Twubakane

Decentralization and Health Program
Let's Build Together

Annual Report 2006

Twubakane Decentralization and Health Program
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Acronyms

ANC	Antenatal Care
AQ/SP	Amodiaquine/ Sulfadoxine-pyrimethamine
BCC	Behavior Change Communications
BTC	Belgian Technical Cooperation
CBIS	Community Based (Health) Information System
CPA	Complementary Package of Activities
CPR	Contraceptive Prevalence Rate
DIF	District Incentive Funds
DIP	Decentralization Implementation Policy
EDPRS	Economic Development and Poverty Reduction Strategy
FP	Family Planning
GBV	Gender Based Violence
GOR	Government of Rwanda
HBM	Home Based Management
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICT	Information, Communication Technology
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment
IRC	International Rescue Committee
ITN	Insecticide Treated Net
IUD	Intrauterine Device
LTM	Long-Term Methods
LTPM	Long-Term and Permanent Methods
MCH	Maternal and Child Health
MINALOC	Ministry of Local Administration
MINISANTE	Ministry of Health
MPA	Minimum Package of Activities
MTEF	Medium Term Expenditure Framework
NDISP	National Decentralization Implementation Support Program
NGO	Nongovernmental Organization
NHA	National Health Accounts
NIMCP	National Integrated Malaria Control Program
PAQ	*Partenariat pour l'Amélioration de la Qualité*
PMTCT	Prevention of Mother-to-Child Transmission
PNBC	*Programme de Nutrition au Base Communitaire*
PPH	Postpartum Hemorrhage
RALGA	Rwandese Association of Local Government Authorities
RDSF	Rwanda Decentralization Strategic Framework
RH	Reproductive Health
SP	Sulfadoxine-pyrimethamine
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Twubakane Implementing Partners

IntraHealth (lead partner)

RTI International

Tulane University

EngenderHealth

VNG

RALGA

Pro-Femmes

Government of Rwanda
- **Ministry of Local Government**
- **Ministry of Health**

Introduction

The five-year USAID-funded Twubakane Decentralization and Health Program had a unique opportunity in 2006 to offer timely support to the Government of Rwanda to take advantage of the new phase of decentralization to improve health care services management and delivery. Immediately following the district mayoral elections in February 2006, the Twubakane team was on the ground with our district partners, helping them develop the historic performance-based contracts signed between the mayors and the President of Rwanda—imihigo—as well as annual plans and budgets. Decentralization support also included central-level technical assistance to ministries and to RALGA.

The Twubakane Program District Incentive Funds, launched in July, were a timely intervention that gave districts financial and technical resources to implement innovative health and resource mobilization activities. Throughout the year, Twubakane continued to help district teams analyze their own strengths and weaknesses, and better understand roles and responsibilities, particularly related to health services management and delivery.

Twubakane also continued in its efforts to help Rwandans increase access to and use of high quality family health services—family planning, reproductive health, child survival, malaria and nutrition. Support to policy and program development at the central level was balanced with technical assistance and training for key interventions, including family planning, emergency obstetrics and neonatal care, the integrated management of childhood illnesses, home based management and facility based management and prevention of malaria and malaria in pregnancy, and community based nutrition. Capacity building of health care providers was complimented by the creation of community-provider partnerships through PAQ teams, and the orientation of and support to local authorities to help them become champions for health in their communities.

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

As the name Twubakane indicates, the program builds together through partnerships at all levels, with the GOR, civil society partners, the private sector, and communities. Maintaining successful partnerships continues to be the key to achieving the results described in this second annual report.

Performance Review by Component

Component 1: Family Planning/Reproductive Health Access and Quality

Increasing Access to and Use of Family Planning (FP)

"Before, I was always struggling with either a child or pregnancy. Now I have the time and energy to do more, and I think it will result in my farm being more productive."
—Muriel, a 38-year-old widow cultivator with five children ranging in age from three to 22 years, at Kibungo Health Center waiting for the FP services

"Our contraceptive rate increased from 8% in 2005 to 12.3% in 2006 because we increased our efforts at sensitizing families to come for family planning services at our health center."
—Epiphanie, Director of Kibungo Health Center, a Twubakane-supported health facility

Repositioning Family Planning: The year 2006 was an important one for family planning in Rwanda. In November 2006, the 2005 Demographic Health Survey was released, showing that the use of modern contraceptives had more than doubled since 2000, increasing from 4% to 10.3%. At the district level, Twubakane offered a series of orientation sessions for local authorities on population and health issues related to family planning. The Twubakane Program sponsored clinical trainings for providers in FP methods and reintroduced long-term FP methods at the health center level. Anecdotal evidence indicates that there is a great demand for these methods, particularly the Jadelle implants that assure five years of protection. (See Annex 1, tables 3 and 6 for additional details.)

"I was using the three months' injectable. Now I want to change to a long-lasting method so that I can pursue my studies. I will choose the five-year implant."
—Uwamahoro, 27, mother of two

Utilization would have been even higher if not for some unfortunate stock outs due to extremely high demand for implants and problems in obtaining intrauterine device (IUD) insertion kits. Twubakane is working with the MINISANTE, other partners and health centers to resolve these problems, especially to ensure that contraceptive commodity forecasting meets the needs in this context of rapidly rising use.

An important component of improving service provision is formative supervision of providers. Throughout the year, Twubakane has worked with district health staff to follow up on trainings offered and problem solve with health center staff on issues such as stock outs, patient flow and staffing patterns with increased demand.

Much effort focused on preparing an updated curriculum and strategy to train providers in FP throughout Rwanda. Three key partners—UNFPA, Capacity Project/IntraHealth and the Twubakane Program—agreed upon a plan to sponsor three rounds of trainings in 2007 to create a nationwide training pool in all 30 districts. These trainings are part of a joint workplan among USAID-funded family planning partners, including PSI, the Capacity Project and Twubakane.

An important and innovative intervention initiated in 2006 was the establishment of eight secondary posts for FP in collaboration with Catholic health facilities (which do not offer all FP methods). To set up these posts, the administrative authorities offer a room, often in the sector offices, and Twubakane supports the purchase of supplies and equipment. For most of the secondary posts, the health facility itself provides the trained health care provider. Initial data have shown that the secondary posts are contributing greatly to satisfying unmet need for FP among clients of these facilities.

- Financed production of 800 flipcharts in Kinyarwanda as part of revised information, education and communication/behavior change communications (IEC/BCC) material development

- Trained and supplied health facilities in 11 districts with Standard Days Methods (SDM) in collaboration with Georgetown University's Institute for Reproductive Health Awareness Project, thereby increasing the methods available to couples.

Improving Access to Safe Motherhood Services

"Before, we transferred cesarean cases to Kibungo Hospital and risked delays and danger en route. Now, we have reopened our 'salle d'operation,' and we are even performing cesareans to help mothers who have complications while giving birth."—Kipendo, service provider, Rwinkwavu Hospital

Twubakane initiated activities in 2006 that will contribute to reduction of maternal mortality and expansion of reproductive health services available to families. Seven hospital based teams of trainers have been trained in emergency obstetric and neonatal care. These trainers' skills have been validated, and they are beginning to train health center level providers in 2007. As part of this training, the practice of Active Management of Third Stage Labor (AMTSL) was taught, and hospital staff has already seen a reduction in the number of hemorrhages during delivery. To complement this work, many districts are including safe motherhood projects in their District Incentive Funds grants and purchasing equipment for health centers such as delivery beds or traditional ambulances to facilitate referrals.

A shift toward focused antenatal care, whereby women access care earlier and often and receive high-quality integrated services, has been underway in Rwanda since 2005 (see Annex 1, Table 2, antenatal care). As part of the integration process, Twubakane used the 2005 training on intermittent presumptive treatment (IPT) to update providers on the complete package of services comprising focused antenatal care (FANC), and continued to support supervision of FANC services this year. During 2006, Twubakane also supported mobilization of local authorities and communities to encourage use of maternal health services, and emphasized the necessity of inclusion of FANC in the national Strategy for Reduction of Maternal Mortality as a component of high-quality integrated services. Many of the health center community-provider partnership (PAQ) teams also focused efforts on resolving problems linked to low rate of deliveries in health facilities, and documented increased rates of deliveries in facilities due to their efforts. (See Annex 4.)

- *Gender based violence (GBV) assessment:* Through this PEPFAR-funded activity, Twubakane is supporting an initiative to improve prevention and management of GBV in the context of antenatal care/prevention of mother-to-child transmission (ANC/PMTCT) services. The preparatory work for the assessment was completed in 2006, and the assessment will be conducted in 2007 once all necessary approvals are received.

- *Gender work with ProFemmes, RALGA:* Orientation provided to both organizations about gender integration approaches and a gender-sensitive approach in decentralization and health programs. Both organizations gained understanding of how they could intervene at the district level.

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

"I'm very happy with this program, and I thank all the people who introduced it. My two young children were treated with medicine provided by our neighbor, who is distributing malaria drugs. They are now healthy. Before, I had to go to the health center, which is very far away from my home, and I had to pay a lot more money."
—Verena, 30, mother of four. Two of her children were treated by an HBM community health distributor for Masaka Health Center

"Since we introduced Home Based Management for malaria, we are no longer overwhelmed by many patients at the health center. Most of the fever cases are treated at the community level by community distributors, and we receive only severe cases and have time for preventive activities."
—Sister Scholastique, a nurse at Masaka Health Center, Kicukiro District, one of the health centers where the Twubakane Program is supporting HBM

Improving Prevention and Treatment of Malaria

The designation of Rwanda as a President's Malaria Initiative (PMI) country is fitting: Malaria is responsible for at least 40% of all hospital consultations. In the first quarter of 2006, the national Home Based Management (HBM) for malaria fever was launched in collaboration with the National Integrated Malaria Control Program (NIMCP) with Twubakane's support. By the end of the year, ten health centers were supporting HBM services in the districts of Nyarugenge, Kicukiro and Gasabo. Over the course of the year, 662 community health workers were trained to administer Amodiaquine/Sulfadoxine-pyrimethamine (AQ/SP) treatment to children under five suspected of having malaria. Data from the three districts show that between July and December 2006, a total of 6,560 children with malaria were treated at the community level; 84.2% of them were treated within 24 hours of fever onset and in 94.5% of the cases, the fever was cured. At the end of the year, plans had begun for expansion of this key service through funding from PMI such that next year 14 districts will be covered by HBM programs with support from international nongovernmental organizations (NGOs) and the National Integrated Malaria Control Program.

Neonatal care in hospital.

In 2005, Twubakane had trained 546 health care providers (250 in Twubakane districts) in the use of IPT in the context of integrated focused antenatal care. In November 2006 follow-up visits with health centers were conducted to measure use of IPT during antenatal care. Twubakane found that less than 60% of pregnant women were receiving the recommended two doses. Reasons include incorrect estimations of target populations resulting in false calculations of coverage, stock outs and need for increased outreach in communities about the importance of IPT. Twubakane has helped districts create improvement strategies and will include training health center staff on IPT along with focused antenatal care as part of the FY07 PMI Malaria Operational Plan (MOP).

Availability and distribution of insecticide treated nets (ITNs) have been an ongoing challenge for Rwanda in 2006. Because the use of ITNs is vital for malaria control, and because this was one of the key indicators included in the performance-based contracts signed between the mayors and the President of the Republic, districts are eager to resolve the problem. Twubakane has facilitated meetings, along with the National Integrated Malaria Control Program (NIMCP), to help district staff and partners solve this problem. With the start of the PMI, the supply and distribution of ITNs is expected to improve. Twubakane has helped distribute available ITNs through ANC and as part of DIF grant activities.

- Twubakane procured 1.75 million tablets of sulfadoxine-pyrimethamine (SP) to cover needs for Rwanda through mid-2007. Additional purchasing is included in the PMI plan for FY07.
- Twubakane trained 32 hospital staff members in Kigali on Coartem, the new ACT medication being introduced in Rwanda. Hospital staff will now train health center staff members in their catchment areas.

Integrated Management of Childhood Illnesses (IMCI)/Nutrition

"We are no longer registering as many cases of severe malnutrition as we did before the introduction of the community based nutrition program. All of the parents have been sensitized to their role in fighting malnutrition—we do monitoring in every family and advise them on what to do if the child is tending toward malnutrition."
—A community health worker in Kirehe District

Nutrition
Twubakane continues to advocate for and support improved nutrition in young children in Rwanda, an important intervention, as the 2005 DHS showed that nearly half of Rwandan children under five suffer from some form of malnutrition. This year, Twubakane focused on laying the foundation for a community based nutrition program in three districts—Kayonza, Kirehe and Ngoma. In collaboration with the national nutrition technical working group, training modules and monitoring tools were developed. Twubakane trained 82 health center staff and 290 community health workers and procured and distributed supplies needed for implementation, including baby weighing scales, client registers and BCC materials. Each district health center is prepared to start three community based nutrition sites. In 2007, this approach will be rolled out to the other Twubakane-supported districts, in conjunction with community based IMCI.

Integrated Management of Childhood Illnesses
Twubakane supported the MINISANTE MCH Task Force desk to develop the three-component IMCI operational plan: health provider training, health system improvement and community IMCI promotion. Twubakane worked with other IMCI partners to reach consensus on harmonized activities to avoid duplication of efforts. Training started with instruction for 20 trainers and 30 providers in six districts supported by partners, including UNICEF, IRC and Concern. Selection of target health centers in each of the 12 Twubakane districts also occurred. Start up, however, has been slow; supervision visits in the fourth quarter revealed that only four of 12 health centers had initiated IMCI activities. Twubakane is offering additional support to the health centers to ensure that IMCI is implemented.

Component 3: Decentralization Planning, Policy and Management

Support to Rwandese Association of Local Government Authorities (RALGA)

"With the support of the Twubakane Program, RALGA has remarkably improved its interventions; and we have a permanent employee paid by Twubakane who is supporting us in capacity building, one of the pillars and raison d'etre of RALGA. We are really grateful for Twubakane's support."
—Johnson Mugaga, Executive Secretary, RALGA

RALGA has the mandate to strengthen its members—local governments of Rwanda—and advocate for their interests. Twubakane also supports two staff members, RALGA's Capacity Building Officer, and the Communications Officer (hired in early 2007). In 2006, most of the support focused on assisting RALGA with mobilization of its members following the new phase of decentralization. Twubakane assisted RALGA with organizational development (job descriptions, recruitment and orientation of members from the 30 districts), conducting the first general assembly meeting and election of a Board of Directors, and supported development of their strategic plan for 2006-2008. Two intensive support activities have been to 1) assist RALGA with conducting a Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment in each of the 30 districts and 2) plan and contract a grant for Anti-corruption and Transparency. The SWOT self-assessments were completed at the

Infant treated during national campaign.

end of 2006, focusing first on strengths and weaknesses; a second phase will focus on opportunities and threats and will help districts integrate the process into the *imihigo* and regular planning process of local governments. The process received many positive comments and helped participants realize the vast range of capacities a local government needs to accomplish its tasks and responsibilities.

Some of the key findings, according to the districts' self-assessments, are that districts:

- Are equipped with a fair level of capacity to fulfill their tasks and responsibilities
- Feel confident that they are well prepared to fully implement decentralization
- Believe that they have a relatively clear understanding of their current roles and responsibilities and the administrative changes as a result of the decentralization process
- Have fair capacity to involve citizens actively in planning and decision making
- Have a high level of capacity to support decentralized health care service delivery and management.

Capacity areas that are considered rather weak include: Information Communication Technology (ICT) and database infrastructure and expertise; disaster management; fuel, energy and transportation; and vocational training.

The Anti-corruption Initiative will provide $141,000 for one year to RALGA with targeted technical assistance from partners RTI International and VNG, and is designed to strengthen the capacity of local governments in Rwanda to govern in a more transparent, accountable, effective and efficient manner. Through this initiative, a variety of training and educational activities will support districts in ensuring transparency in their work.

Health Care Financing

The National Health Accounts is an annual process to inform policy and serve the needs of the government and other Rwandan health sector stakeholders, including program directors, policy makers and development partners. In order to conduct the assessment annually, MINISANTE has recognized the need for capacity building. This past year, Twubakane focused on helping to institutionalize the process whereby local capacity is being built to sustain the process in future years. All the partners working on this effort have developed a comprehensive plan in collaboration with MINISANTE to coordinate training, surveys and analysis. A memorandum of understanding (MOU) was signed at the end of 2006 by all partners contributing technically and financially to the NHA workplan. These include GTZ, BTC, WHO, National University of Rwanda's School of Public Health and Health Systems 20/20 (led by Abt and RTI). All partners plan to finish the 2006 assessment by the third quarter of 2007.

Training *mutuelles* managers.

District Health Plans

One of the essential components to decentralization in Rwanda is that each district creates its own performance contract with the central government based on the particular needs/situation of the district. In order to prepare for these contracts, the districts also develop a district health plan each year. In late 2006, MINISANTE asked for district health plans by mid-December, a deadline most districts were unable to meet. With assistance from Twubakane, BTC, GTZ and WHO, a data entry form and tables and a set of easy instructions for districts to follow were developed. Upon receipt of the instructions from MINISANTE, districts sought Twubakane staff assistance with preparation of the health operational plans and that of the *imihigo* performance contract reports.

Transferring More Resources to Districts

In order for district health services to function, they need funding transferred from the central to the district level. An essential component of the Fiscal Decentralization Policy is how these funds will be transferred and is described by the equalization formula. In September, the Government of Rwanda (GOR) cabinet also approved an increase in the percentage allocation to local governments from 3% to 5% of central government resources; this increase had been recommended by Twubakane and RALGA as part of changes to decentralization policies and laws. This will support increased local financial autonomy.

Support to Pro-Femmes

To support the involvement of civil society in health and decentralization, the Twubakane Program also worked in collaboration with Pro-Femmes, a network of 48 Rwandan associations and organizations working on the promotion of women, peace and development. In 2006 Twubakane supported the organization with a subgrant to support the strengthening of the member organizations' capacity to develop and implement projects, especially projects related to general health, the prevention of gender based violence, and the reduction of maternal mortality. With support from Twubakane, Pro-Femmes conducted an institutional assessment and developed a capacity-building plan for its member organizations. Pro-Femmes also organized workshops and seminars on gender and gender based violence for member organizations, and trained member organizations' staff in developing, managing and evaluating projects and programs.

- *Health Costing Study:* This study, intended to provide the "true costs" of providing health services, was initially conducted by the School of Public Health (SPH). The MINISANTE asked Twubakane in 2006 to work with the SPH to revise the data and complete data collection and analysis of "gaps" thereby presenting the government with a complete picture. Twubakane partner RTI now subcontracts with the SPH to undertake this study and assist

them in capacity building of the SPH to conduct this at the district level in the future.

- Twubakane provided assistance to MINALOC through the National Decentralization Implementation Strategy staff to formulate the J4 (RDSF) and the National Decentralization Implementation Support Program (NDISP) over the latter half of 2006. These will provide a guide to MINALOC, local government authorities and development partners on decentralization activities going forward. Much of the detailed work on this activity will be in 2007.
- *Joint Health Sector Review:* Twubakane assisted the MINISANTE, at their request, to plan, organize and finance the review in October 2006. Twubakane contributed facilitation and presentation information to the participants. The general objectives of the workshop were to review the status of the implementation of the Health Sector Strategic Plan (HSSP) and challenges to moving forward; to review the visions, contributions and role of MINISANTE and its development partners in advancing the work, policies and procedures of MINISANTE in the health sector.

Component 4: District-Level Capacity Building District Incentive Funds (DIF)

"In the framework of supporting the reduction of mother and child mortality, we asked the District of Nyamagabe to fund the electrification of the maternity service of the Kaduha Hospital through the DIF…The maternity service of the Kaduha Hospital now has light from solar energy thanks to funding from IntraHealth in partnership with the district and the hospital. We thank IntraHealth for its much-appreciated support, and hope for continued collaboration."
—Dr. Marc Rugemintwaza, Director, Kaduha Hospital

"I really appreciate the initiative of Twubakane and the Rwamagana District giving us these goats. I'm sure my future will be brighter; this goat is going to produce, and I will be able to pay my mutuelles *subscription fee and school fees for my children."*
—A beneficiary of a goat granted by the District of Rwamagana through the support of Twubakane DIFs

"I have never been as proud as today in my every day work: it's really encouraging to go to the community with tangible support for its development. These goats and pigs that we have granted to the people of Mageragere sector are an important achievement to me and to the District of Nyarugenge. Many thanks to the Twubakane Program, which helped us in this achievement."
—An agronomist of Nyarugenge District, in a ceremony to distribute goats and pigs to the local people's associations, through the support of DIF

After development of the DIF Procedures Manual, with input from USAID, MINALOC and MINISANTE, and extensive work with the 12 districts, the District Incentive Funds (DIFs) were officially launched in July 2006. Eleven of the districts received their initial allotment of funds by July, while the remaining district, Nyaruguru, did not receive funds until the fourth quarter of the year due to delays in planning for a major health center renovation. Each district received $100,000 for a variety of activities, including providing equipment to health facilities, supporting community mobilization activities, supporting income-generating activities to increase *mutuelles* membership, building public latrines and supporting fiscal census to increase revenues for health. The DIF grants are one of the Twubakane Program's main tools for providing the districts not only with direct funding but also with the opportunity to strengthen their budget and planning capabilities and demonstrate their management skills.

Much of the first half of 2006 focused on preparing the DIF grants manual and procedures, training the districts on the DIFs, assisting them with project identification and proposals and preparing them to receive funds. An essential capacity building step was to train district accountants in preparation and management of budgets as well as software to track funds. Three Twubakane staff with support from the five field coordinators monitored and evaluated DIF grant activities and coached district technical staff in the management of the grants and their implementation.

As with any first-year endeavor as significant as the DIFs, many challenges were encountered. Early field observation of these challenges led Twubakane staff to increase the level and intensity of support visits. Challenges include:

- Districts' difficulties in launching and managing several activities at the same time given many competing priorities
- Problem of delegation of responsibilities for project management to district-level technicians, sector technicians and local NGOs
- Lack of clear definition of roles and responsibilities of officials and technicians at the district level
- Problems with accounting procedures and expense reconciliation; district accountants overworked and not able to focus on DIF grants accounting on a regular and consistent basis unless Twubakane staff is present; receipts sometimes kept by the district technician and not turned over to the accountant in a timely fashion for data entry and processing.

A new cistern for clean water, built through DIF grant.

During the fourth quarter, the Twubakane team and districts began to prepare for the second year of grants. A management decision was made, based on the progress on Year 1 grants, to offer a no-cost extension to March 31, 2007, in order to allow the districts to complete their Year 1 projects and prepare for Year 2. As part of this preparation, two provincial peer exchange visits occurred in October (Eastern) and November (Southern). These visits allowed districts to discuss problems and share solutions and based on this prepare for the planning of 2007 DIF grants. In addition, a one-day refresher training was held for all 12 district accountants that not only focused on management of DIF funds but also highlighted challenges encountered with reporting of fund expenditures. Throughout the year, district mayors have expressed their appreciation to Twubakane for its support to their districts.

See Annex 3 on page 18 for 2006 DIF grant results by district.

- Preparation of Medium Term Expenditure Framework: Twubakane helped districts finalize their medium-term expenditure frameworks and development plans. These had to be in alignment with the Economic Development and Poverty Reduction Strategy, national sectoral strategies and the GOR's Vision 2020. Twubakane provided orientations and guidelines on MTEF preparation; several districts' DIF grants financed additional assistance.

- Assisted districts with resource mobilization strategies such as the development of tax systems, including lists of taxpayers, resource base assessment, property tax records, simplified cadastral surveys, public-private partnerships and revenue enhancement schemes.

Component 5: Health Facilities Management and *Mutuelles*

Health Care Financing—*Mutuelles*

Twubakane supports Rwanda's successful *mutuelles* program both at the national level and within the 12 districts. At the national level, Twubakane support has been provided through the technical working group and has focused on helping the *Cellule Technique d'Appui au Mutuelles de Santé (CTAMS)* with production and distribution of new guidelines, technical manuals and management tools, addressing the issue of membership and subscription fees for indigents and navigating the new *mutuelles* laws and helping determine the best ways to operationalize them. With the GTZ, Twubakane helped the CTAMS develop a system to train and supervise *mutuelles* managers in all districts such that by the end of 2006 assistance could move to other capacity building activities. This work was completed by October 2006.

Record keeping for *mutuelles*.

At the district level, Twubakane continues to provide targeted and general assistance as requested by the districts. A key area of support in 2006 was supervision of administrative and financial management of *mutuelles*. Twubakane staff provided feedback during visits and offered on-the-job training. Tracking membership numbers is important to assist districts with management of *mutuelles* and is a key indicator for Twubakane. With the new district configurations, many districts needed assistance to accurately define catchment areas, thereby permitting *mutuelles* to improve their reporting figures. By the end of 2006, the *mutuelles* enrollment rate for the 12 Twubakane-supported districts was at 66.2% (up from 31% at the end of 2005). In the 12 districts, the rate of utilization of curative health services among mutuelles members also increased from 46% in 2005 to more than 65% by the end of 2006, according to data from CTAMS and the Health Management Information System desk.

Health Facilities Management

Twubakane has been supporting health facilities at two levels over the past year: centrally and in the districts. With the decentralization process, many new staff members are leading health facilities (hospitals and health centers) and their roles, responsibilities and capacities to manage are not clear throughout the 12 districts.

At the central level, Twubakane support has been focused on revising national policies, norms and protocols for a range of health services. The process for reaching consensus on what aspects of health will be included, what each partner's role would be and understanding the sequence of steps to render the revisions logical has required a great amount of effort from all involved. By the end of 2006, MINISANTE, together with Twubakane, the Belgian Technical Cooperation (BTC), Constella Futures Group and other partners, had agreed upon a process and timeline for completing the revisions, with significant technical assistance to be provided by Twubakane. These revisions, upon completion, will have significant impact on the minimum and complementary packages of activities and the quality of services.

Twubakane used an approach aimed at integration of a range of services (e.g., FP/RH, child health, malaria, *mutuelles*) when providing assistance at the district level. Participatory workshops were held with health care providers, district and sector health officers, health centers and personnel to integrate services into their workplan and long-range strategic plans. Many district health officials did not understand the importance or need for strategic and business plans; therefore Twubakane has helped to develop these along with administrative manuals. Four hospitals—Kigeme, Gitwe, Kibagabaga and Kibungo—have been selected for targeted assistance with development of these documents, and they will work with three corresponding health centers in the process. Twubakane has noted at the health center level that effective management has

often depended on the leadership of a particular director rather than tools and procedural guidelines. This development process will help ameliorate this situation with a goal of overall improved health facilities management.

- Co-financed and supported a National *Mutuelles* Workshop that included the presentation of management tools along with the demonstration of a computer program intended to assist with managing *mutuelles* operations and finances.

Component 6: Community Engagement and Oversight *Partenariat pour l Amélioration de la Qualité* (PAQ)

The community-provider partnership approach—called *Partenariat pour l'Amélioration de la Qualité*, or PAQ—is recognized as a foundation for increasing community participation in the planning and management of health care and health care facilities at the local level. PAQ teams provide district and sector officials access to information about the quality of health services. During 2006, 80 teams were established across the 12 districts. PAQ team members include district-level technicians and various civil society organizations (including churches, youth groups, men's and women's groups, local associations). The teams addressed issues ranging from health center hygiene, health care provider attitudes, treatment adherence for different patient groups (e.g., people living with HIV/AIDS and pregnant women) and sensitizing communities on health issues (FP, ANC, child health) to medication stock outs. Twubakane staff and field coordinators support PAQ activities through regular visits, training and advocacy at the district level. Financial support to PAQ teams was included in several of the DIF grants in 2006. PAQ teams have achieved impressive results in improved service provision and in ownership of health services by the local authorities. (See Annex 4 for examples.)

> *"I was aware of all the problems that were raised in our PAQ team meeting and had even contacted concerned people to address those problems, but in vain. In just one meeting of PAQ, we came up with solutions to all those problems because all the concerned people are present in the meeting and sensitized to their roles and responsibilities, thanks to Twubakane, which introduced this PAQ approach."*
> —Maburanturo Gaspard, Director of Nzige Health Center, in Rwamagana District, Eastern Province

Minister of Health visits DIF project at Munini Health Center.

Twubakane also worked with Freeplay Foundation to train 20 trainers in the use of Lifeline radios in the 12 districts as the first step in the distribution of 180 radios. These radios will be used to support listening groups.

Twubakane's Support at Central and District Levels

Central-Level Support

The decentralization process in Rwanda has transferred much of the focus for development to the district level; however, much support is still needed at the central level in the areas of policies and activities that affect the entire country. As noted earlier, Twubakane has balanced district-level focused work with needs at the central level. Key areas of support in 2006 were in the areas of policy development or revision. A number of policies, including a) National Community Health Policy, b) Fiscal Decentralization Policy, c) Communications and d) Minimum and Complementary Package of Activities (MA/CPA) were finalized or initiated during 2006. The latter area will require a collaborative effort of many partners and will continue throughout 2007 (see Health Facilities Management section). Twubakane also continues to support both the MINISANTE and the MINALOC in key national priority areas and in responding to administrative reforms and decentralization.

Building blocks to policy development and coordination throughout Rwanda have been the effective functioning of several national coordination and technical working groups. Twubakane participates in the following groups: Health Cluster, family planning, maternal health, Integrated Management of Childhood Illnesses (IMCI) (part of MCH Task Force), nutrition, *mutuelles* and human resources. Products of these working groups include national strategies (e.g., maternal mortality), joint training plans and standardized training and BCC documents.

Twubakane has also participated in national health campaigns to promote health messages and provide mass service delivery. Examples include National Vitamin A/ITN/Measles/Mebendazole Day, during which an estimated 95% of Rwanda children were provided with ITNs, immunizations and medicine, National Breastfeeding Promotion Week, Nutritional Advocacy Day and African Malaria Day.

Recognizing the importance of health data to inform decision making, Twubakane was asked by USAID and MINISANTE to assist Rwanda with a national Health Management Information System (HMIS) assessment. The scope of work included analyzing information systems supporting MINISANTE and its dependent institutions, decentralized HIV/AIDS coordination entities and non-facility based HIV/AIDS activities and decentralized health structures such as health centers and hospitals and related health donor projects. The assessment was completed in May 2006 and recommendations were presented to stakeholders during the Health Cluster meeting. After additional discussions on the recommendations during the MINISANTE's Joint Sector Review in October, the MINISANTE determined that improving the HMIS should be its priority, and pledged to support implementation of the recommendations. A complement to this level of data collection is the Community Based Health Information System (CBIS) that

Twubakane is piloting in Kicukiro and Kirehe districts. Data collection tools and indicators have been developed with input from the MINISANTE and a variety of partners, and the tools are being tested in the two districts during the first quarter of 2007.

District-Level Support

Since the new phase of decentralization in Rwanda began in early 2006, districts have recognized Twubakane as a resource for assistance with the decentralization process, particularly where health is concerned. In March 2006, Twubakane provided assistance to districts to support them in the development of their plan for the year and performance-based contracts, which would be signed by the mayor and the President of the Republic. This assistance was participatory, involving key stakeholders at the district level, and focused on identifying "quick wins" for each district. As the year progressed, districts repeatedly asked Twubakane for additional assistance to help revise and monitor and develop plans for 2007. Many of the DIF projects included assistance relating to these contracts such as the fiscal census of tax payers, development of the MTEF, training on fiscal planning and management and resource mobilization strategies.

Good Governance Workshops

Twubakane's assistance at the district level regarding good governance started with a request from the Mayor of Kamonyi District during the second quarter to support the district in training district and sector staff in leadership and good governance. The success of this workshop led MINALOC to ask Twubakane to offer similar training to other districts. By the end of 2006, governance and leadership training was conducted, in collaboration with RALGA, in five districts: Kamonyi, Muhanga, Kicukiro, Nyarugenge and Gasabo, with more than 950 participants. The workshops addressed best practices in good governance, the importance of community participation in service delivery, roles and responsibilities of elected officials and civil servants, district laws and an orientation on budgeting and planning at the local level for better service delivery. Clarification of roles at different levels—district down to cell—was essential; this had been an apparent point of confusion for many participants.

- Partnership with Columbia/Access Project to build human capacity to deliver comprehensive quality health services with a focus on management of health services at the district level. Twubakane and Access are working together in the Kayonza District and have developed a joint approach together with the Mayor of Kayonza, the Vice Mayor for Economic Development, the District Health Officer and the *Mutuelles* Manager.
- Successful public-private partnerships: With support from Twubakane, the District of Rwamagana decided to increase revenues from the collection of market taxes by privatizing its main marketplace. The district visited Nyabihu District in the Western Province, where markets had been successfully privatized, with revenues dramatically increasing in less than four months, passing from 08 to 31 million Frw per month. The two districts plan to continue the partnership, and Twubakane plans to share lessons learned in market privatization with other districts.

Internal Program Process Milestones

Monitoring and Evaluation

The addition of one member to the M&E team has facilitated work on refining data collection systems, working with each component to ensure submission of PMP related data, and data collection when needed. Toward the end of 2006, the indicators for Twubakane were revised to correspond with the new Foreign Assistance Framework and the USAID/State Department Operational Plan.

National Steering Committee

The role of the Steering Committee is to follow the programmatic and strategic orientation and activities of the Twubakane Program and provide guidance to ensure the ongoing relevance and impact of its work. The composition of this committee—permanent secretaries of both MINALOC and MINISANTE along with district representatives and USAID—presents a scheduling challenge. Thus, the committee has not met as often as intended this year, mainly due to administrative reforms and the unavailability of a quorum of members. The Steering Committee is planning to meet in early April 2007.

Field Offices

The Twubakane Program field coordinators play pivotal roles in the program, acting as liaison agents between the Twubakane office and operations in Kigali and our program activities at the local level. In order to better support district-level work, Twubakane engaged a fifth field coordinator and two assistants. Each of the five field coordinators is currently based in one district, with an office in the district offices, and covers two to three districts. They continue to be instrumental in supporting the districts and coordinating and organizing technical activities supported by Twubakane. District-level authorities have frequently expressed their appreciation of the hands-on support they receive from the field coordinators.

Annual Retreat

Following the model of its successful team-building retreat in 2005, Twubakane held a retreat in September 2006 to give the team an opportunity to reflect on progress, ensure that activities were producing desired results, improve internal systems and document Twubakane's achievements and success stories. Outcomes of these discussions contributed to initial planning for the 2007 program year.

Clients at a family planning clinic.

ANNEXES

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Annex 1: PMP Indicater Results for 2006

Evaluation Methodology

Information from the HMIS (monthly health center data) was obtained for the 143 Twubakane health centers at baseline (2005) and a year later (2006). Information that was not available through the HMIS, or was incomplete, was obtained from rapid facility assessment surveys conducted at health centers.

Rapid Facility Assessment Surveys

A baseline survey (Rapid Facilities' Assessment) was conducted at all 143 health centers in October 2005. Given the expense of conducting a survey it was not possible to repeat the baseline survey of all 143 health centers a year later. Hence, a sub-sample of 40 health centers was selected for the follow-up survey in November 2006. The results from the 40 health centers in the 2006 survey were compared with the results from those same 40 health centers at baseline (October 2005).

These 40 health centers were selected in a non-random fashion for reasons pertaining to feasibility of the survey in a short period of time and to ensure that sufficient data could be obtained for each of the 12 Twubakane districts to provide a snapshot of results over time for each district. An effort was made to ensure sufficient rural-urban diversity in the selection of health centers.

The method of selection was to choose four health centers from districts that did not have a hospital and three health centers from districts that had a hospital (in the latter districts the survey included one hospital and those hospital results were analyzed separately from the health centers). In each district one urban health center was selected and the others were rural or semi-rural. For the purpose of this survey the evaluators classified a health center as rural/semi-rural or urban based on its proximity to an administrative center and commercial enterprises.

The survey was conducted by sending data collectors to the 40 health centers to conduct an interview with a representative of the health center, i.e. the health center manager or a staff member appointed by the manager. Often the health center representative called in another staff member to provide or confirm data. When needed, the data collectors asked to see documentation to verify results (e.g., to confirm that refrigerators had an appropriate temperature for vaccine storage the data collectors looked at daily records posted on the refrigerators).

SWOT Assessment

A 'Strengths, Weaknesses, Opportunities, Threats' capacity self-assessment was conducted in October 2005 in all Twubakane districts with district and sector officials. Data was extracted from the

Table 1. Health Centers in Twubakane and in the Sub-Sample of 40 Health Centers

Rural-Urban Location of Health Centers+	Twubakane	Sub-Sample of 40 Health Centers
Rural or Semi-Rural	79%	72.5%
Urban	21%	27.5%

\+ As indicated above, the determination of rural-urban location was made by the evaluation team based on proximity of the health center to an administrative district and commercial enterprises.

Table 2. Client Utilization of MCH/RH Services in Twubakane Project Area

Indicators	2004/2005 + Baseline Results	2005/2006 + Mid-Term Results	2004/2005 to 2005/2006 % Change Results
Couple Years Protection	31,277†	**48,883†**	**+ 56%**
Children Who Received DTP3 Immunizations	105,401~	**107,176~**	**+ 1.7%**
ANC Clients who had 4 Antenatal Care Visits^	6,895~	**10,581~**	**+ 53%**

\+ Baseline: October 2004–September 2005; Mid-Term October 2005–September 2006

† CYP data were obtained from the Deliver Project, which collects monthly data from health centers, hospitals and health posts.

~ Data on DTP3 and ANC were obtained by Twubakane from health centers' monthly reports.

^ Because we observed data entry problems at health centers in recording four "standard visits" at appropriate stages in the pregnancy we interpret the four visits simply as visits at any time during the pregnancy and not as "standard visits."

SWOT on planning and public reporting of health sector activities and financial management for Twubakane's baseline.

The 56% increase in CYP reported above reflects the increased emphasis in Rwanda on family planning as well as the combined efforts of local health services and the Twubakane Program. At the national level there were two relevant developments during this reporting period: family planning was a priority area in performance contracts districts signed with the President of the Republic and authorization was given to health centers to offer long-term methods. Also notable was the Twubakane project's intensive training of service providers in the use of long term methods and its follow-up to ensure the quality of their services after training. This enabled health care centers to begin offering long-term methods like IUDs and Norplant. Twubakane's distribution to districts of cycle beads also made the Standard Days Method more accessible to health center clients.

There was also a sizeable increase (+56%) in the number of pregnant women having four ANC visits during their pregnancy. (Note: because we observed data entry problems at health centers in recording four "standard visits" at appropriate stages in the pregnancy we interpret the four visits simply as visits at any time during the pregnancy and not as "standard visits"). While this increase in the number of women having four ANC visits still represents a small minority of all pregnant women who gave birth during this period, it is, nonetheless, a notable result.

One factor contributing to this increase in ANC visits may have been the fact that in health centers receiving Twubakane support, more services were offered to women during antenatal visits. This is the focused antenatal care approach in which multiple services are offered to clients at the same time. Twubakane provided training in focused ANC to service providers in health centers. In addition, Twubakane conducted leadership workshops with officials from districts, sectors and cells and with community representatives in which the importance of ANC was emphasized in presentations on reproductive health. Attendees (including representatives from women's organizations) were both sensitized and mobilized to educate women in their community about the importance of ANC.

The 1.7% increase in the number of children receiving the DTP3 immunizations was less than the estimated population growth rate in Rwanda (2.43% in 2005); hence, there was no change in the coverage rate for DTP3 immunizations. Most children continue to receive the DTP3 immunizations. According to the 2000 DHS, the coverage rate of DTP3 in the Twubakane Program area was 84%; this is unlikely to have changed significantly since then (similarly it remained nearly static in all of Rwanda from 2000 to 2005).

Table 3. Provision of Family Health Services in Health Centers

Indicators	October 2005 Entire Twubakane Program Area	October 2005 Sample of 40 Twubakane Health Centers^	November 2006 Sample of 40 Twubakane Health Centers^
Percent health centers providing minimum package of activities (MPA) in family health	3%	3%	20%
Specific activities in MPA+			
Prenuptial consultations	10%	8%	43%
Prenatal consultations	93%	100%	100%
Infant Delivery	84%	85%+	85%+
Post-natal consultations	47%	60%	65%
Post-abortion Care	62%	68%†	65%†
Family Planning	75%	83%	85%
Vaccinations	93%	100%	100%
Growth Monitoring	83%	83%	85%
Percent health centers with functional cold chains able to store vaccines~	59%	70%	77%
Percent health centers providing modern contraceptive methods	73%	80%	80%
Of health centers providing modern contraception, % offering different methods:			
IUD	2%	3%	19%
Norplant Implants	11%	16%	34%
Injectables	99%	100%	100%
Oral Contraceptives	99%	100%	100%
Male Condom	98%	100%	100%
Female Condom	18%	28%	25%
Standard Days Method	11%	13%	69%
Average # of modern contraceptive methods offered by health centers providing contraception	3.32	3.72	4.5

^ The same 40 health centers were assessed in 2005 and 2006.
+ The seven health centers that did not provide delivery services were located adjacent or very close to a hospital that did.
† One health center indicated in 2005 that it provided post-abortion care but in 2006 that it did not. It is improbable that this reflects a discontinuation of the service in that center. It is more likely that different respondents at that health center in those two years interpreted the question differently.
~ This means a health center with a refrigerator functioning with the appropriate temperature for vaccine storage.

The increase in the percent of health centers offering the full minimum package of activities (from 3% to 20%) was attributable to the large increase in the number of health centers offering prenuptial services (from 8% to 43%). This increase in prenuptial counseling is likely connected to HIV-testing. As most health centers are now able to provide VCT services they are also able to offer prenuptial counseling.

Some churches now request or require parishioners to obtain prenuptial counseling, with the HIV testing it includes, before marrying.

It should be noted that in our sample of 40 health centers, seven centers were adjacent or in very close proximity to hospitals that provide services included in the MPA. Hence, when services such as delivery services are not available in those health centers they are, nonetheless, available nearby.

The other notable change in Table 2 was the increase in percentages of health centers offering long-term family planning methods (IUD, Norplant) and the fixed days method. This resulted in an increase in the average number of contraceptive methods offered by health centers. This result is no doubt attributable in large part to the authorization health centers received to offer long term methods and to Twubakane's intensive training and follow-up supervision of service providers in the use of long term methods and in the standard day method. In addition, Twubakane's distribution to districts of cycle beads for the standard days method made this method more accessible in health centers. A further contributing factor may have been the leadership workshops Twubakane offered to district, sector and cell officials and community representatives; these workshops included a presentation on family planning methods.

One aspect of family planning services that did not change during the reporting period was the percent of health centers offering any modern method of contraception (80%). This was because most faith based health centers in the sample did not offer family planning services.

From 2005 to 2006 there was a sizeable increase in the percent of health centers reported to be enrolling more than 50% of their catchment population in *mutuelles*. This was no doubt influenced by the fact that in 2006 a law was passed mandating that all Rwandans should have health insurance and districts signed performance contracts with the President's Office in which *mutuelles* figured as a priority area.

Table 4. Health Centers: *Mutuelles* and Community Engagement

Indicators	October 2005 All Twubakane Health Centers	October 2005 Sample of 40 Twubakane Health Centers^	November 2006 Sample of 40 Twubakane Health Centers^
Percent of health centers reported to have more than 50% of their catchment population registered in *mutuelles*	13%	**10% +**	**78%**
Percent of health centers with a PAQ ~	11%	**15%**	**78%**
At health centers with PAQs, frequency of PAQ meetings:	Not asked	**Not asked**	
Once per month			**81%**
Every two months			**10%**
Once per trimester			**3%**
Other			**7%**

^ The same 40 health centers were assessed in 2005 and in 2006
+ This low percent would mainly be attributable to actual low enrollments in *mutuelles*; however, it is also true that there was a significant amount of missing data on membership in *mutuelles* at that time.
~ PAQ=*Partenariat pour l'Amelioration de Qualité* [of health services]

Twubakane contributed to the *mutuelles* by providing funding through the District Incentive Funds to support mutuelle associations and offering training in mutuelle management to mutuelle committees. These contributions, intended to improve *mutuelles*' management and service provision, better positioned them to increase enrollments. It is also true, however, that there was a significant amount of missing data on membership in 2005, when *mutuelles* were just getting underway, and this likely resulted in underestimates of enrollment at baseline in 2005.

Another notable result was the considerable increase (15% to 78%) in health centers with a PAQ. The PAQs were initiated by Twubakane's predecessor, the PRIME Project (also led by IntraHealth), as a means of bringing communities and health centers together to improve the quality of local health services. The great expansion in PAQs in 2006 was attributable in large part to Twubakane's focus on establishing PAQs in health centers where they did not exist and on sensitizing community leaders to them.

The results on district health care management cannot, at present, be compared with any previous results as the SWOT analysis has been conducted only once. Table 4 indicates that there is considerable room for improvement in districts' public reporting on their financial performance and on health sector activities.

For the few health centers (8%) with mechanisms to publicly report on their financial performance the most common mechanisms were public meetings and pamphlets. For health centers with mechanisms to publicly report on their health sector activities, the most common mechanisms were: public meetings, radio messages and information boards.

Table 5. District Management*

Indicator	Baseline information (for the 12 Districts) October 2006
Percentage of districts that have at least two mechanisms (one written and one oral) in place for public reporting on health sector activities+	58%
Percentage of districts that have at least two mechanisms (one written and one oral) in place for public reporting on their financial performance+	8%
Percentage of districts reporting and documenting mechanisms implemented to obtain citizen participation in developing plans and budgets	92%
Percentage of districts with annual plans and an MTEF† that include the full range of health activities^	100%

*This information was obtained from a SWOT assessment ("Strengths, Weaknesses, Opportunities, Threats" assessment of district and sector officials) conducted by Twubakane in October 2006.
+Mechanisms may include public meetings, newsletters, pamphlets, information boards, posters, etc.
†MTEF = Medium Term Expenditure Framework
^Full range of health activities includes prevention, treatment/promotion, infrastructure, equipment, staffing.

Annex 2: Training Activities 2006

	Content Area	Number of People Trained	Types of Trainees
Component One. Family Planning/Reproductive Health Access and Quality			
Subcomponent: Family Planning			
	All FP methods (include long and short term methods)	124	Health center staff/providers from Twubakane supported districts
	Short-term methods	87	Health center staff/providers representing Twubakane supported districts
	Long-term methods (Norplant, Jadel, IUD)	37	Health center staff/providers representing Twubakane supported districts
	Supervisors of FP	6	District supervisors
	All FP methods	140	Community Health Workers
		24	Service providers; (all health facilities in 12 districts have at least one trained provider)
	Orientation to FP (+RH)	983	District/sector authorities
	Standard Days Method	60	Health center providers
Subcomponent: Reproductive Health			
	EONC	7 teams of 3 providers (21 trainers)	Each team composed of 1 physician, 1 midwife, 1 anesthetist
Component Two. Child Health/Nutrition/Malaria			
Subcomponent: Malaria			
	HBM Program Clinical Training	42 trainers	Providers, Trainers (health care providers)
	HBM Program Orientation	276	Manager/Supervisors (40) and local authorities (263)
	HBM Program Distributors	662	Community Health Workers
	Coartem for Malaria Case Management	32	Hospital staff (physicians, chiefs of nursing, supervisors and nurses)
Subcomponent: Child Health			
	IMCI Training of Trainers	20	National trainers and medical doctors
	IMCI Clinical Training	30	Health care providers
	CBN/HEARTH Training of Trainers	103	Clinical Trainers
	CBN/HEARTH Program Training	26	Community based health workers
Component Three. Decentralization Policy, Planning and Management			
	New Financial Management and Reporting Software (FMAN SOFT)	30	District Accountants from all 30 districts

Training Activities			
	Content Area	**Number of People Trained**	**Types of Trainees**
Component Four. District Capacity Building			
	Development of district plans, providing technical assistance to health components of plans	124	District teams
	District Incentive Funds (DIF) Orientation	304	Mayors and District Authorities (36) and Technical Teams (268)
	Orientation and training to prepare budgets according to DIF procedures	12	District accountants
	District Good Governance and Leadership Workshops	983	Muhanga, Kamonyi, Ruhango, Kicukiro, and Nyarugenge district civil servants, district officials and technical staff at district and sector levels
	Refresher training on financial management, accounting best practices and better tracking the DIF grants accounting.	12	District Accountants
	Participatory planning and budgeting workshops for 2007 Imihigo contracts.	120	Muhanga, Kamonyi, and Kirehe District officials
Component Five. Health Facilities Management and *Mutuelles*			
	Administration and financial *mutuelles* management	529	*Mutuelles* managers and health officials
Component Six. Community Engagement, Participation and Oversight			
	PAQ Teams Training on family health (FP/RH, CS/M/N, establishing and supporting PAQ teams)	106	PAQ Facilitators: district level technicians, representatives of civil society organizations.
	Lifeline Radios Training of Trainers in radio use	20	District Health and ICT officers
Cross Cutting Themes			
	Gender gender-integration approaches and gender-sensitive approach in decentralization and health programs	20	Pro-Femmes, RALGA, Capacity and Twubakane staff

CBN	Community Based Nutrition
DIF	District Incentive Fund
EONC	Emergency Obstetric and Neonatal Care
HBM	Home Based Management of Malaria Fever
IMCI	Integrated Management of Childhood Illness
PAQ	*Partenariat pour l'Amélioration de la Qualité*

Annex 3: District Incentive Funds Activities Completed in 2006

KIGALI

1. Gasabo		
	Activities	**Achievements**
1.	Development of income-generating activities to increase *mutuelles* membership, as verified by number of child-headed households participating in income-generating activities	15 income-generating activities implemented by child-headed households
2.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base available List of taxpayers increased from 7,000 to 40,700
3.	Purchase, distribution and promotion of 10,000 insecticide-treated nets to promote malaria prevention and reduction of mosquito breeding sites by the drainage of stagnant water ponds within the District	1000 (instead of 10,000 due to supply problems) ITN purchased and distributed to the sectors

2. Kicukiro		
	Activities	**Achievements**
1.	Increasing access to family planning services, as verified by the establishment of five new sites practicing advanced outreach strategy	100 persons (from National Youth Council, National Women's Council, health educators) oriented on FP 140 elected officials and health educators trained/oriented on FP 14 providers trained in clinical FP
2.	Supporting prevention of diarrheal disease, as verified by construction of 1,500 latrines	Two public modern latrines constructed in two sectors of the Kicukiro District More than 1,500 households oriented in construction/use of latrines
3.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base available 340,000 taxpayers assessed

3. Nyarugenge		
	Activities	**Achievements**
1.	Support to an income-generating activity and increased and improved nutritional services of the local population, as verified by the creation and management of vegetable gardens and associations of producers in the sector of Mageragere	250 households, of which the most are widows, benefited Five tons of manure purchased 15 hectares of vegetables planted
2.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base available List of taxpayers increased from 8,600 to 27,000

Annex 3: District Incentive Funds Activities Completed in 2006

EASTERN PROVINCE

4. Ngoma		
	Activities	**Achievements**
1.	Support to construct 640 improved wood stoves	685 improved wood stoves constructed, used by households
2.	Supporting for prevention of diarrheal disease, as verified by the construction of 56 latrines at public markets and commercial centers	56 public latrines constructed
3.	Support to improved hygiene and water quality/quantity through the construction of 20 demonstration rain-water catchment cisterns at community health worker sites at the cell level	48 cisterns constructed

5. Kirehe		
	Activities	**Achievements**
1.	Strengthen the financial planning, budgeting and resource mobilization capacity of the District of Kirehe, as verified by the production of the 2007-2009 MTEF planning exercise and reports of the district team	Mid-Term Expenditure Framework document available and used
2.	Support for the reduction of morbidity and improved hygiene in the local population, as verified by the training of 180 community health workers (three per cell) in best practices for public hygiene campaigns	180 community health workers trained in best practices in hygiene and sanitation
3.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base of taxpayers available as tool for planning

6. Kayonza		
	Activities	**Achievements**
1.	Renovation and equipment of district offices, as verified by presence of office equipment and partitions	Eleven computers purchased, placed in the district and sector offices
2.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base of taxpayers available

7. Rwamagana		
	Activities	**Achievements**
1.	Support to raising goats as an income-generating activities for indigents to improve *mutuelles* membership, as verified by purchase and distribution of 1968 goats	1968 indigents benefited; 24 goats distributed in each cell (82 cells)
2.	Purchase, distribution and promotion of 8500 insecticide-treated nets to promote malaria prevention, as verified by purchase and documentation of distribution and promotional activities	12,000 ITNs were purchased and distributed to households

Annex 3: District Incentive Funds Activities Completed in 2006

SOUTHERN PROVINCE

8. Kamonyi

	Activities	Achievements
1.	Support to improved hygiene and water quality/quantity through the construction of a rain-water catchment cistern and a ten-unit latrine at the Remera-Rukoma school compound	Ten improved and ventilated latrines constructed Four cisterns constructed
2.	Purchase medical equipment for the ten district health centers and hospital, as verified by the presence and use of the equipment	Equipment procured for health centers/hospital
3.	Strengthen planning, resource mobilization, monitoring and evaluation capacity of the District of Kamonyi, as verified by work plans, workshop and training reports of the district team	Capacity-building workshop held Planning work sessions held and corresponding documents produced (MTEF, operational plan, performance plan)

9. Muhanga

	Activities	Achievements
1.	Strengthen planning, resource mobilization, monitoring and evaluation capacity of the District of Muhanga, as verified by workshop and training reports of the district team	Workshops held to develop MTEF, performance and operational plans Fiscal assessment, list of tax payers was established
2.	Purchase medical equipment for health centers in Nyabinoni and Gasovu, as verified by presence of equipment in health centers	Medical equipment procured, delivered to health centers
3.	Support to district pharmacy	District pharmacy was assisted by the supply of medicines valued at 8,000,000 Frw

10. Ruhango

	Activities	Achievements
1.	Support for safe motherhood through purchase of equipment for health centers and district hospital	Equipment procured for hospital in Gitwe
2.	Support for increased *mutuelles* membership among indigents, as verified by the purchase of 1000 goats for income-generating activities	700 goats and 200 piglets provided to indigents
3.	Support to update taxpayers data base, as verified by availability of the tax payers lists in cells and sectors	Complete data base of taxpayers available
4.	Support to strengthen ICT, as verified by purchase of computers and installation of network	Seven computers, five UPS, two printers and one photo-copier procured Computers were connected to internet

Annex 3: District Incentive Funds Activities Completed in 2006

SOUTHERN PROVINCE

11. Nyamagabe		
	Activities	**Achievements**
1.	Support for increased *mutuelles* membership among indigents, as verified by the plantation of passion fruit in 5 sectors	Activity began in 5 sectors
2.	Support for the reduction of maternal and neonatal mortality through awareness-raising campaigns, improved reference system, and solar energy installations in Kigeme Hospital and Kaduha Hospital	Sensitization meetings organized by community health agents in each cellule, and in health centers during antenatal visits Fuel supplied to make ambulances available for referrals Solar energy installed and operational in Kaduha Hospital

12. Nyaruguru		
	Activities	**Achievements**
1.	Renovation and equipment of Munini Health Center, including addition of consultation rooms and in-patient wards	Renovation work began, to be completed by March 2007

Annex 4: Results from Selected PAQ Teams, Twubakane Districts, 2006

Kigali

Districts	PAQ Teams	Achievements
Gasabo	**Kagugu**	• Employment of three additional nurses and a doctor that visits twice per week • Poor reception has been resolved: a receptionist was recruited and hired • Creation of new consultation room to reduce waiting time • Improve respect of work hours
	Jali	• Construction of laundry line to dry inpatient gowns • Purchase of additional sheets and blankets for inpatient beds. • Improvement in hygiene: an additional cleaning person recruited and hired
Kicukiro	**Kabuga**	• Construction of incinerator • Improved reception • Election of health committee that previously did not exist
Nyarugenge	**Butamwa**	• Stock outs existed; HC took measures to resolve the problem and no more stockouts are occurring. • Improved hygiene–toilettes and inpatient rooms – by hiring a staff person • Through regular HC staff meetings, measures identified to improve quality of services

Eastern Province

Districts	PAQ Teams	Achievements
Ngoma	**Gituku**	• Regular meetings held and outcomes documented (true for most PAQ teams) • Deliveries at health center increased from zero to 32/month; staff member added in reception to welcome clients • Visited 150 households to determine if they have ITNs and are using them; only 50 have and use ITNs; remaining would like to buy one
	Rukura	• Frequency of client visits increased from 50 to 80 per day • Suggestion box created and paint purchased for beautification • Two water cisterns purchased and installed
Kirehe	**Nasho**	• The use of the HC has increased: between 350-400 patients per month vs. 100-150 before the PAQ team started • The activities of the health agents and traditional birth attendants are better organized with the HC • Communication between the HC and the community about health has become easier
Kayonza	**Nyamirama**	• Improved behavior by providers to improve reception • Increased use of the health posts after education of village members • Transport of TB patients to the health post where they can regularly take medication; previously many non-compliant TB patients
	Ndego	• Inventory of traditional practitioners to establish association. • Improved organization of services; PAQ team in collaboration with health committee defined work hours and assure these are respected • Construction of kitchen and store room by community work group
Rwamagana	**Rubona**	• Deliveries at the HC have increased from 11% to 44% in five months • ANC clients increased from 70% to 90% in five months • Creation of a revolving fund to allow team members access to funds if needed
	Nzige	• Acquisition of hospital equipment (25 beds, 25 mattresses, 60 sets of sheets, 45 blankets) donated by EGPAF • Renovation and maintenance (paint, gardens/grounds, toilets) • Organized awareness-raising events for *mutuelles*; membership increased from 43% to 60% in two months • Creation of new association, "Health Stars," to promote improved quality of services and community mobilization for increased use of services

Annex 4: Results from Selected PAQ Teams, Twubakane Districts, 2006

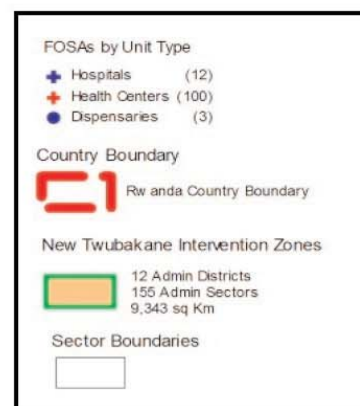
Southern Province

Districts	PAQ Teams	Achievements
Kamonyi	**Gihara**	• Reenforcement of health care personnel through recruitment of two nurses and a laboratory technician • Repairs to the road leading to the HC • Reorganization of the *mutuelles* led to increased membership (25% to 45%)
Muhanga	**Nyabinoni**	• Furnishing of the night-guard room • *Mutuelles* membership increased from 17 to 65% during four months; rate of re-enrolment was 27% at the end of January 2007 • Development of nutrition education project and promotion of home gardens for improved nutrition
	Gasovu	• Creation of a position to address integration of FP, vaccination and issues related to inaccessiblity due to geographic location • Involvement of churches in education about health issues • Creation of a sub-committee to monitor the achievements of the PAQ team
Ruhango	**Karambi**	• Repair to a bridge connecting the HC to the cells of the Karambi sector • Delivery rate has increased from 15% to 35% • The services at the HC are better organized and the hygiene has improved
Nyamagabe	**Kitabi**	• Integration of FP, vaccination, and VCT services • Health committee purchased needed materials • Reorganization of services and creation of an additional position to increase access to services
	Mbuga	• Integration of FP and vaccination services • Frequency of visits increased • Creation of a sub-group for education to increase the acceptability of VCT/PMTCT by men
	Nyarusiza	• Advocacy at the sector level and with World Vision to install potable water at the HC • Road leading to the HC was repaired through community work group • *Mutuelles* membership rate increased from 42% to 60% in four months • Development of a project to enclose the HC submitted to the district
Nyaruguru	**Coko**	• Creation of incentives for TBAs • Fifty TBAs turned in the material they used for deliveries at home; now actively participating in education about HC deliveries and accompanying women to the center • Number of deliveries at the HC increased from four to 50 per month
	Nyamyumba	• Creation of incentives to encourage women to deliver at the HC and for the birth attendant who accompanies them: soap and cloth for the baby and 500 Frw for the accompanying attendant • Immunization rate increased from 44% to 85% in five months • Use of family planning increased from 3% to 8% in five months

Annex 5: Twubakane Intervention Zones

TWUBAKANE - Decentralization and Health Program

District Name	Province Name	Number of Admin Sectors	Area Sq Km	Perimeter Km	Population Yr 2002
KAYONZA	EST	12	1,813.21	196.93	220,802
NGOMA	EST	14	871.80	163.03	232,165
KIREHE	EST	12	1,190.28	191.43	229,468
RWAMAGANA	EST	15	685.17	135.58	209,423
		53	**4,560.46**	**686.97**	**891,858**
NYAMAGABE	SUD	19	1,095.43	204.05	284,852
MUHANGA	SUD	12	650.78	179.21	340,369
KAMONYI	SUD	12	658.64	169.80	292,772
NYARUGURU	SUD	15	1,014.97	188.63	233,815
RUHANGO	SUD	9	629.74	163.68	210,000
		67	**4,049.56**	**905.37**	**1,361,808**
GASABO	VILLE DE KIGALI	15	431.24	110.16	320,516
KICUKIRO	VILLE DE KIGALI	10	167.50	82.34	207,819
NYARUGENGE	VILLE DE KIGALI	10	134.59	106.31	236,990
		35	**733.32**	**298.82**	**765,325**
12	3	155	9,343.34	1,891.16	3,018,991



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

KAMONYI
RWAMAGANA
KAYONZA
GASABO
NYARUGENGE
MUHANGA
KICUKIRO
NYAMAGABE
RUHANGO
NGOMA
KIREHE
NYARUGURU
0 30 60
kilometers

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