methodology		Rescheduled for 2008
NHA courses being offered		Rescheduled for 2008

**Support to Pro-Femmes Twese Hamwe:** The Twubakane Program’s collaboration with Pro-Femmes this year focused on strengthening the capacity of Pro-Femmes’ member organizations to work efficiently in the context of decentralization. Through Twubakane’s grant to Pro-Femmes, member organizations received support in conceptualizing health-related projects that they could propose to districts or other development partners. Member organizations also received support to outreach and mobilization activities related to FP and safe motherhood. The overall goal of this year’s grant was not only to strengthen Pro-Femmes’ members but also to collaborate with these organizations to achieve results in FP and RH. In 2008, Twubakane will work to strengthen the partnership with Pro-Femmes by involving the network more directly in the program’s strategic interventions related to responses to GBV and RH.

### Component 4: District-Level Capacity Building

This year, Twubakane continued to support participatory district capacity building at the national level, in collaboration with RALGA. In the 12 Twubakane-supported districts, capacity building included district SWOT analyses, good governance and leadership workshops, and support for Joint Action Development Forums (JADFs) and for district resource mobilization (fiscal census, market privatization). Twubakane also worked to engage mayors and other local health authorities. Feedback from Twubakane-supported districts showed they appreciate the program’s combined technical and financial support.

This year, 2007, Twubakane technical staff and field coordinators have noted an improved capacity of the district, sector and health facility staff and officials to lead and direct their own budget and planning exercises. While they depend less on Twubakane assistance, they appreciate the constant and regular presence of Twubakane staff in the districts; district officials know that they can count on our coaching, mentoring relationship and on-the-job advice.

**District Incentive Funds (DIF):** One of Twubakane’s main capacity building tools used to budget and plan is the DIF. In 2007, each district received \$150,000 for activities selected by the district for implementation during the year. All activities were ones included in the DDPs and annual action plans required by the GOR. Over the course of the year, Twubakane has witnessed progress in districts’ ability to plan, budget and manage these grants. Districts now include discussion of DIF status during weekly district meetings, consult with ministries regarding activity implementation, are beginning the tender process for procurement in advance of receiving funds, and executive secretaries regularly monitor sector-level activities. While this is marked improvement from the first year, Twubakane recognizes the challenges



*Before and After: The top photo shows the washing hall; the bottom photo shows the washing machine—bought with DIFs—now used instead.*



districts face in implementing the grants totaling \$150,000, documenting cost-share and preparing for subsequent granting cycles. Twubakane solutions to challenges included those listed in the following table. For examples of DIF results by district, see Annex One.

Challenge	Solution
Continued tendency to centralize decision making at the district level instead of working at the sector level	Twubakane requires proof that representatives of sectors are involved in DIF planning process.
Unrealistic and ambitious plans for activities to be completed in a 12-month time frame	Twubakane field coordinators work with district teams to ensure more realistic planning.
Overburdened district accountants	Twubakane accountants provide hands-on support and on-the-job training to district accountants.
Key health officials not always consulted in process of determining priorities for DIF grants	Twubakane requires proof that representatives of district hospital and HCs are involved in DIF planning process.
Delays in starting tender process for purchasing	Twubakane encouraged districts to launch tender process earlier and often in advance of receiving funds.

**Joint Action Development Forums:** The District JADF is a mechanism through which the district government administration and its stakeholders meet to discuss and coordinate development planning, budgeting, monitoring and evaluation. Twubakane staff helped districts organize initial JADF meetings, and in some districts Twubakane staff members have been elected as officials of the JADF committees. JADFs have served as important committees in the finalizing of the five-year DDPs as they have helped with the validation of the vision, mission and priority setting of the districts. The JADFs are becoming more functional and sustainable as both districts and development partners perceive the benefits of supporting and participating in the forum.

**Good Governance Workshops:** In addition to collaborating with RALGA to implement the national ACI, Twubakane continued to collaborate with the 12 program districts to organize decentralized trainings on good governance and leadership. An additional five districts (Kayonza, Nyamagabe, Nyaruguru, Ngoma and Kirehe) organized these participatory trainings in 2007, which address management issues facing districts (e.g., instability of staff, clarity in roles and responsibilities, sound financial management, conflict resolution) using a methodology adapted from Steven Covey's *7 Habits of Highly Effective People*. The workshops aim to help districts with management issues and become more proactive instead of reactive to the myriad of activities being implemented in each district.

*"I have never seen any other organization which gives such financial and technical support. Twubakane has a permanent staff in the district, we work with them day to day and discuss our priorities; I ask you to clap your hands for Twubakane,"* said the mayor of Ngoma District addressing the Minister Musoni and participants during the governance workshop's closing ceremony.

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 and a year later in December 2007 (see methodology section of Annex Four for a description of how they were conducted).

**Table 7: Progress in District-Level Planning, Budgeting and Managing, All Twubakane Districts**

Indicator	Results 2006	Results 2007		Targets 2007	Data Source
<b>PUBLIC REPORTING</b>					
% districts that have mechanisms in place for public reporting on health sector activities <sup>†</sup>	58%	67%		70%	SWOT
% districts that have mechanisms in place for public reporting on their financial performance <sup>†</sup>	8%	36%		20%	SWOT
<b>FINANCIAL PLANS AND BUDGETS</b>					
% districts with annual plans and a Medium Term Expenditure Framework (MTEF) that includes a full range of health activities	100%	100%		100%	SWOT
% districts that have plans and budgets documented to reflect citizen input	92%	100%		100%	SWOT

<sup>†</sup>Districts must have both an oral and written mechanism to be counted in these public reporting results.

Table 7 illustrates the notable increase in the percent of districts with at least one oral and one written mechanism for reporting on their financial performance. For the other indicators of progress in district-level planning, budgeting and managing, the targets were realized or came very close.

To share information on financial performance, at baseline most of the districts also used oral mechanisms, mainly public meetings of health committees, district councils, CHWs, opinion leaders and PAQ team (58%). Information boards were also used by a small proportion of districts (13%). Other mechanisms used by small proportions of the districts included: performance contracts presentations (*Imihigo*); cultural and religious exhibitions and events; open door events which bring together all district stakeholder to discuss the district's main achievements and challenges; national population mobilization programs such as community works (*umuganda*), village tribunals (*Gacaca*), community conviviality programs (*Ubusabane*) and others (including *Ubudehe*, *Itorero*). In the 2007 SWOT—in all 12 districts that Twubakane supports—the district public sector staff and health officials interviewed demonstrated that they understood the district's roles and responsibilities concerning the budgeting and planning process for health sector activities. Their annual plans and three-year plans (MTEFs) included the full range of health activities, including prevention, treatment, promotion, infrastructure, equipment and staffing.

To strengthen districts' financial management and planning practices, including the integrity of those practices, Twubakane supported capacity building of district entities as well as individual public sector officials. In the past year Twubakane conducted or contributed to the training in management and fiscal management of almost three times as many people as targeted (Table 8).

**Table 8: Public Sector Capacity Building, All Twubakane Districts**

Indicator	Results 2006	Results 2007		Target 2007	Data source
<b>USG ASSISTANCE FOR CAPACITY BUILDING IN PUBLIC SECTOR</b>					
# sub-national government entities receiving USG assistance to improve their performance	12	12		12	Twubakane
# sub-national governments receiving USG assistance to increase their annual own-source revenues	12	12		12	Twubakane
# individuals who received USG-assisted training, including management skills and fiscal management, to strengthen local government and/or decentralization	2,114	4,450		1,500	Twubakane
Female		1,018		525	
Male		3,432		975	
<b>ANTI-CORRUPTION</b>					
# USG-supported anti-corruption measures implemented	n/a	2		4	RALGA
# of government officials receiving USG-supported anti-corruption training	n/a	216		800	RALGA
Female		52		400	
Male		164		400	

## Component 5: Health Facilities Management and *Mutuelles*

**Revision of Health Care Norms and Standards:** A significant undertaking of the MINISANTE is the revision to the MPA/CPAs for health facilities and the health care norms, standards and protocols. MINISANTE has selected a wide range of services needing revision (12 categories). Twubakane has provided international technical assistance at several points during 2007 and has collaborated with many local partners to ensure consensus on the documents' content. This activity has been faced with challenges throughout the year, particularly concerning follow-up from the MINISANTE in finalizing the process and ensuring buy-in of stakeholders, which has not been consistent. At the end of 2007, MINISANTE had a complete draft of norms and standards and intended to circulate it to elicit technical feedback from a wide range of stakeholders. Once this feedback is received, Twubakane will support MINISANTE to further revise the documents, field-test them and finalize and disseminate them nationally.

One of the PMP indicators for Twubakane is the number of HCs providing services included in the MPA for Family Health. The revision of the norms, standards and protocols will influence these results over time as the updated documents are disseminated and Twubakane, along with other projects and donors, support their implementation. Table 9 presents data on the percentage of HCs providing the services in Rwanda's MPA. This year, four additional health services have been added to the initial list: VCT, clinical IMCI, epidemiological surveillance, and hygiene.

**Table 9: Health Centers Providing Services in Minimum Package of Activities for Family Health**

Services	2005 Results <i>All 110 HCs</i>	2007 Results <i>Random Sample of 60 HCs</i>	Target 2007	Data Source
% HCs providing MPA according to <u>previous</u> year's definition	3%	8%	15%	RFA
% HCs providing MPA according to <u>current</u> year's definition	n/a	7%	n/a	RFA
Prenuptial consultations	9%	18%		RFA
Prenatal consultations	93%	93%		RFA
Infant delivery	83%	93%		RFA
Post-natal consultations	45%	75%		RFA
Post-abortion care	60%	77%		RFA
FP	72%	72%		RFA
Vaccinations	91%	100%		RFA
Growth monitoring	81%	98%		RFA
VCT	n/a	85%		RFA
Clinical IMCI	n/a	63%		RFA
Epidemiological surveillance	n/a	88%		RFA
Hygiene	n/a	82%		RFA

Table 9 illustrates that there has been almost a tripling in the percent of HCs offering the MPA according to last year's definition (the basic eight services). However, it is far short of the target, primarily due to the dearth of HCs offering pre-nuptial consultations. If that particular service was not considered, most HCs would offer the full package of activities under both the previous definition and the current expanded definition of the MPA.

**Health Care Financing—*Mutuelles*:** Implementation of *mutuelles* on a national level is managed by the MINISANTE's *Mutuelles* Technical Support Unit, or *Cellule d'Appui Technique aux Mutuelles de Santé*. Throughout 2007, Twubakane provided support to this unit, along with collaborators GTZ, BIT-STEP, Belgian Technical Cooperation (BTC), the Global Fund and new partner Department for International Development (DFID). Partners convene regularly in a technical working group to discuss national-level implementation and share experiences from Twubakane-supported districts. A new accounting software package intended to improve management and implementation of *mutuelles*—*Mutuelles Accounting Software*—was pilot-tested in Nyarugenge District with Twubakane support in early 2007, and the rollout of the software was planned in the latter part of the year. Twubakane also supported printing and distribution of essential *mutuelles* member forms as well as training *mutuelles* supervisors on

When describing the benefits of the peer exchanges about *mutuelles* management, the Health Director for the Kicukiro District Gatera Emerance said, regarding the advantages of *mutuelles*, that “*people get care on time therefore the rate of hospitalization has decreased and therefore people are healthier compared to before. There has also been a reduction in the illegal sale of medicines in the market places. We thank the partners who assist in this arena, particularly Twubakane.*”

formative supervision (in Twubakane-supported districts only, but this will have national implication as the approach is implemented across the country).

During each quarter of 2007, Twubakane’s *mutuelles* team provided support to *mutuelles* managers and management committees in 11 of the 12 districts. This support is designed to improve management capacity of *mutuelles* managers and involves observation of and feedback given to managers during and after a full day of work, allowing for on-the-job training and advice. Other key types of support have been peer exchanges for *mutuelles* managers and HC directors, support and semi-annual meetings convening several districts simultaneously. These types of exchanges are appreciated by *mutuelles* managers and provide a forum to problem-solve common challenges and highlight positive experiences, thereby offering an opportunity to share these nationally and make improvements within their own districts. Enrollment rates for 2007 have remained high, with a total of 2,376,986 *mutuelles* members in the 12 Twubakane-supported districts (see Table 10). Challenges continuing to face *mutuelles* success are financial accountability, poor functioning of management committees, inability to use management tools to provide data for decision making and insufficient supervision by districts.

During 2007, the Twubakane routine data collection at districts’ *mutuelles* units showed that the health facilities included in the Twubakane zone had slightly fewer *mutuelles* members than the targets set for 2007 (Table 10). Across the 12 districts, an estimated 72% of the district populations are enrolled in *mutuelles* at HCs supported by Twubakane.

**Table 10: Mutuelles Membership**

Indicator	Results 2007	Target 2007	Data source
# people covered with health financing arrangements (in Twubakane districts)	2,376,986	2,415,193	Districts’ <i>mutuelles</i> units
% population in the districts supported by Twubakane that are enrolled in <i>mutuelles</i> ( Pop=3,307,144+ )	72%+		

+ 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.

While Twubakane had intended to report on the rate of utilization of health services by *mutuelles* members, that data proved inaccessible for too many facilities. If these results are more widely available in future years, they will be reported.

**Health Financing Management:** Based on a selection in late 2006 with MINISANTE, Twubakane focused assistance in 2007 on four districts, their hospitals and selected HCs. The assistance aims to increase the facilities’ capacity to better manage their resources by supporting the development of strategic plans.

**Table 11: Facilities Receiving Assistance for Health Financing Management, by District**

District	Hospital	Health Centers
Gasabo	Kibagabaga	None
Ngoma	Kibungo	12 HCs
Kayonza	Rwinkwavu, Gahini	12 HCs
Nyamagabe	Kigeme	Kitabi
Ruhango	Gitwe	13 HCs
Nyarugenge	Muhima	None

Situation analyses identified priority areas for the strategic plan such as: quality of care, insufficient human resources, 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 will provide support to develop operational plans (all facilities) and business plans (hospitals only). In late 2007, Twubakane piloted a tool to develop these plans in Nyamagabe District and developed a strategy to provide support to all districts (12 district hospitals and 131 HCs) to devise and implement such plans.

## Component 6: Community Engagement and Oversight

Over the last year, Twubakane has worked closely at the national level with a variety of stakeholders to finalize the national strategy and policy for community health. These documents reflect the integrated approach to services at the community level adopted by the GOR. Although Twubakane recognizes 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 is working with the MINISANTE's Community Health Desk and other partners to support the approach.

During the latter part of 2007, the policy was translated into practice through production of a comprehensive training guide covering all services offered by CHWs, including HBM, IMCI, FP and HIV education and palliative care. In addition to the training guide, Twubakane has assisted the Community Health Desk with harmonizing and standardizing health messages to be delivered by CHWs and collected by them in a reference booklet.

**Partenariat pour l'Amélioration de la Qualité (PAQ):** The PAQ approach has been officially identified by the MINISANTE as a best practice in quality assurance and an approach that should be supported in all

*"If we really want to attain and convince community members to participate in their own health care, we need PAQ teams—truly pairing decentralization and health." -- Mr. Nshamihigo, supervisor at Kabgayi Hospital*

of the country's HCs. PAQ teams, which bring together HC managers and health care providers with local leaders and community representatives, are a mechanism to improve the service quality and increase community participation in planning and management of health care and health care facilities at the local level. During 2007, a total of 31 PAQ teams were established at HCs, bringing PAQ coverage to 98% of all HCs in all 12 districts. During the past year, Twubakane focused on bringing coverage to 100% as well as ensuring PAQ team sustainability by training and mentoring PAQ team supervisors.

These individuals are existing HC supervisors who visit PAQ teams, along with district and sector authorities and district hospital supervisors, to support PAQ team functioning and encourage self-sufficiency. Some PAQ teams have now created sub-groups to address particular issues, some districts are funding PAQ activities through DIFs and 24 teams were given Lifeline Radios due to their high-level performance. Twubakane also updated PAQ training materials, adding an enhanced component on monitoring and support to teams.

*"The PAQ approach introduced by Twubakane in our health center greatly helped in sensitizing the population to achieve this record in family planning." -- Etienne Munyaneza, manager of Sangaza Health Center in Ngoma District. This district won a national prize as FP champion 2007.*

As shown in Table 12, 100% of the HCs visited during data collection for the 2007 RFA had a PAQ. Indicative of their active functioning, 80% of the HCs had a PAQ that reported having met at least once in the past six months (68% of the HCs had a PAQ that had met in the past three months).

**Table 12: Community Engagement in Health Centers Through PAQs**

Indicator	Results 2005 <i>All 110 HCs</i>	Results 2007 <i>Random Sample of 60 HCs</i>	Target 2007	Data Source
% HCs that have established a PAQ for communities to provide input on quality of services <sup>+</sup>	10%	100%	100%	RFA
% HCs with a PAQ that is currently actively functioning <sup>^</sup>	n/a	80%	90%	RFA
<i>Most recent PAQ meeting:</i> <i>In the last 3 months</i> <i>4-6 months ago</i> <i>More than 6 months ago</i>		<i>41 (68%)</i> <i>7 (12%)</i> <i>12 (20%)</i>		

+Established means they have had a PAQ launching meeting and a management committee was formed.

^Active means that the PAQ team has met at least once in the previous six months.

Table 13 provides district-level results for PAQs, obtained from the 2007 RFA. As shown, in only one district, Nyaruguru, were the PAQs in the sample mainly inactive. Only one of the six PAQs in that district had met in the past six months. In all other districts, a high number of the PAQs were active.

**Table 13: District-Level Results for PAQs in the 2007 Sample of 60 Health Centers**

District	# HCs Visited	# PAQ Teams at HCs Visited	# PAQ Teams that Met in Past Six Months in HCs	# PAQ Teams that Influenced At Least One HC Decision in the Past Year
Gasabo	5	5	4	4
Kicukiro	3	3	2	3
Nyarugenge	2	2	2	2
Kayonza	5	5	4	3
Rwamagana	5	5	4	5
Ngoma	6	6	6	5
Kirehe	5	5	5	5
Muhanga	7	7	7	6
Kamonyi	4	4	3	4
Ruhango	6	6	6	6
Nyaruguru	6	6	1	2
Nyamagabe	6	6	4	4
Total	60	60	48	49

Interviews with members of PAQs at the 60 HCs visited revealed considerable PAQ engagement in different aspects of improving the quality of health care. These included (i) community mobilization activities pertaining to better health seeking practices and use of health care services and (ii)

modification of different facets of health care services to enhance quality. The latter included physical and material characteristics of HCs, accessibility of health services due to hours and schedules, and quality of service delivery by staff with regard to their personal conduct vis-a-vis patients. PAQ members conveyed a fairly broad-based perception that they are serving a useful and active role in health care in their communities and are influencing decisions made at the HCs. (See Annex Two for selected PAQ achievements by district.)

**Last Mile Initiative/Community-Based Health Information System (CBIS):** During 2007, Twubakane was contacted by Systems, Research and Applications (SRA), a US-based organization that received funding from USAID/Washington for a pilot test of telecommunications to support the CBIS. SRA has contracted this to IntraHealth International and secured a project extension through September 2008. Equipment for the pilot test will be supplied by Qualcomm and will be based on CDMA (code division multiple access) technology, currently used by Rwandatel (recently purchased by Lap Green). The project activities were launched in early 2008 due to delays in contract negotiations and confirmation of the maintenance of CDMA technology. Discussions of implementation possibilities with TRAC were held since success will require close coordination with existing TRAC efforts. The foundation for the telecommunications pilot was the test of the CBIS collected on paper by CHWs in two districts: Kayonza and Kirehe. The selection of CBIS indicators was an arduous process, but by the end of 2007, a list of 27 indicators was agreed upon by all stakeholders and MINISANTE and will be the basis for the SRA pilot.

*"[The CBIS tools] are very beneficial for our sector, and even if MINISANTE is not able to expand the project, the sector will continue to use the tools because they contribute greatly to health planning." --Mr. Ruzage Wellare, head of social affairs, Gahara Sector, Kirehe District*



*Community health workers (left photo) and health center. (right photo)*



## TWUBAKANE'S SUPPORT AT THE CENTRAL LEVEL

### Central-Level Support

Twubakane applies the tenets that the central level plays a key role in stewarding decentralization therefore supporting central-level ministries in their role is key to decentralization success. To ensure effective and efficient decentralization, the central-level government must standardize and disseminate key policies and procedures, track resources available at both central and decentralized levels and support capacity building at all levels of the country. As Twubakane has noted previously, working closely with the central government to develop solid policies can initially be seen as taking more time—sometimes difficult to justify in an environment that encourages rapid results and quick wins.

However, only through national policies that are evidence-based and ensure equity in the quality of services can results be achieved—and sustained.

Twubakane continues to play an active role in the Health Cluster and Decentralization Cluster and the associated technical working groups, including groups working on FP, *mutuelles*, human resources, maternal health, IMCI and general MCH.

#### Health Campaigns

During 2007, Twubakane participated in and supported the following national health campaigns: World Health Day, Breastfeeding Week, Vitamin A /Immunizations/ Mebendazole and Africa Malaria Day.

Twubakane has been a key partner in the FP technical working group, leading the preparation of a national cadre of FP trainers and procuring revised IEC/BCC materials. In the area of safe motherhood, Twubakane, with ACCESS, has been supporting MCH Task Force efforts to finalize the Strategy for Reducing Maternal Mortality, now with MINISANTE for final review.

## INTERNAL PROGRAM PROCESS MILESTONES

### Continuing Application

In July 2007, Twubakane presented its continuing application for the second half of the five-year program to USAID and the GOR. The application served as an opportunity to share results, lessons learned and best practices, and Twubakane worked with stakeholders and partners to prepare for the midterm program review and application.

The continuing application presentation took place on July 10, 2007, with representatives from the USG and the GOR, including the US ambassador and ministers/secretaries general from the MINISANTE and MINALOC, as well as from other international agencies, Rwandan organizations and stakeholders. An overview of the Twubakane approach along with results and strategies for the program's six components were presented, with active involvement of stakeholders. Finally, Twubakane presented lessons learned and future plans, then showed a video documenting program results.

Partners' feedback was positive, with stakeholders appreciating Twubakane's responsiveness, flexibility and support of GOR-led priority programs. Several participants noted that the Twubakane approach, particularly the combined technical assistance and financial assistance through the DIF grants, should serve as a model for other development partner interventions. Participants also noted that they would have liked more opportunities to discuss challenges encountered during the first phase of program implementation.

After feedback was incorporated into the proposal, Twubakane submitted it to USAID/Rwanda on July 13, and USAID approved the continuing application in December 2008 and raised the budget ceiling to \$30,699,000, allowing for additional funding for malaria control, FP and GBV prevention and response.

### Steering Committee

The Steering Committee's role is to monitor Twubakane's programmatic and strategic orientation and activities and to provide guidance to ensure the continuing relevance and impact of its work. The Steering Committee met only once in 2007, on April 5, to review progress and share results from 2006 and plans for 2007. Committee members were especially interested in how the DIF grants process can

be streamlined and move forward—despite the challenges related to districts’ capacity and overall workload.

Unfortunately, organizing regular quarterly committee meetings has not been possible. Twubakane has been in communication with MINISANTE and MINALOC and is trying to ascertain how to make this mechanism more functional. During the first meeting in 2008, we will discuss with members the usefulness of the committee and whether its composition or meeting schedule should be revised.

## **Field Offices**

The Twubakane field coordinators continue to play pivotal roles, acting as liaisons between the Twubakane office and operations in Kigali and our local program activities. This year, field coordinators continued to support DIF grants by monitoring implementation of DIF-supported activities, and the coordinators played an active role in the district Joint Action Forums. Toward the end of 2007, field coordinators became more involved in supporting (initiating, organizing, monitoring) activities from all components given their location within the districts. District-level authorities continue to express their appreciation of the coordinators’ hands-on support. Given the coordinators’ heavy workloads—most cover two to three districts—in early 2008, Twubakane will recruit and post four additional assistant field coordinators.

## **Monitoring and Evaluation (M&E)**

Throughout the year, Twubakane M&E activities were focused on an ongoing process of data collection and analysis in order to report quarterly on program performance. In January 2007, PMP indicators were changed, and a new PMP system was developed and put into use. To comply with USAID’s new Operational Plan requirements, the Twubakane M&E team collected data on all performance indicators for the period October 2006 – September 2007. The main data source of most indicators is the national HMIS, but some information was also collected from a mini-RFA, from district mini-surveys and from Twubakane project records.

## **Annual Retreat**

Following the model of successful team-building retreats in preceding program years, Twubakane held an all-team retreat in November 2007, providing an opportunity for the staff to reflect on the progress to date in 2007 and to begin planning for 2008. In using a reflection-planning process, team members were able to assess the degree to which activities implemented produced desired results and to recognize program achievements and areas for documentation.

## ANNEXES

### Annex One: District Incentive Funds: Activities Completed in 2007

#### KIGALI

GASABO		
	Activities	Achievements
1	Develop and support income-generating activities for child-headed households in Kinyinya Sector to increase <i>mutuelles</i> membership and support the Association of the Blind in Kimironko Sector	<ul style="list-style-type: none"> <li>• 110 householders of vulnerable children were assisted to put in place a kitchen garden. Each child has a garden and has been trained to care for it. Through these gardens children can increase their income, afford to pay <i>mutuelles</i> fees, and satisfy their nutritional needs.</li> <li>• A physical therapy center for the blind has been rehabilitated.</li> </ul>
2	Provide training in IMCI and nutritional education and support to ten households per sector of the Gasabo District	<ul style="list-style-type: none"> <li>• Associations and cooperatives received training on IMCI (e.g., caring for malnourished children) and management of small income-generating projects.</li> <li>• Mosquito nets and two cows (for breeding) were given to PAQ committee of Gikomero's HC in order to care for malnourished children and persons infected by HIV/AIDS.</li> </ul>
3	Improve hygiene of the local population in Gisozi and Remera sectors, prevent gastro-intestinal and diarrheal diseases, and reduce parasitic infections through the construction of three public latrines at three public gathering places	<ul style="list-style-type: none"> <li>• Renovation work of three public latrines at three public places—such as taxi parking and sport exercise places—began and will be completed by March 2008.</li> </ul>
4	Strengthen the planning and budgeting capacity of the Gasabo District	<ul style="list-style-type: none"> <li>• The five-year DDP for 2008-2012 was completed and approved by the District Council.</li> </ul>
5	Support the district to carry out focused hygiene education programs in the Gikomero, Rutunga and Nduba sectors	<ul style="list-style-type: none"> <li>• CHWs received education about proper hygiene. Participants included 49 workers representing 14 associations of CHWs and others associations working for health and hygiene promotion.</li> <li>• Some vulnerable families were visited, and they received personal hygienic materials to consolidate hygiene.</li> </ul>
6	Rehabilitation of municipal infrastructure for improved service delivery at Kimironko's public market (electric and sanitary installations)	<ul style="list-style-type: none"> <li>• Renovation work of the market (making it more secure and well-lit, ensuring reliable refrigerated food, and repairing storm drainage canals and the septic tank system) began in December and will be done by March 2008.</li> </ul>
7	Support the reduction of maternal and neonatal death rates in Gasabo District through focused FP training programs of CHWs and the local population	<ul style="list-style-type: none"> <li>• A training focused on FP and contraceptive methods was provided to CHWs and the local authorities.</li> </ul>

<b>KICUKIRO</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Strengthen data management capacity of the Kicukiro District by computerizing data from different services of the district (marital status, human resources, town planning and health at the district level as well as on the sector level)	<ul style="list-style-type: none"> <li>• A contract has been signed between the district and a consultant who will install data processing software program and train staff on its use.</li> </ul>
2	Support prevention of diarrhea diseases in two primary schools of the sectors Busanza and Niboye	<ul style="list-style-type: none"> <li>• Modern tanks were purchased and installed for the storage of water and rainwater collection at two primary schools (Busanza and Niboye).</li> </ul>
3	Rehabilitate the dispensary of Kicukiro Sector	<ul style="list-style-type: none"> <li>• The dispensary of Kicukiro Sector has been renovated (100% achieved). Two rooms (delivery and hospitalization) are operational.</li> </ul>
4	Support improving RH and access to FP services through logistic assistance to the sites created as secondary posts and purchase of materials for EONC	<ul style="list-style-type: none"> <li>• 328 CHWs were trained on FP and contraceptive methods.</li> <li>• A purchase order was made for materials for EONC.</li> </ul>
5	Strengthen planning, budgeting capacity of the Kicukiro District	<ul style="list-style-type: none"> <li>• The five-year DDP (2008-2012) was completed and approved by the District Council.</li> </ul>

<b>NYARUGENGE</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Rehabilitate and purchase equipment for the HCs of Butamwa, Mwendo, Kabusunzu and Gitega and purchase medical material for the hospital of Muhima	<ul style="list-style-type: none"> <li>• Renovation of the Kabusunzu and Butamwa HCs was completed.</li> <li>• The supplier of medical equipment has been selected and is waiting to sign the procurement contract.</li> </ul>
2	Support improving the hygiene of the local population	<ul style="list-style-type: none"> <li>• Hygienic and cleaning materials for the BAHEZA association, responsible for removal of household waste in the Rwazamenyo sector, were purchased.</li> </ul>
3	Strengthen planning and budgeting capacity of the Nyarugenge District	<ul style="list-style-type: none"> <li>• The five-year DDP (2008-2012) was completed and approved by the District Council.</li> </ul>

## **EASTERN PROVINCE**

<b>NGOMA</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Strengthen Ngoma District's data management capacity by computerizing data for different district services by the purchase of the computers for district and sector levels	<ul style="list-style-type: none"> <li>• 24 laptop computers were distributed and used in different district units and sectors of the district.</li> </ul>

<b>NGOMA</b>		
	<b>Activities</b>	<b>Achievements</b>
2	Support efforts to increase awareness about and interest in decentralization and health programs	<ul style="list-style-type: none"> <li>Each Friday, from 20:00 to 20:45, emissions on decentralization and health were diffused on IZUBA radio.</li> </ul>
3	Strengthen Ngoma District's planning and budgeting capacity	<ul style="list-style-type: none"> <li>The five-year DDP (2008-2012) was completed and approved by the District Council.</li> </ul>
4	Purchase medical equipment for the district hospital and HCs	<ul style="list-style-type: none"> <li>Medical equipment at the district hospital and water tanks in HCs were distributed.</li> </ul>

<b>KIREHE</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Strengthen the district's and sectors' technical unit capacity to collect, analyze, process and use data for informed decision making	<ul style="list-style-type: none"> <li>20 laptops were purchased, distributed and used in all administrative sectors and the district departments, and reports are produced at the district level.</li> </ul>
2	Support PAQ teams to participate in income-generating activities as a means of becoming more self-sustaining and effective	<ul style="list-style-type: none"> <li>At the end of year 2007, this activity was awaiting the last transfer to finance the income-generating activities.</li> </ul>
3	Improve the conditions of hygiene at community health facilities and the health of the population of Kirehe	<ul style="list-style-type: none"> <li>184 district water cisterns were cleaned and disinfected.</li> </ul>
4	Strengthen planning and budgeting capacity of decentralized authorities of Kirehe District through a series of training activities	<ul style="list-style-type: none"> <li>Training seminars held facilitated development of action plans at the cell, sector and district levels for 2008.</li> </ul>
5	Improve health service delivery at the health facility of Mushikiri with the purchase of medical equipment	<ul style="list-style-type: none"> <li>The health facility of Mushikiri is operational, and the medical equipment has been purchased and is being used.</li> </ul>
6	Promote the gender equality and fight against family and sexual violence by organizing training and sensitizing meetings	<ul style="list-style-type: none"> <li>Community committees against family and sexual violence are set up on the cell level throughout the whole district.</li> </ul>
7	Renovate former sub-prefecture office building and transform it into the district administrative offices	<ul style="list-style-type: none"> <li>Part of the office building was rehabilitated, and the solar energy was installed.</li> </ul>
8	Strengthen the Kirehe District's planning and budgeting capacity	<ul style="list-style-type: none"> <li>The DDP for 2008-2012 was completed and reviewed by the representatives of the population and approved by the District Council.</li> </ul>

<b>KAYONZA</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Purchase medical equipment for seven medical centers of Kayonza District	<ul style="list-style-type: none"> <li>Medical equipment was distributed and is being used in the two district hospitals and other HCs.</li> </ul>

<b>KAYONZA</b>		
	<b>Activities</b>	<b>Achievements</b>
2	Rehabilitate HCs of Cyarubare, Mukarange and Nyakabungo	<ul style="list-style-type: none"> <li>• Three HCs are partially rehabilitated as of December, 2007.</li> </ul>
3	Finalize rehabilitation of district offices	<ul style="list-style-type: none"> <li>• The district offices are rehabilitated and occupied by the staff.</li> </ul>
4	Strengthen Kayonza District's planning and budgeting capacity	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and reviewed by the representatives of the population and approved by the District Council.</li> </ul>

<b>RWAMAGANA</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Purchase and use medical equipment at seven HCs of Rwamagana District	<ul style="list-style-type: none"> <li>• Medical equipment was distributed and is now being used in Rwamagana hospital and HCs.</li> </ul>
2	Renovate infrastructure of Ruhunda's and Nyagasambu's HCs	<ul style="list-style-type: none"> <li>• At the end of December 2007, Ruhunda's HC was partially rehabilitated.</li> </ul>
3	Improve health and hygiene of sector residents through the water drainage canal rehabilitation in seven sectors and the purchase of eight water cisterns for use at eight HCs	<ul style="list-style-type: none"> <li>• 32 water sources were rehabilitated, and eight water cisterns were installed in eight HCs of the district.</li> </ul>
4	Improve health and hygiene of the residents of Rwamagana city through the purchase of public trash receptacles/bins	<ul style="list-style-type: none"> <li>• 16 trash receptacles bins were purchased and installed in public places of the district.</li> </ul>
5	Strengthen the Rwamagana District's planning and budgeting capacity	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and reviewed by the representatives of the population and approved by the District Council.</li> </ul>

## **SOUTHERN PROVINCE**

<b>KAMONYI</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Strengthen Kamonyi District's planning, budgeting and resource mobilization capacity	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and approved by the Kamonyi District Council.</li> <li>• MTEF 2008-2010 as well as the 2008 action plan documents were produced.</li> <li>• A document on the investment opportunities in the district was produced.</li> </ul>
2	Rehabilitate and extend the maternity ward of Remera Rukoma hospital	<ul style="list-style-type: none"> <li>• Renovation work of the maternity ward of Remera Rukoma hospital began and will be completed by March 2008.</li> </ul>

<b>KAMONYI</b>		
	<b>Activities</b>	<b>Achievements</b>
3	Support the mapping of 300 plots in the village of Rugazi	<ul style="list-style-type: none"> <li>• A plot plan has been developed and contains other documents such as the list of the people to be expropriated, the estimate value of these properties, the plan and cost of partitioning.</li> </ul>
4	Strengthen Musambira HC capacities through nutritional training and education activities to support the reduction of cases of malnutrition	<ul style="list-style-type: none"> <li>• Demonstration fields of the new varieties of the fruits and vegetables have been put in place at the HC.</li> <li>• Six associations (196 persons) have been created and are entertaining common gardens in villages (6 gardens).</li> <li>• Fruit and vegetable seeds and agricultural materials (200 hoes, 10 watering cans and 10 shovels) were purchased and distributed to the members of associations.</li> </ul>

<b>MUHANGA</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Purchase medical equipment for Kabgayi Hospital, the HCs of Birehe, Rutobwe and Gitega as well as the community HCs of Nyarusange and Mushishiro of the Muhanga District	<ul style="list-style-type: none"> <li>• The purchase order for the medical equipment has been submitted to the supplier.</li> </ul>
2	Rehabilitate three buildings, internal medicine room of Kabgayi Hospital, two buildings of the maternity ward of the HCs of Gitega and Birehe	<ul style="list-style-type: none"> <li>• Renovation of the maternity rooms of Kabgayi hospital and Gitega Health Center began and will be completed by March 2008.</li> </ul>
3	Strengthen Muhanga District's planning, budgeting and resource mobilization capacity	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and approved by the Muhanga District Council.</li> <li>• MTEF and 2008 action plan were produced.</li> </ul>

<b>RUHANGO</b>		
	<b>Activities</b>	<b>Achievements</b>
1	Strengthen capacity of Ruhango District's HC laboratory staff	<ul style="list-style-type: none"> <li>• Training, in two sessions, of 28 laboratory staff of the HCs was held.</li> <li>• A training manual, «le manuel de formation de biotechnologiques,» was produced and is now available.</li> </ul>
2	Mobilize and encourage women to be delivered in the HCs	<ul style="list-style-type: none"> <li>• Money was sent to the HCs to purchase materials that women and their babies would need following the birth (such as cloth to wrap the infants)</li> </ul>
3	Strengthen Ruhango District's planning, budgeting and resource mobilization capacity	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and approved by the Ruhango District Council.</li> <li>• MTEF and 2008 action plan were produced.</li> </ul>

RUHANGO		
	Activities	Achievements
4	Purchase medical equipment for Ruhango District's hospital and 13 HCs	<ul style="list-style-type: none"> <li>• Equipment was purchased and stored at Gitwe Hospital. It will be distributed to the HCs.</li> </ul>
5.	Support the task forces of the sectors, cell and <i>imidugudu</i> with the mobilization for the improvement of RH and use of the services offering the various FP methods	<ul style="list-style-type: none"> <li>• Task forces (9) of 5 persons each have been put in place.</li> <li>• The task forces have been oriented on contraceptives methods and the work of mobilization on RH.</li> </ul>

NYAMAGABE		
	Activities	Achievements
1	Support "indigents" in four sectors for passion fruit production as an income-generating activity so that plantation profits can be used for subscription fees to the community health insurance programs ( <i>mutuelles</i> )	<ul style="list-style-type: none"> <li>• 2,000 households were identified for support.</li> <li>• The first advance was paid to the supplier of passion fruit seed.</li> </ul>
2	Support the reduction of Nyamagabe District's maternal and neonatal death rates by renovating the maternity wards of health facilities	<ul style="list-style-type: none"> <li>• Renovation work of the maternity of Kigeme's hospital began and has to be completed by March 2008.</li> </ul>
3	Strengthen Nyamagabe District's planning and budgeting capacity and management of the data	<ul style="list-style-type: none"> <li>• The five-year DDP (2008-2012) was produced and approved by the Nyamagabe District Council.</li> <li>• Two laptops were purchased to facilitate planning.</li> </ul>

NYARUGURU		
	Activities	Achievements
1	Support finishing the renovation of the building of the former MINAGRI-DANK project that will house the Munini hospital of Nyaruguru District	<ul style="list-style-type: none"> <li>• Renovation work of Munini's hospital will be completed by March 2008. It is achieved at 95%.</li> </ul>
2	Strengthen Nyaruguru District's capacity in planning and budgeting, and management of data, as verified by the production of the five-year DDP and the purchase of three laptops	<ul style="list-style-type: none"> <li>• The DDP for 2008-2012 was completed and approved by the Nyaruguru District Council.</li> </ul>

## Annex Two: Results from Selected PAQ Teams, Twubakane Districts, 2007

### PAQ - KIGALI

Districts	PAQ Teams	Achievements
Gasabo	Gikomero	<ul style="list-style-type: none"> <li>Initiated a milk cow project at the HC to provide nourishment for malnourished children, as well as planted vegetables and fruit trees. Financing provided by DIF grant</li> <li>Organized sub-PAQ committees to focus on utilization of services, facility deliveries and <i>mutuelles</i> membership. Over the year, service utilization has increased from 23% to 53%, deliveries from 38 to 64 per month.</li> <li>Reorganized staff and emphasized punctuality and better triage of clients; as a result, waiting lines have decreased.</li> </ul>
Kicukiro	Masaka	<ul style="list-style-type: none"> <li>Increased <i>mutuelles</i> membership, particularly among indigents (77% to 89%) and percentage of women expected to deliver who return to facility for delivery (58% to 78%)</li> <li>Initiated a milk cow project at the HC to provide nourishment for malnourished children. Financing provided by DIF grant</li> <li>Supported reorganization of services to improve reception of clients and overall work environment for providers</li> </ul>
Nyarugenge	Gitega	<ul style="list-style-type: none"> <li>Organized mobilization efforts to increase service utilization, along with improving cramped service delivery area. Service utilization has increased as have referrals for deliveries at Muhima Hospital and new users of FP.</li> <li>Implemented a calendar system to monitor <i>mutuelles</i> membership payments to increase overall number of households becoming members</li> <li>Advocated for expansion of selected services (consultation rooms and <i>mutuelles</i> office) at the HC and reorganization of examination rooms</li> </ul>

## PAQ - EASTERN PROVINCE

Districts	PAQ Teams	Achievements
Ngoma	Gituku	<ul style="list-style-type: none"> <li>Inventoried malnourished infants around the HC and provided food support (SOSOMA – fortified flour) to mothers and their infants</li> <li>Constructed demonstration cooking area to allow mothers to learn how to prepare nutritious foods for their malnourished children</li> <li>Purchased IBIGOMA (baby blankets) for newborns which encouraged an increase of facility-based deliveries from 23 to 73 per month</li> </ul>
	Nyange	<ul style="list-style-type: none"> <li>PAQ team, together with HC staff, agreed that FP is a pillar service and that each staff member needs to encourage FP use as appropriate.</li> <li>Using funds from the performance-based contract with the HC, the HC staff purchased baby clothes for newborns and waived delivery fees. Deliveries at the HC have increased from 13 to 77 per month.</li> <li>Manages a two-hectare crop of pineapples and herd of four cows, thereby contributing to overall development of the community</li> </ul>
	Sangaza	<ul style="list-style-type: none"> <li>PAQ team, together with HC staff, agreed that FP is a pillar service and that each staff member needs to encourage clients to consider FP use if appropriate.</li> <li>Manages a grain mill and two public telephones (TUVUGANE) to generate income</li> <li>Covered <i>mutuelles</i> membership fees for 50 indigent families in the HC catchment area</li> </ul>
Kirehe	Gahara	<ul style="list-style-type: none"> <li>Engaged a midwife to provide delivery services at the HC</li> <li>Established a calendar of mobilization activities to be conducted by CHWs as part of effort to encourage <i>mutuelles</i> membership</li> <li>Renovated HC including painting and building a gate and fence enclosing the HC grounds</li> </ul>
	Nyamugali	<ul style="list-style-type: none"> <li>Advocated to install a reliable water source for the HC and directional signs indicating location and hours of services</li> <li>Implemented system for deliveries whereby women with four prenatal visits may have their delivery fees waived</li> <li>Reduced ambulance fees for <i>mutuelles</i> members and increased fees for non-members</li> </ul>
	Mulindi	<ul style="list-style-type: none"> <li>Involved INTORE (traditional restaurant and cultural groups) in increasing <i>mutuelles</i> membership; each INTORE has joined a <i>mutuelles</i>.</li> <li>Planted a garden around HC to improve appearance and cleanliness</li> <li>Established a management committee instead of having the HC manager be the only manager</li> </ul>
Kayonza	Ndego	<ul style="list-style-type: none"> <li>Organized sub-committees focusing on utilization of MCH services, especially FP, vaccinations and facility deliveries. As a result of mobilization efforts, service fees generated have increased from 650,000 Rwf to 1,500,000 Rwf per month, deliveries from 20 to 98 per month and return visits for FP clients from 12% to 56%.</li> <li>In collaboration with local village leaders, mobilized indigents to join <i>mutuelles</i> thereby increasing membership for the HC catchment area from 43% to 94% by October 2007</li> <li>Renovated maternity ward and <i>mutuelles</i> office using DIF grant</li> </ul>

Districts	PAQ Teams	Achievements
	<b>Nyamirama</b>	<ul style="list-style-type: none"> <li>Health management committee now meets regularly to analyze service delivery issues and propose solutions.</li> <li>Initiated community-based nutrition activities at HC to support reduction of malnutrition in the catchment area</li> <li>Advocated for establishment of HC instead of health post based on increased service utilization. Health facility was upgraded to HC using DIF grant and beginning in November 2007, the HC offered the Minimum Package of Services</li> </ul>
<b>Rwamagana</b>	<b>Nzige</b>	<ul style="list-style-type: none"> <li>Organized sub-committees to focus on facility deliveries and FP resulting in an increase of 30 to 49 deliveries per month and return visits for FP clients from 16% to 39%</li> <li>Expanded HC services for nutrition and added latrines at the HC</li> <li>Implemented a calendar system to monitor <i>mutuelles</i> membership payments to increase overall number of households becoming members—percentage increased from 55% to 88%.</li> </ul>
	<b>Kabarondo</b>	<ul style="list-style-type: none"> <li>Modified service hours and organization of services, improving reception of clients and work environment for providers</li> <li>Established income-generating project using DIF grant</li> <li>Initiated restaurant hygiene inspection by PAQ team members</li> </ul>
	<b>Ruhunda</b>	<ul style="list-style-type: none"> <li>Purchased equipment for EONC (including delivery beds) and renovated the HC using DIF grant</li> <li>Modified service hours and organization of services, improving reception of clients and work environment for providers</li> <li>Held mobilization activities to increase facility deliveries from 30 to 49 per month</li> </ul>

### PAQ - SOUTHERN PROVINCE

Districts	PAQ Teams	Achievements
<b>Kamonyi</b>	<b>Musambira</b>	<ul style="list-style-type: none"> <li>Constructed latrines at HC</li> <li>Requested audit of HC and found misuse of funds; replaced accountant, and financial reports are now provided to PAQ team each quarter.</li> <li>Increased participation in ANC/PMTCT (109 women currently followed), including male participation</li> </ul>
	<b>Kayenzi</b>	<ul style="list-style-type: none"> <li><i>Mutuelles</i> membership has reached 76% of HC catchment area residents.</li> <li>Recommendation made to the health management committee to improve reception and confidentiality and to create a secondary post for vaccines and FP, which nurses will staff twice per week</li> <li>Mobilized outreach activities resulting in increase in FP clients requesting the Standard Days Method</li> </ul>
<b>Muhanga</b>	<b>Nyabinoni</b>	<ul style="list-style-type: none"> <li>Constructed six offices within HC compound (two of which were for <i>mutuelles</i> and one for night call)</li> <li>Purchased a milk cow to provide milk for malnourished children; sale of milk locally has generated funds to provide <i>mutuelles</i> membership for 154 indigents</li> </ul>

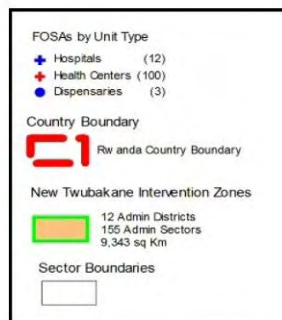
Districts	PAQ Teams	Achievements
		<ul style="list-style-type: none"> <li>Organized sub-committees to increase service utilization; consultations increased from 268 to 835 per month by November 2007, and vaccination coverage was 98.7% in October 2007.</li> </ul>
	<b>Birehe</b>	<ul style="list-style-type: none"> <li>Instituted monthly staff meetings organized by the health management committee</li> <li>Increased service utilization and number of FP clients from 69 to 198 per month</li> <li>Encouraged greater use of services by <i>mutuelles</i> members</li> </ul>
<b>Ruhango</b>	<b>Gishweru</b>	<ul style="list-style-type: none"> <li>Instituted weekly staff meetings; some staff changes have occurred.</li> <li>Constructed a demonstration cooking area to combat malnourishment among children</li> <li>Improved reception of clients which has reduced waiting time and encouraged increased utilization of services (from 39% to 86%)</li> </ul>
	<b>Muremure</b>	<ul style="list-style-type: none"> <li>Increased service utilization from 128 to 555 patients per month and FP clients from 198 to 393 per month</li> <li>Utilization of services by <i>mutuelles</i> members increased from 23 to 69%</li> <li>Expanded HC services and purchased equipment using DIF grant</li> </ul>
<b>Nyamagabe</b>	<b>Mbuga</b>	<ul style="list-style-type: none"> <li><i>Mutuelles</i> membership reached 69% for HC catchment area residents</li> <li>Reorganized layout of HC to facilitate client flow</li> <li>Initiated weekly staff meetings to review service provision</li> </ul>
	<b>Rugege</b>	<ul style="list-style-type: none"> <li>Reorganized staff and required punctuality and efficiency of service delivery</li> <li>Initiated an income-generating project to finance needed services/supplies</li> <li>Increased utilization of services from 55 to 85% and return visits for FP clients from 3% to 12%</li> </ul>
<b>Nyaruguru</b>	<b>Coko</b>	<ul style="list-style-type: none"> <li>Organized sub-committees to focus on increasing services from 76% to 137% and deliveries at the HC from 43 to 77 per month</li> <li><i>Mutuelles</i> committee meeting regularly</li> <li>Expanded consultation rooms and delivery room</li> </ul>
	<b>Kibeho</b>	<ul style="list-style-type: none"> <li>Increased service utilization from 15% to 30%, facility deliveries from 20 to 30 per month and return visits for FP clients from 5% to 10%</li> <li>Initiated an income-generating project to finance needed services/supplies</li> <li>Adapted work hours to allow for service coverage during rest breaks</li> </ul>

## Annex Three: Twubakane's Intervention Zone

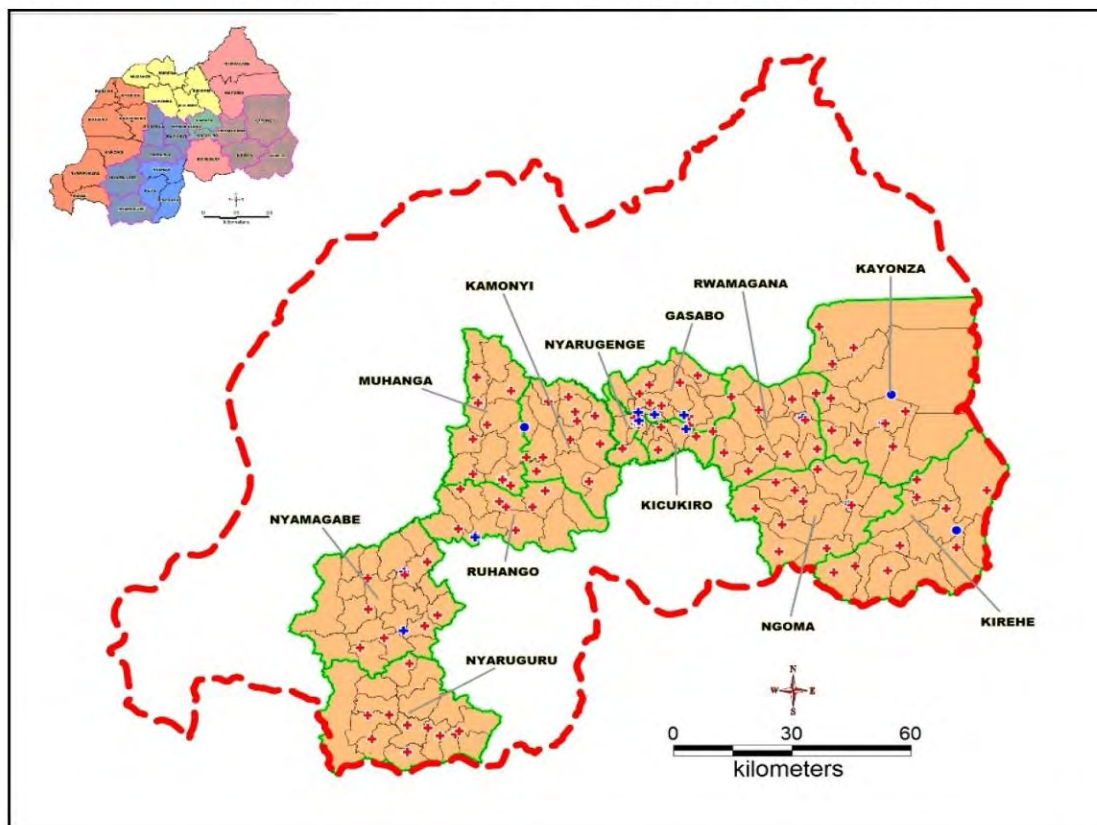
**RWANDA: Population of New Districts** (Note: Population growth rate = 2.85 % per annum)

Source = MINALOC and Rwanda Census Data, March 2006

Province	District	Population	
		Year: 2002	Year: 2006
KIGALI		<b>765,325</b>	<b>852,572</b>
	NYARUGENGE	236,990	264,007
	GASABO	320,516	357,055
	KICUKIRO	207,819	231,510
SOUTH		<b>1,308,585</b>	<b>1,457,764</b>
	NYARUGURU	234,190	260,888
	NYAMAGABE	280,007	311,928
	RUHANGO	245,833	273,858
	MUHANGA	287,219	319,962
	KAMONYI	261,336	291,128
EAST		<b>894,802</b>	<b>996,809</b>
	RWAMAGANA	220,502	245,639
	KAYONZA	209,723	233,631
	KIREHE	229,468	255,627
	NGOMA	235,109	261,911
<b>Total population</b>		<b>2,968,712</b>	<b>3,307,145</b>



**New Twubakane Intervention Zones** (Approved at the November 16, 2005 Steering Committee Meeting)



## Annex Four: Monitoring and Evaluation Methodology and Indicator Definitions

Throughout the year Twubakane M&E activities focused on the ongoing data collection and analysis needed for reports of quarterly program performance. In January 2007, PMP indicators were changed, in accordance with the USG's 'Investing in People' indicators, and a new PMP monitoring system was developed and implemented.

As stated earlier in the report, the period for data reported was October 2006 – September 2007, except when otherwise stated. This allows for comparison of 2007 targets with previous years' results. The sources of data were all HCs and district hospitals receiving Twubakane support unless otherwise stated. By 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 for HCs) 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.

It should be noted that during the course of the year, HCs have been added in districts. Hence, there may be fewer HCs reporting results early in the year than toward the end of the year. Also, 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 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 131 HCs in the 12 Twubakane zones. However for the indicators on assisted deliveries, postpartum visits, and diarrhea cases treated, the sample includes the 12 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 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 March 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. This survey will be repeated with the same 60 HCs next year, and at the end of the project a full RFA of all health facilities will be conducted.

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. This year, as in the previous year, 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. One difference this year was that the data collection tool was much shorter than previously. This exercise coincided with a district planning process; Twubakane staff who actively support this annual district planning process used this opportunity to administer the SWOT questionnaire to district officials.

It should be noted that for several indicators that were to be reported in this annual report, data could not be collected due to its unavailability. This includes data on AMTSL and the utilization rate of health services by *mutuelles* members.

#### Data Analysis

The data analysis for the PMP indicators is descriptive (percentages and numerical counts). In this report, except for a few newly presented indicators, aggregate results for the 12 districts are presented. This contrasts with the quarterly reports in which results were disaggregated to provide district-level results. Details about indicator definitions and methods of calculations are provided for each indicator in the following section.

For a few indicators which have remained constant in the project from 2005 to 2007, there is baseline data from 2005. However, comparisons between 2005 and 2007 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 provided by FP services during a one-year period based upon the volume of all contraceptives provided to clients during that period. Couple years of protection 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. Data Source: The DELIVER Project

**# People Reached with Family Planning/Reproductive Health Messages:** # individuals in target population who have seen or heard a FP message. It is calculated by summing: # of patients who have received FP services at HCs and hospitals in the last month of the reporting period, i.e. either the last month of the year or the last month of the trimester + # of people who have been exposed to FP education/sensitization at health facilities + # of people who have been exposed to FP messages through communication activities supported by Twubakane. Data source: HMIS monthly forms and Twubakane project records

**# SDP with Stock-Outs of Contraceptive Commodities:** # of SDPs reporting stock-outs of any contraceptive commodity offered by the SDP at any time during the reporting period. Data Source: The DELIVER Project

**# People Trained in Family Planning/Reproductive Health:** # of people (health professionals, primary health care workers, CHWs, volunteers, non-health personnel) Twubakane has trained in FP/RH. RH includes FP, ANC, maternity/safe delivery, and neonatal care, and training includes training courses, workshops and on-the-job training. Data source: Twubakane project records

**# People Trained in Maternal/Newborn Health:** # of people (health professionals, primary health care workers, CHWs, volunteers, non-health personnel) trained in maternal and/or newborn health and nutrition care. Data source: Twubakane project records

**% of Health Centers Providing Modern Contraceptive Methods:** # of HCs that offer modern contraceptive methods/# of HCs visited. This indicator is aggregated by method. Data source: RFA

**# ANC Visits by Skilled Providers:** # ANC visits at HCs assisted by Twubakane. It is calculated by summing: # of standard visits in 1st trimester + # of standard visits in 2nd trimester + # of standard visits in 7th or 8th month + # of standard visits in 9th month. Data source: HMIS monthly forms from HCs

**# Deliveries with Skilled Birth Attendants:** # of deliveries with an SBA. This includes a medically trained doctor, nurse, or midwife. It does not include TBAs. It is calculated by summing the # of deliveries at HCs and hospitals. Data source: HMIS monthly forms

**# of Postpartum/Newborn Visits Within Three Days of Birth:** # of postpartum/newborn visits within three days of birth (includes all skilled attendant deliveries plus all facility or outreach postpartum/newborn visits within three days for mothers/newborns who did not have an SBA delivery) Data Source: HMIS monthly forms

**# Service Delivery Points with USG Support:** Sum of all the hospitals, HCs and secondary FP posts receiving financial or technical support from Twubakane. Data source: Twubakane project records

**% of Health Centers that Offer Essential Emergency Obstetrical and Neonatal Care:** # of HCs that offer the six necessary interventions for essential EONC/# of HCs visited. This indicator is aggregated by intervention. Data source: RFA

**% of Hospitals that Offer Comprehensive Emergency Obstetrical and Neonatal Care:** # of hospitals that offer the eight necessary interventions for comprehensive EONC/# of HCs visited. This indicator is aggregated by intervention. Data source: RFA

## CHILD SURVIVAL

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

**# Children <12 Months Who Received DPT3 Immunizations:** # of children less than 12 months who received DPT3 in a given year in Twubakane districts. Data Source: HMIS monthly forms

**# People Trained in Child Health and Nutrition:** # of people (health professionals, primary health care workers, CHWs, volunteers, non-health personnel) trained in child health care and child nutrition. Data source: Twubakane project records

## NUTRITION

**# Children <5 Who Received Vitamin A:** While this indicator is intended to include # of children under 5 years of age who received vitamin A from USG-supported programs, in fact it is really the # of doses of vitamin A dispensed to children under 5 by USG-supported programs. Includes: # of doses of vitamin A received by children <5 in each mass campaign + # of children <5 who received vitamin A at HCs 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 # of doses rather than # of children. Data source: UNICEF or EPI program data on mass campaign and HMIS monthly reports

**# Children Reached by Nutrition Programs:** # of children < 5 years reached by programs that promote good infant and young child feeding and/or growth promotion programs. Includes: # of children < 5 years old treated for malnutrition at HCs + # children <5 in growth promotion programs at HCs. 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. Data source: HMIS monthly reports

## MALARIA

**# People Trained in Treatment or Prevention of Malaria:** # of people (medical personnel, health workers, community workers, etc.) trained in malaria treatment or prevention. Data source: Twubakane project records

## **DECENTRALIZATION, POLICY PLANNING AND MANAGEMENT**

### **MINISANTE Develops and Disseminates a Costing Tool of Minimum and Complementary Activity**

**Packages:** MINISANTE will be using a budgeting process that uses unit costs for the MPA in HCs and CPA in hospitals. Data source: Documentation and oral descriptions of achievements of the various steps processes

**Timely Production, Completion and Dissemination of National Health Accounts:** The timing of the production, completion and dissemination of the NHA will be recorded on the timeline set by MINISANTE in collaboration with Twubakane. Data source: Documentation and oral descriptions of achievements of the various steps' processes

**NHA courses started in Rwandan training institutions:** The adaptation and introduction of curriculum, training of trainers, and NHA course offerings will be recorded. Data source: Documentation and oral descriptions of achievements of the various steps processes

## **DISTRICT LEVEL PLANNING, BUDGETING, AND MANAGING**

**% Districts That Have Mechanisms in Place for Public Reporting on Health Sector Activities:** # of districts that have mechanism in place/12 Twubakane-supported districts. Data source: SWOT

**% Districts That Have Mechanisms in Place for Public Reporting on Their Financial Performance:** # of districts that have mechanisms in place/12 Twubakane-supported districts. Data source: SWOT

**% Districts With Annual Plans and an MTEF that Include a Full Range of Health Activities:** # of districts that have a finalized annual plan/12 Twubakane-supported districts. Data source: SWOT

**% Districts That Have Plans and Budgets Documented to Reflect Citizen Input:** # of districts that have documented plans and budgets with citizen input/12 Twubakane-supported districts. Data source: SWOT

## **USG ASSISTANCE FOR CAPACITY BUILDING IN PUBLIC SECTOR**

**# of Sub-National Government Entities Receiving USG Assistance to Improve Their Performance:** # of sub-national entities (refers to 'local governments' and their departments and divisions) receiving USG financial or technical assistance. For Twubakane, "entities" refers to districts. Annually this number should be all 12 districts because all 12 receive DIFs.

**# of Sub-National Governments Receiving USG Assistance To Increase Their Annual Own-Source Revenues:** # of districts receiving technical or financial support (can be DIFs used for increasing their own revenue) to help them learn how to increase their own revenues.

**# of Individuals Who Received USG-Assisted Training, Including Management Skills and Fiscal Management, to Strengthen Local Government and/or Decentralization:** # of individuals who participated in any training or education event, whether short-term or long-term, in-country or abroad. Data source: Twubakane training reports

**# 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, and that observable steps are taken to initiate implementation and repeated, continued and/or expanded to demonstrate that implementation is continuing. Data Source: RALGA

**# of Government Officials Receiving USG-Supported Anti-Corruption Training:** # of government officials in training or education events, whether short-term or long-term, in-country or abroad. Data Source: RALGA

#### HEALTH FACILITIES MANAGEMENT AND MUTUELLES

**# of People Covered with Health Financing Arrangements:** # of people covered by USG-supported health insurance (*mutuelles*) for all 12 Twubakane-supported districts. Data Source: Districts

**% of Population in the Districts Supported by Twubakane That Are Enrolled in *Mutuelles*:** # of people covered by USG-supported health insurance (*mutuelles*) for all 12 Twubakane-supported districts/the estimated population for all 12 Twubakane-supported districts.

**% of Health Centers Providing the MPA in Family Health:** # of HCs offering the 12 services included in the MPA/the # of HCs visited. This indicator is aggregated by health service. Data Source: RFA

#### COMMUNITY ENGAGEMENT AND OVERSIGHT

**% of Health Centers That Have Established a Mechanism for Communities To Provide Input On Quality of Services (PAQ):** # of HCs with an established PAQ team/total # of HCs visited. "Established" means that they have had a launching meeting and a management committee was formed. Data source: RFA

**% Health Centers With An Active Mechanism for Communities To Provide Input On Quality of Services (PAQ):** # of HCs with a PAQ that met and discussed service delivery issues in the community during the previous six months/total # of HCs visited. Data source: RFA

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