

Community-Provider Partnerships for Quality Improvement in Rwanda



Assessment of the Partenariat pour l'Amélioration de la Qualité (PAQ) Approach

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TWUBAKANE
Decentralization and Health Program
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TABLE OF CONTENTS

Acronyms	1
Glossary	2
Executive Summary	3
1. Background	4
1.1. Rwandan Operating Environment	4
1.2. Health in Rwanda	5
2. Program Description.....	6
2.1. Partenariat pour l’Amélioration de la Qualité (PAQ) Committees	6
3. Methodology	8
3.1. Objectives	8
3.2. Assessment Design	9
3.3. Analysis	11
3.4. Protection of Human Subjects	11
4. Findings	12
4.1. Participants	12
4.2. PAQ Committee Operations.....	14
4.3. Perceived Quality of Health Services.....	18
4.4. PAQ Impact on Health Care System.....	20
4.5. PAQ Sustainability	27
5. Discussion	29
5.1. PAQ Effectiveness	29
5.2. Barriers to Effectiveness	30
5.3. Sustainability	31
5.4. Assessment Limitations.....	32
6. Recommendations	33
6.1. PAQ Committee Recommendations	33
6.2. PAQ Impact on Health Care System.....	33
6.3. Sustainability	34
7. Conclusions	35
Appendix 1: PAQ Committees’ Integrative Role within Health System and Administrative Structure of Rwanda	36
Appendix 2: PAQ Assessment Questionnaires.....	37
Appendix 3: Informed Consent Statement.....	54

TABLES

Table 1: Key Maternal and Child Health (MCH) Indicators	5
Table 2: Number of Existing PAQ Committees, by Province, District and Health Center	8
Table 3: PAQ Assessment Sites, by Region, District, Sector and Location Type.....	11
Table 4: Type and Number of Interviews Conducted.....	12
Table 5: Individual Interview Participants.....	13
Table 6: Focus Group Participants.....	14
Table 7: Internal PAQ Activities	14
Table 8: Community Perceptions of PAQ Outreach Topics.....	27
Table 9: Sources of Funding for PAQ Committee Operating Expenses	28

FIGURES

Figure 1: PAQ Team Participants	7
Figure 2: PAQ Committee Functionality	15
Figure 3: Community Member-Suggested Areas of Health Center Improvement	19
Figure 4: Service Statistics on Assisted Deliveries, Vaccinations and ANC Visits	21
Figure 5: Community Respondents Familiar with PAQ (%).....	26

ACRONYMS

ANC	Antenatal Care
ASM	Maternal Health Worker
CDLS	Commission de District de la Lutte Contre le SIDA (District AIDS Council)
CHAMP	Community HIV/AIDS Mobilization Project
CHW	Community Health Worker
CPR	Contraceptive Prevalence
CYP	Contraceptive Years of Protection
DHS	Demographic Health Survey
DIF	District Incentive Funds
EDPRS	Economic Development and Poverty Reduction Strategy
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
GOR	Government of Rwanda
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MINALOC	Ministry of Local Government, Good Governance, Community Development and Social Affairs
MOH	Ministry of Health
MPA	Minimum Package of Activities
NEPAD	New Partnership for African Development Health Strategy
NGO	Nongovernmental Organization
PAQ	Partenariat pour l'Amélioration de la Qualité (Partnership for Quality Improvement)
PBF	Performance-Based Financing (L'Approche Contractuelle)
PRSP	Poverty Reduction Strategy Paper
RALGA	Rwandese Association of Local Government Authorities
RDSF	Rwanda Decentralization Strategic Framework
SCF	Save the Children Federation
TB	Tuberculosis
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VNG	Netherlands International Cooperation Agency

GLOSSARY

Agent de Santé Communautaire	Community Health Agent
Animateur	Moderator
Animateur de Santé Communautaire	Community Health Agent
Chargé des Affaires Sociales	Social Affairs Program Manager
Comité de Pilotage	Steering Committee
Commission de la Lutte Contre le SIDA	National AIDS Council
Conseille National des Femmes	National Council of Women
Conseille National de la Jeunesse	National Youth Council
Directeur de l'Hôpital du District	District Hospital Director
Directeur de l'Unité de la Santé, Promotion de la Famille et Protection des Droits de l'Enfant	Director of the Health Unit, Women's Promotion and Protection of Children's Rights
Formation Sanitaire	Health Facility
MINISANTE	Ministry of Health
Mutuelle de Santé	Community Health Insurance
Représentant des Affaires Sociales	Social Affairs Representative
Titulaire	Health Center Manager
Umudugudu	Village

Executive Summary

Since 2005, the Twubakane Decentralization and Health Program, funded by the United States Agency for International Development (USAID), has collaborated with the Ministry of Health (MOH) and select districts of Rwanda to support community-provider partnership teams for quality assurance. Known in Rwanda as PAQ (*Partenariat pour l'Amélioration de la Qualité*), the approach covers 136 health centers in 12 of Rwanda's 30 districts. The vision for the PAQ teams is to increase the involvement of Rwandan communities in health center decision-making and management and improve access to and use of high-quality family health services. PAQ teams, composed of health center managers, providers and community representatives, meet regularly to identify gaps in quality and solutions for meeting those gaps.

The functionality of the PAQ teams has been monitored regularly by the Twubakane program. A facilities assessment conducted in December 2008 that included an evaluation of the initiative, found that 74% of PAQ teams had influenced improvements in health center functioning in 2008, and 79% of PAQ teams had mobilized community members to use services (including family planning, antenatal care and delivery services).

The assessment discussed in this report will further explore why and how PAQ committees work and identify the characteristics that make PAQ committees effective in improving the quality of health services using primarily qualitative methods (interviews and focus groups). Respondents included community members, health center personnel, sector and district representatives, and PAQ committee members. In general, assessment results show high levels of both community and government awareness of the PAQ committees and their activities. More than four-fifths (84%) of community respondents had heard of the committees, and most sector and district representatives spoke favorably of the PAQ committees' role within the local health care system. All of the committees' executive boards had met at least once in the last quarter, indicating a high level of commitment on the part of the PAQ committees' key members.

The assessment findings also suggest that most PAQ committees have achieved their intended purpose by raising service quality at local health centers. Stakeholder perceptions regarding PAQ achievements focused on two health center outcomes (physical infrastructure and environment, and service organization and delivery) as well as two community outcomes (community partnerships and community outreach). Health center outcomes were most relevant to health center personnel and the PAQ committee members themselves, while PAQ achievements in community outreach and education were almost universally mentioned. Community members indicated that they care about the quality of services (and are willing to volunteer their time to improve quality) and health providers acknowledged that listening to communities can make their work easier and more efficient. Overall, the successes highlighted by this assessment and the 2008 facilities assessment suggest that the PAQ approach should be scaled up to Rwanda's other districts.

1. Background

Rwanda's population of more than 10 million is the most densely concentrated in Africa, and fertility and maternal mortality rates are still among the highest on the continent. The country has made great progress over the past several years in many outcomes, reducing infant mortality and that of children under-five, increasing the use of modern contraception, antenatal and delivery care, and stabilizing the HIV prevalence rate. Utilization of overall health services also has increased, thanks to a variety of progressive programs, including national health insurance and performance-based financing. However, continued efforts are required to achieve consistent high-quality health services so that Rwanda will meet the Millennium Development Goals.

1.1. Rwandan Operating Environment

The Rwandan government has been very active in assuring universal health care for all. The Government of Rwanda's (GOR) Health Sector Strategic Plan, HSSP II, 2009 – 2012, supports major strengthening of interventions along three strategic objectives: 1) maternal and child health, family planning, reproductive health and nutrition; 2) prevention of diseases and promotion of health; and 3) treatment and control of diseases. Rwanda's National Policy for Quality Health Care (2008) focuses on strengthening the supervisory system at the facility and community levels to achieve and sustain high quality health services. The policy includes expansion of the community-quality improvement partnership model. The performance-based financing (PBF)¹ system also has contributed to improving the overall quality of care, as has the innovative community health insurance scheme (known in Rwanda as "*mutuelles*") which has reduced financial barriers to health care. Prior to the introduction of PBF, the PAQ approach was initiated by the PRIME II Project and the MOH in conjunction with the community health insurance scheme and the launch of the family planning movement. The PAQ approach was seen as a key mechanism to mobilize community participation for these newly introduced initiatives.

Rwanda's health system defines specific responsibilities for health care at each level, including the central level. These levels encompass the reference hospitals and tertiary care, the district hospitals (one for each of the country's 30 districts), health centers (eventually at least one for each of the country's 416 sectors) and, at the community level, community health workers and, in some cases, community health posts.

Rwanda's MOH began working on a National Community Health Policy in 2006. The policy, which was adopted in 2008, includes provision of holistic and sustainable health services at the community level and recommends active participation of the population in program planning and implementation, and harmonizes several community-based interventions into one, using uniform training strategies and curricula, and incentive/motivation schemes. Rwanda is developing a national plan to mobilize and support 60,000 community health workers (CHWs), focusing on an integrated package of community health services.

Rwanda embarked on a new phase of decentralization in 2005, a process that has and continues to have a major impact on all levels of government. In addition to territorial reform and redistricting, the new phase of decentralization involves new roles and responsibilities at all levels. Under the new administrative system, health districts were incorporated into the districts as departments of health and social services, and health officials responsible for district-level service delivery and management report directly to

¹ PBF is a contract between the providers of health care services and the investors which uses remuneration as a motivational tool for improving performance. Based on volume and the quality of health outcomes, public health facilities will receive contributions towards their standard operating budgets per standard fixed rates set forth but the Government of Rwanda (GOR). These funds can be used for personnel bonuses, training, and for the general operating expenses of the health facility.

locally elected officials. In August 2007, the Rwandan Ministry of Local Government, Good Governance, Community Development and Social Affairs (MINALOC) published the Rwanda Decentralization Strategic Framework (RDSF) as implementation guidelines for the National Decentralization Policy to promote good governance; reduce poverty; and to improve the efficiency, effectiveness and accountability of service delivery in the public domain. The process of defining the Decentralization Strategic Framework involved local and international partners to solidify a common vision towards achieving national development objectives. As outlined in the framework, each level of government from central to *Umudugudu*² has responsibilities to ensure that quality health care services are delivered. Each administrative level is explicitly responsible for:

- Providing basic health care
- Fighting against HIV/AIDS and other pandemics
- Promoting basic hygiene
- Promoting good nutrition
- Installing national medical insurance systems³.

1.2. Health in Rwanda

Rwanda's progressive programs and supportive policy environment have resulted in improvements in key health outcomes, as demonstrated in Table 1.

Table 1: Key Maternal and Child Health (MCH) Indicators
(DHS Surveys)*

INDICATORS	1992	2000	2005	2007-08
Infant mortality rate/1000 live births	85	107	86	62
Under-five mortality rate/1000 live births	150	196	152	103
Maternal mortality rate /100,000 live births	NA	1071	750	NA
Use of modern contraception	13%	4%	10%	27%
Use of antenatal care (at least one visit)	94%	92%	94%	96%
Deliveries assisted by trained personnel	26%	31%	39%	52%

*Barrere T, et al. Enquête Démographique et de Santé, Rwanda 1992. Calverton, Maryland; Macro International Inc, 1994. Office National de la Population (ONAPO) [Rwanda], ORC Macro. Enquête Démographique et de Santé, Rwanda 2000. Calverton, Maryland; ORC Macro, 2001.

Institut National de la Statistique du Rwanda (INSR), ORC Macro. Rwanda Demographic and Health Survey 2005. Calverton, Maryland; INSR and ORC Macro, 2006.

National Institute of Statistics (NIS) [Rwanda], Ministry of Health (MOH) [Rwanda], and Macro International Inc. Rwanda Service Provision Assessment Survey 2007. Calverton, Maryland; NISR, MOH, and Macro International Inc., 2008.

The contraceptive prevalence rate in Rwanda increased dramatically, from 4% in 2000 to 10% in 2005, and by early 2008, modern contraceptive use was 27.4%, an additional dramatic gain in less than three years. Although Rwanda has made unprecedented advances in the use of modern contraception, the country's total fertility rate is still high at 5.5. The issues of population growth and family planning have become prominent in Rwanda's Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012.

Rwanda's under-five mortality rate decreased from 152 per live births in 2005 to 103 (Rwanda Interim Demographic Health Survey [DHS] 2007-08), the infant mortality rate decreased from 86 to 62, and the neonatal mortality rate from 37 to 28. The maternal mortality rate, last measured in the 2005 DHS, is high

² Community

³ Rwanda, Ministry of Local Government, Good Governance, Community Development and Social Affairs, Rwanda Decentralization Strategic Framework (Kigali: MINALOC Rwanda, August 2007) 54-57.

at 750 per 100,000 live births. Results from the interim DHS of 2007-08 found that births delivered by a health professional increased from 39% in 2005 to 52% in 2007-08. Although 96% of women use ANC services, most seek their first visit late in their pregnancy and do not attend the recommended four ANC visits. Expansion of the national integrated community health package will improve prompt care seeking.

2. Program Description

The five-year USAID-funded Twubakane Decentralization and Health Program began in January 2005. Twubakane is a Kinyarwandan word meaning “let’s build together.” The Twubakane Program is implemented by IntraHealth International, RTI International, and Tulane University, Payson Center for International Development and Technology Transfer and other partners. The overall goal of the program 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, represented by USAID, and the GOR, represented by the Ministry of Local Government and the MOH. Twubakane also works in partnership with the Rwandese Association of Local Government Authorities (RALGA), EngenderHealth, VNG (Netherlands International Cooperation Agency) and Pro-Femmes.

Twubakane has six integrated components: 1) family planning and reproductive health; 2) child survival, malaria and nutrition; 3) decentralization policy, planning, and management; 4) district-level capacity building; 5) health facilities management and *mutuelles*; and 6) community engagement and oversight. Among the more innovative features of the program is its District Incentive Fund (DIF), which provides a total of \$6 million in grants directly to Rwanda’s districts to strengthen health service delivery at decentralized levels.

Twubakane was originally designed to work in four provinces: Gikongoro, Gitarama, Kibungo and the City of Kigali. Pursuant to the GOR’s redistricting and territorial reform, the Twubakane Program, in collaboration with USAID and partner ministries, is supporting 12 of the country’s 30 districts (which closely align with the four former provinces).

2.1. *Partenariat pour l’Amélioration de la Qualité (PAQ) Committees*

Partnership-Defined Quality is a methodology developed by Save the Children/US in the mid-1990s to strengthen community participation in assessing quality and promoting improvements in health care service delivery.⁴ The approach recognizes that health care providers and consumers have differing perceptions of quality and seeks to bridge and derive insight from both perspectives. With the help of Save the Children, the PRIME II project adapted the methodology and initiated the approach in Rwanda in 2001. This approach was expanded under the ACQUIRE Project (implementation led by IntraHealth in Rwanda) and included in the design of the Twubakane Program. Starting in 2005, Twubakane has focused on fostering the development of Community Quality Improvement Partnerships, or PAQ committees (*Partenariat pour l’Amélioration de la Qualité*) at local health centers in 12 of Rwanda’s 30 districts.

Assessments in various countries suggest that, in some communities, clients avoid local health centers at least in part due to perceptions that service quality is poor. The broad goal of the PAQ approach is therefore to address underutilization of health services by assessing perceived quality of care problems, identifying potential solutions, and ensuring that solutions are implemented. Ideally, an “effective” PAQ

⁴ Ronnie Lovich, Marcie Rubardt, Debbie Fagan, Mary Beth Powers, “Partnership Defined Quality.” Washington, DC: Save the Children/US, January 2003. 1.

committee would raise the standard of care, as defined by the community and other stakeholders, so that poor quality of services is no longer an impediment to health center use.

Figure 1: PAQ Team Participants

<p>Community Representatives</p> <ul style="list-style-type: none">• Community health workers• School representatives• Church representatives• Local nongovernmental organization (NGO) representatives• Police• People living with HIV• Private sector representatives• Traditional healers <p>Health Center Representatives</p> <ul style="list-style-type: none">• Health center staff• Health center managers• Health committee managers• Health insurance manager <p>Sector Representatives</p> <ul style="list-style-type: none">• Executive secretary• Manager of social affairs• National Youth Council coordinator• National Women’s Council coordinator

To support the establishment of PAQ committees, the Twubakane Program compiled a list of entities that would adequately represent various groups at the sector, community and health center levels. Through nomination and election, each PAQ committee then recruited 15-25 members. Figure 1 lists the range of positions that *may* serve on a PAQ committee. All PAQ members volunteer their time.

The health center manager (*titulaire*) is always a member of the PAQ committee. Additional members of the health center staff and the health insurance manager sit on the committee if elected by the health center staff as their representatives. Many PAQ members are appointed to the committees because of the public service focus of their positions. Representative CHWs are elected by their communities. PAQ committees typically include the sector representatives to the national youth and women’s councils, as well as the sector-level program manager of social affairs.

PAQ committees elect an executive board consisting of a president, vice president, secretary, treasurer, and any other members they consider necessary. The full PAQ

committees normally meet quarterly, while the executive board confers monthly and on an as-needed basis.

Within the 12 districts supported by the Twubakane Program in the City of Kigali and the Eastern and Southern provinces, there are 155 sectors and 136 health centers. When the Twubakane Program started in 2005, 26 PAQ committees were already in place, established by the PRIME II and ACQUIRE projects. At the end of 2006, the number of PAQ committees had increased to 99, growing to 130 by the end of 2008.

Table 2: Number of Existing PAQ Committees, by Province, District and Health Center
(Twubakane 2008 Facility Assessment)

PROVINCE	DISTRICT NAME	HEALTH CENTERS (#)	PAQ COMMITTEES (#)
Kigali	Gasabo	10	10
	Kicukiro	7	7
	Nyarugenge	8	8
Eastern	Kayonza	13	13
	Kirehe	12	12
	Ngoma	12	12
	Rwamagana	11	10
Southern	Kamonyi	11	9
	Muhanga	13	11
	Nyamagabe	13	12
	Nyaruguru	13	13
	Ruhango	13	13
TOTAL	12 Districts	136	130

Once established, PAQ committees examine the differing views of service quality held by health care providers and community members. In general, health care providers tend to use medical outcomes to define quality, whereas community members often associate quality with factors such as cleanliness, comfort, reception by the staff, and timeliness of services. Each PAQ committee comes up with a common definition of quality that includes the perspectives of both providers and community members. The Twubakane Program staff has helped PAQ committee members determine priority gaps in quality, using the common definitions generated by stakeholders. After identifying priority gaps, each PAQ committee develops an action plan, identifying needed changes at both the health center and community levels. As applicable, PAQ committees communicate desired health center changes or service improvements to health center staff, sector administrative staff, or district authorities who then decide whether and how to respond to the request.

When health centers implement important reforms, PAQ committee members (including community and sector representatives) can inform community members of the changes and encourage them to use health center services. PAQ committees also elicit ongoing suggestions from community members through community meetings and have come to play an important role in community mobilization efforts. In addition, the PAQ committees are seen as an important vehicle for promoting the national health insurance plan⁵ and for disseminating health sector policies and strategies.

3. Methodology

The overall purpose of the assessment was to better understand *why* and *how* PAQ committees work and to identify the characteristics that make PAQ committees effective in improving the quality of health services. A secondary aim of the assessment was to generate recommendations for PAQ sustainability and replication, both in Rwanda and internationally.

3.1. Objectives

Using individual interviews and focus group discussions, the assessment explored four specific objectives, described more fully below:

⁵ IntraHealth International. "Implementation Process for Quality Improvement Through Partnership." July, 2002. 3.

- Objective 1: Evaluate stakeholder awareness and perceptions of PAQ committees
- Objective 2: Evaluate effectiveness of PAQ committees in influencing health center functioning
- Objective 3: Analyze PAQ committee member characteristics
- Objective 4: Identify factors contributing to PAQ committee sustainability.

3.1.1. Objective 1

This objective compared **stakeholder perceptions of the role of PAQ committees** with the committees' intended role as defined by the Twubakane Program. We considered the differing though complementary viewpoints of a variety of stakeholders, including community members, health officials and PAQ committee members themselves.

3.1.2. Objective 2

The second objective focused on the PAQ committees' effectiveness in influencing health center functioning. To determine **PAQ committee effectiveness**, we asked respondents to describe changes in local health activities that they attributed to their PAQ committee's efforts. We then compared changes listed by respondents with the results *expected* from PAQ-supported activities, as well as with *actual* changes at health centers. We used three proxy indicators to define **health center functioning** from initiation of the PAQ committees through August 2008: number of antenatal care visits, number of deliveries attended by a skilled provider, and number of children less than 12 months receiving DPT3 vaccination.

3.1.3. Objective 3

The third objective explored **characteristics of PAQ committee members** that may explain why some aspects of the PAQ approach have been successful and others less so. This included issues such as PAQ member motivation and PAQ supervision.

3.1.4. Objective 4

The last objective acknowledges the importance of understanding the factors that make PAQ committees **sustainable**.

3.2. Assessment Design

The assessment used qualitative methods (semi-structured individual interviews and focus groups) to gather key stakeholders' opinions and experiences at the central level and in 12 assessment sites.

3.2.1. Participants

Interviews and/or focus groups were conducted with five broad categories of informants: community members; health center staff and managers; sector representatives and administrators; district administrators; and PAQ committee members (who are drawn from most of the other categories). Each category is described more fully below.

For the purposes of the assessment, **community members** were individuals who had ever visited the selected health center. Community members were recruited within walking distance of the health center, either in the facility waiting area, on the street, or in their homes.

Health center staffing is determined by the number of people in the center's catchment area. However, notwithstanding government efforts to bring more staff into the system through education, many health centers are understaffed, particularly in regards to nursing staff. As a result, health center staff members

generally hold both clinical and managerial responsibilities. In addition to these duties, some employees carry out laboratory, reception or pharmacy functions.

Health center managers (*titulaires*) oversee all of the health center's activities and staff. They are in charge of delivering a minimum package of quality services, managing finances, maintaining adequate equipment and supplies, supervising the health insurance plan, conducting community outreach activities, maintaining public relations, reporting to sector and district administrators, and collaborating with donor organizations.

The **sector administration** is responsible for the management and oversight of all health activities in the sector. Sector representatives also are accountable for achieving health targets in health posts or centers. For example, the sector's program manager of social affairs reviews health centers' monthly reports and ensures that health centers reach specified targets for standard indicators in accordance with performance contracts. Also at the sector level, volunteer representatives from the national women's and youth councils play a liaison role between the sector administration and community women and youth.

At the **district level**, the governmental structure includes an administrative health unit with a district director of health. Reporting to this director is the district-level program manager for health and hygiene. This line of command disburses central funding to sectors and health centers, oversees individual health center indicators and collates sector data for the health program. They report to the Ministry of Local Government. District hospitals are managed by the district but also receive technical guidance and supervision from the central level of the MOH.

At the **central level**, the MOH creates policy and strategies that guide the decentralized implementation of health services. Within the MOH, the Community Health Unit takes the lead in developing community health policy and strategies and provides oversight for assuring the quality of community health initiatives.

3.2.2. Instruments

We developed five different semi-structured questionnaires for the different stakeholder categories in both French and Kinyarwanda (see Appendix 2). All stakeholders were asked the following two questions: (1) What do you think the PAQ committee is responsible for? and (2) What achievements do you attribute to the PAQ committee's interventions? The remaining questions were targeted to each type of respondent depending on their expected knowledge and experience.

The questionnaires were tested in a Kigali field site for clarity, cultural appropriateness, and ease of administration. The tools were then revised in both languages. Many of the questions were purposefully redundant across the different stakeholder groups to triangulate responses and clarify the accuracy of the information provided.

3.2.3. Data Collection Team

The data collection team included eight data collectors, one team leader and a supervisor. Data collectors were trained on use of the field guides using classroom role plays. Data collectors then visited the 12 assigned assessment sites in teams. One data collector served as interviewer while a second data collector served as note taker.

The data collectors used paper questionnaires to administer the interviews, which ranged in length from 30 to 60 minutes. With the exception of the district interviews, which were conducted in French, all other interviews were conducted in Kinyarwanda, with responses subsequently translated into French or English by the interviewer or note taker.

3.2.4. Sampling

Sampling was done to purposefully select 12 health centers with established PAQ committees based on location type (rural, urban or semi-urban). Relatively isolated locations lacking easy access to public services or commercial activity were considered **rural**. A town was classified as **semi-urban** if it was near a main road, was within 20 minutes of a regional capital via public transportation and provided some access to public services. **Urban** sites were defined as centers of public administration and commercial activity for their districts.

Twubakane Program staff randomly selected sites from within each location category. The 12 health centers selected that met the criteria are found within 9 of the 12 Twubakane-supported districts. As shown in table 3, rural sites are represented in greater numbers than urban or semi-urban sites because most health centers, in general, are rural. By region, eight of the selected sites were in the Southern region where the PAQ approach started.

Table 3: PAQ Assessment Sites, by Region, District, Sector and Location Type

REGION	DISTRICT	SECTOR	SITE	LOCATION
Southern	Nyaruguru	Cyahinda Busanze	COKO RUNYOMBYI	Rural Rural
	Muhanga	Rugendabari Cyeza	GASAVU GITARAMA	Rural Semi-urban
	Nyamagabe	Tare Gasaka	MBUGA NYAMAGABE	Semi-urban Urban
	Ruhango	Mwendo	GISHWERU	Rural
	Kamonyi	Musambira	MUSAMBIRA	Semi-urban
Eastern	Kirehe	Gahara	GAHARA	Rural
	Ngoma	Mugesera	NYANGE	Rural
	Rwamagana	Bubona	RUBONA	Rural
Kigali	Gasabo	Kimironko	KIMIRONKO	Urban

3.3. Analysis

All responses were recorded directly onto the questionnaires during the interviews. After data collection, team members used simple tables and spreadsheets to enter their data into Microsoft Word (qualitative information) or Microsoft Excel (quantitative information). Data collectors worked on data entry in two-person teams, with supervision by Twubakane staff. Qualitative data were analyzed according to key questions. Informant responses for each of the key questions were coded, collated, and organized into a logical sequence.

3.4. Protection of Human Subjects

The assessment explored opinions and subjective perceptions of PAQ committees and health center services, and the research posed no to minimal risk to participants. Data collectors were trained on research ethics and informed consent. A statement was translated into Kinyarwanda informing potential participants of their right to decline specific questions or the entire interview (see Appendix 3). Informants also were asked permission to take notes and were given the opportunity to ask questions about the assessment.

4. Findings

In the course of analyzing the data, it became clear that there was considerable overlap in the responses addressing the four assessment objectives. We therefore present the assessment's findings by theme, rather than by objective. After describing the assessment's participants, we focus on PAQ committee operations, community perceptions of health care quality, PAQ impact on the health care system, and PAQ sustainability. We also include a number of recommendations that are suggested by the assessment's findings.

4.1. Participants

Table 4 lists the type and number of interviews conducted, by participant category.

Table 4: Type and Number of Interviews Conducted

PARTICIPANT CATEGORY	INTERVIEW TYPE	NUMBER OF INTERVIEWS
Community Members	Individual Interviews	198
Health Center Staff	Individual Interviews	24
Health Center Managers	Individual Interviews	11
PAQ Committees	Focus Groups	19
	Individual Interviews	17
Sector Representatives	Focus Groups	12
District Hospital	Focus Groups	6
	Individual Interviews	7
District Government	Individual Interviews	2
Ministry of Health	Individual Interviews	2
TOTAL NUMBER OF INTERVIEWS		298

4.1.1. Individual Interviews

Community Members: Data collectors interviewed 13 to 27 individuals in each of the 12 sites, for a total of 198 community respondents. Virtually all (97%) of the community members recruited for the assessment were clients of the health center selected as an assessment site. However, only half (53%) had visited the center in the past three months. With an average age of 34 years, community participants were almost evenly divided between men and women (see table 5).

Health Center Staff and Managers: Most of the health center staff who participated in the interviews were women, and more worked in maternity and *mutuelle* (health insurance) services than in other program areas. Facility managers included both men and women.

PAQ Committee Members: Interview participants were selected to represent a range of PAQ committee roles, including executive board members.

District Representatives: District interviews were conducted with administrators at the district hospitals. Further interviews with district government officials were halted after two brief interviews with a mayor and vice-mayor provided little insight into the PAQ approach or the work of the committees.

MOH Representatives: Interviews were conducted with two representatives from the MOH about their views on the PAQ approach. One representative expressed his/her belief that the PAQ approach has been, and will continue to be, successful in mobilizing communities and encouraging the population to participate in their own health care. A second representative stated during the interview that he/she considers the PAQ approach to be an effective tool in sensitizing communities about the community health programs available to them. Thus, he/she believes the approach has the potential of being scaled up to the national level.

Table 5: Individual Interview Participants

PARTICIPANT CATEGORY	NUMBER OF INTERVIEWS	DESCRIPTION
<i>Community Members</i>		Recruited at or near health centers
Male	94	
Female	104	
TOTAL:	198	
<i>Health Center Staff</i>		Maternity, vaccinations, general consultations, health insurance, other staff
TOTAL:	24	
<i>Health Center Managers</i>		Directors (including one pharmacist serving as acting manager)
Male	5	
Female	6	
TOTAL:	11	
<i>PAQ Committee Members</i>		Members of PAQ executive board and other committee members, including community health agents and sector representatives
TOTAL:	17	
<i>District Administrators (Hospital)</i>		Hospital health directors, head nurses, nursing staff, program managers for health insurance and family planning
TOTAL:	7	
<i>District Government</i>		Mayor, vice-mayor in charge of social affairs
TOTAL:	2	
<i>Ministry of Health</i>		Senior level ministry representatives
TOTAL:	2	

4.1.2. Focus Group Discussions

Focus group discussions were carried out with three categories of participants (see table 6). Due to competing demands on potential participants' time, many of the groups included only two participants.

PAQ Committee Members: One to two focus groups with PAQ committee members were conducted in each site.

Sector Administrators: In all 12 focus group discussions with sector administrative authorities, either the executive secretary and/or the social affairs program manager for health participated in the interview. All of the executive secretaries were men (n=8), while four of the seven social affairs directors were women. In the three sites where one or the other was unavailable, other sector officials with knowledge of the PAQ approach participated.

District Officials: The focus groups with district officials were generally brief. The assessment caught district officials at a very busy time of year, which reduced their level of participation. Some district respondents were pulled from other meetings and had time to provide only brief responses.

Table 6: Focus Group Participants

PARTICIPANT CATEGORY	NUMBER OF FOCUS GROUPS	DESCRIPTION
PAQ Committee Members	19	Members of PAQ executive board and other committee members
Sector Representatives and Administrators	12	Primarily executive secretaries and program managers for social affairs, as well as representatives from national women’s and youth councils and others
District Hospital Representatives	6	Hospital health directors, head nurses, nursing staff, program managers for health insurance and family planning

4.2. PAQ Committee Operations

Participants shared a number of comments on the specifics of committee functioning and operations. Comments focused on five aspects of PAQ operations: (1) committee management; (2) committee functionality; (3) external communications; (4) supervision; and (5) participation.

4.2.1. Committee Management

PAQ members reported performing a variety of internal management activities as well as subcommittee tasks (see table 7). Some members also participated in income-generating activities launched by the PAQs to cover PAQ-related expenses and provide resources for families and health centers.

Table 7: Internal PAQ Activities

TYPE OF ACTIVITY	DESCRIPTION
Internal Management	-Call meetings -Set agendas -Facilitate meetings -Write, review, and report meeting minutes -Carry out bookkeeping and financial management -Coordinate PAQ activities
Subcommittee Activities	-Develop income-generating projects -Obtain external financing -Oversee building renovations or improvements

Sector administrators who served on PAQ committees described a level of involvement ranging from irregular attendance to participation in all PAQ meetings. Sector-level members also reported using their authority and influence to help the PAQ teams organize and problem-solve, clarify their objectives and activities, secure financing, develop income-generating activities and organize community education. Other PAQ committee members described the presence of sector-level representatives in their midst as a factor motivating them to carry on with their work. One sector representative highlighted the need for PAQ members to have a baseline level of competence. Commenting on the rocky start-up of their local PAQ committee, the respondent noted that the committee had transitioned into playing a more useful role as members acquired more experience:

[In the beginning] there were some difficulties because members of the PAQ group didn't have as much experience as other people in the community and didn't understand what the PAQ activities were all about. But now the PAQ works as it should [They are able to] find appropriate solutions to problems because they are now experienced.

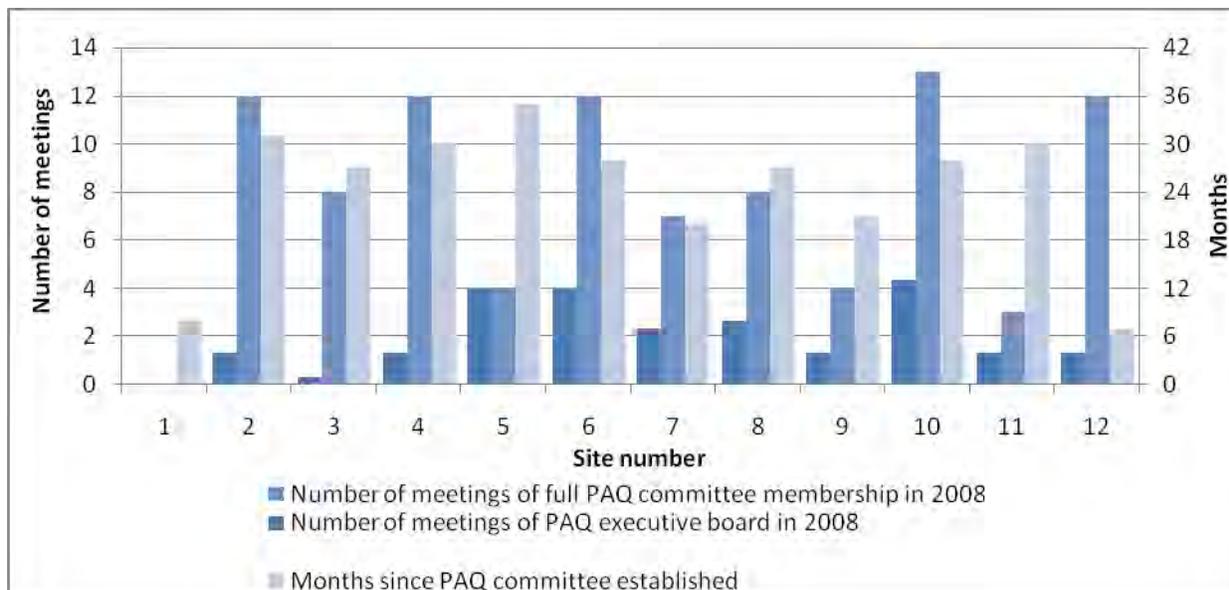
-Sector representative

District administrators admitted to playing a limited role in daily PAQ activities but reported several types of higher-level involvement, including supervising and mentoring committee members, coordinating and monitoring activities, and facilitating or providing funding. Some districts reported sponsoring training courses for PAQ members on topics such as the minimum package of activities for primary care and health outcome monitoring.

4.2.2. Committee Functionality

We used three indicators to examine whether the PAQ committees were functioning as intended: number of months since the PAQ committee was established (PAQ duration), number of meetings of the full PAQ committee in the past year, and number of meetings of the PAQ executive board in the past year.

Figure 2: PAQ Committee Functionality



PAQ Duration: Figure 2 shows the number of months of PAQ committee operation in the 12 sites, by site number. This indicator of PAQ internal functioning assumes that longer-running PAQ committees are more effective and have had more time build their members' skills. However, participants' subsequent comments suggest that PAQ committees can achieve results even in a relatively short period of time.

Meeting Frequency: Assuming that meeting frequency is an indicator of PAQ committee activity, we looked at the number of times that the full PAQ committee membership had met in 2008. All but one of the PAQ committees had met within the last year. Six of the 12 committees reported meeting within the last 30 days, and four committees within the last 60 days. The number of full committee meetings in 2008 ranged from zero to 13.

Executive Board: Figure 2 suggests that regular meetings of the *full* PAQ committee membership may not be necessary for success. All of the PAQ committees' executive boards reported meeting at least once in the last quarter, and eight out of 12 had met within the last month. The high level of executive board involvement points to a notable degree of buy-in and commitment on the part of the PAQ committees' key players. In addition, there are significantly more changes to health facilities and significantly more mobilization activities where PAQ committee meetings are held more frequently than among those in which a PAQ team has not met in the quarter prior to the facilities assessment. When a PAQ committee had met at least once in the previous quarter, there had been an average of 2.39 changes effected at the health facility and 3.13 mobilization activities during the previous year compared to 1.48 changes and 1.95 mobilization activities at sites where the PAQ committee had not met during the previous quarter.

4.2.3. External Communications

PAQ members reported holding periodic meetings with several external stakeholder groups (e.g., community members, health center staff, NGO staff) to share information about their activities. In one district with multiple development partners, a district representative commented on the PAQ committee's assistance in coordinating development activities to avoid duplication of efforts. PAQ members also considered it their responsibility to communicate information about PAQ endeavors to their respective constituencies:

The local authorities are informed of PAQ activities in meetings by their sector representatives... Health personnel are informed of PAQ activities by the director of the health center, the health insurance manager, and the nurse who represents the others during their staff meetings. Community members are informed of PAQ activities by their representative, the women's advisor, the youth advisor and the community health agents during community meetings that we hold in our village.

-PAQ representative

Respondents also noted that the PAQ executive boards submitted written reports on a monthly basis to the health center and to sector authorities to demonstrate their level of effort and monitored the reports for accuracy. However, some respondents suggested that while information flows smoothly from the district to the PAQ committees, the latter have not been consistent in sending information back to the districts.

4.2.4. Supervision

Respondents from all categories described three basic components of supervision:

1. **Training** (e.g., organizational management, education topics, project management)
2. **Guidance** (e.g., problem solving, funding, program design)
3. **Funding** from supervising organizations (for transportation, assessment tours, special projects)

The focus groups and individual interviews with **PAQ committee members** included several questions about the supervision process and additional supervisory needs. In all cases, PAQ respondents reported receiving regular quarterly supervision from Twubakane Program field coordinators, supplemented by more occasional supervision from the sector's director of social affairs or the district health director.

In general, respondents described Twubakane's supervision strategy as one of more frequent supervisory visits at the time of committee start-up, with a gradual decrease in the number of visits as the PAQ team gains experience. Twubakane staff also provides introductory training to members of the PAQ executive boards. In their remarks about supervision, committee members noted that turnover in PAQ committee composition and lack of training for other PAQ team members had resulted in a lack of consistency and lost information. Some respondents also commented on the lack of clear guidelines for supervisory roles and processes. PAQ members identified several additional supervisory needs, including more frequent supervisory visits (up to twice a month), information and training for *all* members on roles and responsibilities, additional assessment visits, and funding for transportation costs.

When **health center staff members** were asked how supervision could be improved, respondents in eight out of 12 focus groups provided suggestions, ranging from organizing meetings, paying for operating expenses or finding funding, providing meeting space and training members on community outreach topics. Health center *staff* also suggested that center *managers* be excluded from PAQ membership to allow committee members to speak openly about health center shortcomings. Health center respondents in the remaining four focus groups had no suggestions regarding supervision.

In general, **district supervision** of PAQ committees coincides with PAQ meetings or other regularly scheduled meetings. A district representative described the multilayered supervision process in this way:

[Twubakane, the PAQ and the district] have a meeting each trimester. We see if, during the last three months, the objectives of improving services at the health center have been reached. For the community, too, to see if they have access to care at the health center and if community outreach has been completed... We [also] have a meeting each month with the PAQ supervisors at the district to see how the supervision is going, how the work is being carried out, and if the strategies are not functional we make them so... After supervision, we have a round table to discuss the results of our monitoring.

-District representative

District officials indicated that their primary supervisory duties were to offer encouragement and advice to the PAQ committees, help elaborate work plans, participate in problem solving and ensure that committee members are active (removing inactive PAQ members and/or health center staff unwilling to respond to PAQ concerns). One respondent noted that an inactive PAQ committee president had proved capable of "paralyzing" a committee. However, district respondents also noted the difficulty of providing regular supervisory visits due to lack of resources for transportation and lack of coordination with Twubakane Program staff. Moreover, with over ten PAQ committees per district, district supervisors conceded that they could not provide the same level of supervision as sector administrators.

4.2.5. Participation

To gain insight into the differences between more and less effective PAQ committees, we asked committee members to discuss the factors motivating them to serve. In reply, most PAQ team members described **internal motivations**, noting that PAQ membership offered a way to serve their communities and reclaim control over community health. Respondents also reported pride in their achievements. One PAQ member stated:

Since health is the foundation of our population's wellbeing, we have been called to do everything in our power to improve it. This is why we give our time and ideas, so that people's health improves.. And when we go into the community around us and the health center functions well, it's because of our interventions. We feel proud of our work.

-PAQ member

District officials discussed several sources of **external motivation**, including providing a small budget for office supplies, transportation to and from PAQ meetings, and meeting refreshments. Administrators also noted that some PAQ teams had organized income-generating activities, which served the dual purposes of motivating ongoing participation and laying the groundwork for sustainability.

Several district representatives spoke at length about problems with committee participation. In one district, the representative reported struggling to improve PAQ meeting attendance. In two other districts, the committees were “restructured” (with agreement from sector, district and Twubakane Program representatives) and inactive PAQ committee members replaced. However, one respondent noted the difficulty of getting rid of some categories of participants such as pastors and teachers, even when inactive.

In interviews and focus groups, PAQ members identified the lack of remuneration for their time and travel as a principal factor limiting their ability to fully execute their PAQ responsibilities. PAQ members requested several types of “working capital”: an operational budget for office supplies, communications, field visits, and educational materials; funds for “special projects” such as nutritional centers, facility fencing, and health insurance premiums for the poor; funding for transportation to and from PAQ and community meetings; and per diems to attend meetings. One PAQ member noted, “When we call a meeting, some people don't come because they have other activities that provide them with money—so we suggest a per diem once per meeting to encourage members to participate in the meetings.”

In addition, PAQ members expressed the wish for ongoing training on health content to enhance their ability to serve as community educators. Members were particularly interested in learning more about topics such as family planning, health-seeking behavior, assisted delivery, and management of income-generating activities. One PAQ member described his/her embarrassment in discussing family planning “because I don't understand family planning as well as others do”. Some respondents reported the need for more training on their scope of work.

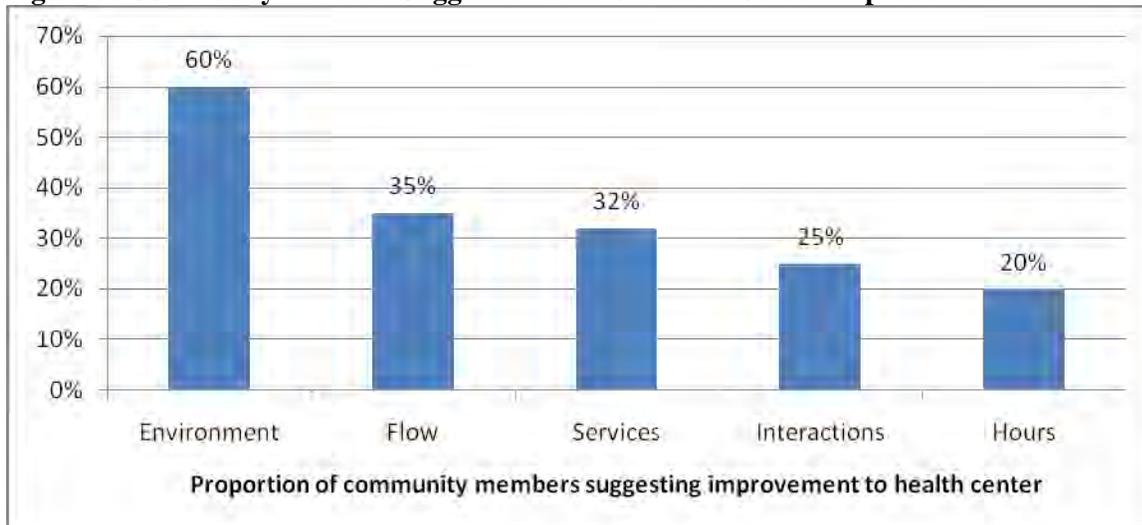
Finally, some PAQ members complained about community members' lack of interest in PAQ activities. Others described additional community barriers, including religious leaders' opposition to family planning, traditional birth attendants' unwillingness to refer women to the health center to give birth, and men's refusal to get HIV testing. In some sites, discontent was also expressed over health center staff's failure to act on the PAQ proposals submitted to the health center.

4.3. Perceived Quality of Health Services

To understand the context in which PAQ committee members carry out their work, we explored community members' perceptions of service quality at local health centers. Although the majority of respondents (170/198 or 86%) rated at least some portion of their health center's services as adequate, many respondents also were forthcoming with suggestions regarding needed improvements. Community members were given the opportunity to indicate whether changes were needed in five central areas: health center hours, availability of services, client-provider interactions, client flow, and physical environment. As shown in Figure 3, three-fifths of respondents (60%) perceived the need for improvement in the

physical environment (e.g., cleanliness, comfort of waiting areas), while 20% to 35% expressed a desire for changes in the other areas.

Figure 3: Community Member-Suggested Areas of Health Center Improvement



In open-ended discussions, a third of community respondents (66/198) mentioned the issue of client **waiting times**. Half of these respondents (33/66) complained about slow service as an impediment to quality care, whereas the other half commented positively on adequate reception and treatment. Some respondents reported choosing one health center over another on the basis of shorter waiting times.

Community respondents expressed appreciation for the **systems** used by health centers to receive patients in an expedient manner, including being received in order of arrival, using numbers, providing waiting areas, providing lab results quickly and filling prescriptions without delay. Respondents also appeared to value health facilities' willingness to give priority to the sickest patients.

In about half a dozen sites, community members noted the need for staff to observe **posted hours of service**. About 9% of community respondents (17/198) expressed unhappiness with late start times, attributing them to tardy arrival, poor organization, and inappropriate use of work hours for personal business and socializing.

The health center staff...should start working at 8 o'clock but most of the time they start around 10 in the morning. During this time the workers are just talking which is very boring for us. Because of this we sometimes go back home without being treated or we go somewhere else.

-Community member

Many community respondents reported that providers' bedside manner was acceptable, attentive or even kindly. However, some suggested that providers' failure to receive clients in a timely manner could be explained by a **lack of caring** on the part of the health center staff: "It's as though they don't even care that you are sick" (community member). Respondents also reported observing incidents of favoritism, with health care providers preferentially receiving and treating "clients they know" (or individuals paying for services out of pocket) "ahead of the others." A community respondent complained:

The health workers are not kind, because when you enter treatment they shout...using such language as, “What brings you here?,” “What do you want?” or “You were just here, what do you want again?” So because of that, I don’t feel comfortable discussing my illnesses.

In five sites, the majority of community respondents reported **staff shortages**, and linked the shortages to long waits. Some respondents acknowledged valid reasons for understaffing, including staff attrition and absences due to vacation or professional meetings.

One fourth of all community members (52/198) mentioned the topic of **hospital transfers** from the health center; of these, most (40/52) were satisfied that transfers and emergency transportation were available for people who could not be treated at the health center. A small proportion of respondents expressed dissatisfaction, focusing on the cost of transfers and bureaucratic delays.

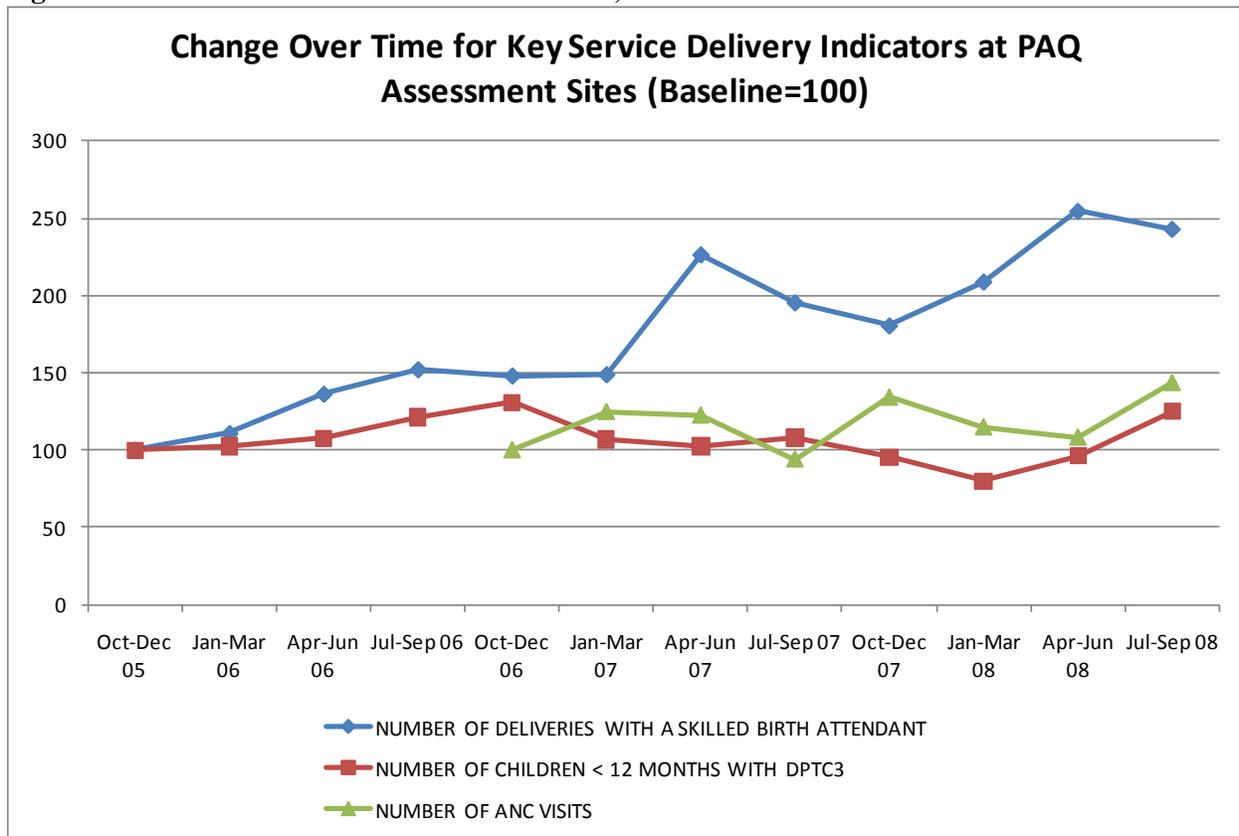
4.4. PAQ Impact on Health Care System

4.4.1. Performance Indicators

To begin gleaning information on PAQ outcomes, we gathered service statistics for three key areas that speak directly to the government’s national health strategy and Twubakane’s core competencies: number of deliveries attended by a skilled professional; number of children under 12 months of age receiving DPT3 vaccinations; and number of antenatal care (ANC) visits during the quarter. To assess the PAQ committees’ influence on the three performance indicators, we examined the indicators over the period of time from the creation of the PAQ committees in each site through August 2008. For the purposes of this analysis, we are less interested in actual numbers than in service delivery trends over time at each health center. Because health centers serve populations of varying sizes, it is not useful to compare numbers across health centers.

For sites with established PAQ committees, we would expect to see increases in all three indicators since the initiation of PAQ activities. The graphs in Figure 4 show that the general service delivery pattern is, in fact, one of increased use of the three services. However, a factor complicating our interpretation of trends is that service delivery numbers were already increasing before the PAQ committees were created. It is not possible to know if the numbers would have risen as significantly in the absence of PAQ committee intervention.

Figure 4: Service Statistics on Assisted Deliveries, Vaccinations and ANC Visits



NOTE: The legends indicate the dates of the PAQ committee’s creation at each site.

For **skilled deliveries**, figure 4 shows a general upward trend in the numbers of attended deliveries in nearly all sites, particularly during the dry season months. However, because the total number of babies delivered in each community is not known, it is difficult to draw conclusions about the proportion of total deliveries that were attended.

The graphs depicting **immunizations** reveal calendar-year cycles in health center vaccination efforts, with notable peaks in the last quarter of the year.

Antenatal care visits climbed steeply in the last quarter of 2008. Concurrent increases in use of other reproductive health services such as family planning suggest that the surge in ANC visits is *not* due to an increase in the number of pregnant women. For example, family planning use increased throughout 2008 (Health Management Information System (HMIS) data), contraceptive years of protection (CYP) nearly doubled from 2007 to 2008 (USAID/DELIVER), and contraceptive prevalence (CPR) rose from 10% in 2005 to 27% in 2007-08 (Rwanda Interim DHS). It is therefore likely that the increase in ANC visits reflects genuine growth in both new and repeat clients. During the PAQ project period, maternal health workers (ASMs – French acronym) received training to encourage women to come to the local health centers; because the ASMs are part of the PAQ team, this training may have enhanced the PAQ committees’ success in bringing about increased use of ANC services.

In the open-ended interviews with health center staff, some center personnel perceived the PAQ committees as having had a noticeable effect on use of the three types of services as well as on the use of family planning and nutrition services. One health center staff member cited a five-fold increase in total use of family planning services (from 6% to 30%) since the inception of the PAQ committee, while

another noted that the proportion of pregnant women using health services had risen from 29% to 61%. Both of these increases were credited to the community outreach done by the PAQ members, though it is likely that there were other contributing factors.

The level of birthing at our health center has increased for two reasons. First, it is because of the community outreach by PAQ members... The second reason for the increase in deliveries is that the women who come to our health center for prenatal visits during the first trimester are each given two pieces of cloth to motivate them to come in. Financing from [a] nongovernmental organization...allows us to provide this incentive to pregnant women to come in regularly for prenatal care.

-Health center staff member

4.4.2. Stakeholder Perceptions of PAQ Outcomes

At the heart of the assessment were stakeholders' comments about the PAQ committees' perceived impact on health centers and the local health care system. Most respondents who were familiar with the PAQ committees—whether PAQ members themselves, community members, health center staff or government officials—perceived the committees as useful and endorsed an expansion of their geographic coverage. As one sector administrator commented, “The PAQ is like a road that has allowed us to go faster in achieving our action plan for health.”

In the focus groups with PAQ committee members, respondents listed the three most important issues that they had identified and addressed as a committee. The top priority, mentioned in nine out of 12 focus groups, was health centers' **physical infrastructure and environment**. The need for improvements in **service organization and delivery**, and the need for **community outreach** on specific topics such as health insurance and family planning, were mentioned in about half of the groups.

Not surprisingly, the PAQ outcomes described by other respondents focused on the same general categories. The following sections discuss four sets of PAQ outcomes in greater detail, two at the health center level, and two at the community level: (1) health center infrastructure and environment; (2) service organization and delivery; (3) community partnerships; and (4) community outreach and education.

4.4.2.1. Health Center Infrastructure and Environment

In most sites, **PAQ committee members** cited improvements in health center hygiene and cleanliness as their most rewarding achievements. In sometimes colorful terms, respondents described a range of activities targeted at improving cleanliness, including mounting trash cans, installing sinks and cisterns, and rehabilitating or building toilets and showers. As one PAQ committee member dramatically observed, “Before the PAQ was initiated, people brought cadavers and dropped them at the front door of the health center. There is no more of that for the time being.” Another committee member commented, “Before, needles and other medical waste were left lying around where people could step on them. Now, there are trashcans for medical waste.”

PAQ committee members also described their role in bringing about a wider variety of infrastructure improvements. These included additional rooms for treatment and laboratory work, fencing, electricity, ambulances, and cafeteria services for staff and patients. At a more basic level, PAQ team members spoke of helping to ensure adequate stocks of supplies and medications.

In contrast to PAQ committee members, fewer than half (44%) of the **community members** interviewed for the assessment cited infrastructure and hygiene improvements as noteworthy examples of PAQ activities. Some community members complained about ongoing shortcomings, including facilities' lack of water, "filthy toilets," old and dirty bedding and mattresses, and lack of mosquito nets. Other respondents were less troubled by issues of facility cleanliness but noted that providers sometimes refused to treat clients perceived as "unclean":

...At our health center...the toilets are always cleaned, they mop the rooms every morning and they do not treat patients if they are unclean.
-Community member

Community members' observations about infrastructure focused on the lack of space for consultations and inpatient care, insufficient materials and unreliable electricity. At health centers where the problems of inpatient space had been addressed, clients expressed satisfaction at not having to share a bed with a "stranger."

Health center personnel and **sector administrators** cited a number of specific changes in physical infrastructure resulting from PAQ decisions and activities. For example, respondents acknowledged that PAQ team efforts (in combination with funding requests to NGOs and government donors) had helped facilities acquire additional rooms for consultations, cafeterias, and needed furniture and equipment. In nine of the 12 health centers, center personnel also credited PAQ teams with enhancing facility hygiene. Staff comments focused on many of the same activities described by the PAQ committee members themselves (e.g., construction of toilets and showers, installation of trash cans and running water). However, health center staff also emphasized the PAQ committees' role in educating patients about clinic and personal hygiene.

4.4.2.2. Service Organization and Delivery

When discussing changes in the organization and delivery of health services, many **PAQ committee members** remarked on the more efficient reception of health center clients. Other PAQ committee members suggested that their hands-on involvement helped ensure that health center personnel came to work on time. A health center manager echoed this view, stating: "There has been a change in how the workforce behaves, being punctual at work. The employees have reduced the number of times they are late." Some PAQ respondents also reported on PAQ efforts to address staffing issues, including correcting staff shortages, appointing someone to work during breaks, or resolving salary inequities between staff members with the same job titles.

Some PAQ team members commented on the "remarkable improvement" in interactions between providers and patients. Alluding to the PAQ committee's oversight role, one respondent suggested that providers' behavior toward clients had become more professional because "the PAQ team functions like the eye of the people." In nine of the 12 sites, **health center staff and managers** reiterated this view, reporting improved provider interactions with clients as a result of PAQ intervention. As one manager reported, "...Because the clients were poorly greeted, they did not come to [our] health center. ...The PAQ committee organized a meeting with the staff to improve our services—the initial reception but also our consultations. After changing our service, the clients have massively renewed their visits to the health center."

To assess the impact of PAQ activities on service organization and delivery from health providers' perspective, we asked **center staff and managers** whether the PAQ approach had made their jobs easier or harder. Half of the health center respondents offered mixed reactions, commenting that the PAQ initiative had made their work both easier *and* harder. Health center managers were more likely than staff

to report favorable changes as a result of the PAQs. In some sites, the PAQ committees were so new that they had not yet had time to produce tangible results.

On the positive side, health center staff indicated that the continuous oversight provided by the PAQ committees motivated them to do their jobs to the best of their abilities and “in service to the community.” Staff also reported that PAQ committees had eased workloads by advocating for additional personnel. On the other hand, while respondents credited PAQ community outreach efforts with attracting more clients to the health centers, the increased clientele was blamed for additional workload imbalances. One respondent commented on the difficulty of providing timely services to so many clients and also lamented the “lack of time for taking a break.” In another health center, however, the manager commented that the PAQ committee had been responsive to the workload challenges:

On the one hand, work has become harder because the PAQ’s community outreach efforts have encouraged community members to come to the health center every time they get sick. On the other hand, work has become easier... The [PAQ] committee members asked the local authorities to improve the services and make the center better. This motivated the personnel to work harder so more people came... After seeing that there were not enough nurses to handle the increased workload, the PAQ committee once again went to the authorities to urge them to recruit more nurses... So we got more help.

-Health center manager

Sector representatives described several improvements in service organization and delivery resulting from PAQ committee monitoring and “regular contact,” including improvements in provider attitudes, punctuality, and ownership over assigned tasks. In one focus group, a sector representative remarked that some health center managers might feel “threatened when the PAQ committee presents flaws, failures and gaps that should be resolved in the course of health center activities.”

According to **district representatives**, the PAQ committees have played a vital role in solving service delivery problems as well as guaranteeing provider accountability. One respondent described the PAQ team’s practical focus (“They discuss what isn’t working and what the source of the problem is”) and elaborated on the issue of accountability:

[Health center personnel] know that the PAQ will confront them if they receive patients poorly... The PAQs show that the personnel must be accountable to the population.

-District representative

4.4.2.3. Community Partnerships

PAQ committee members in more than half of the sites (7/12) called attention to the “improved climate of partnership” and two-way dialogue between health centers and communities. As one PAQ member put it, the growing “unity [between the community, the health center, and the sector] allows us to solve many different problems.” Another committee member described the increased sense of community ownership and involvement in health care decision-making in this way:

We have a suggestion box where clients share their ideas and advice... Clients feel involved in the health center...The health center is no longer an institution belonging to the health center manager but a place that serves the community. Clients can easily give their opinions concerning this or that which occurs at the health center, not to destroy [it] but to make it better.

-PAQ committee member

Both **sector and district representatives** commented on the advantages of having a system in place to “coordinate” community-government communication. One sector representative compared PAQ to a bridge, describing the bridge as a “link [that allows] us to listen to the community’s concerns and explain government health policies to them.” District respondents cautioned, however, that the PAQ approach is not something that can be embraced and implemented overnight. Rather, they suggested that it requires meticulous education to engage stakeholders and gain their understanding and acceptance.

4.4.2.4. Community Outreach and Education

Respondents identified a number of outreach roles for PAQ committee members. Outreach activities might include collecting household-level data on births and deaths, promoting public health insurance, distributing mosquito nets or providing health education. PAQ members noted that the most effective ways to provide community education was to approach community members “on their own turf” in churches and community meetings, to lead “by example” and to demonstrate practical skills such as raising animals or planting gardens.

PAQ committee members described community outreach and education as one of their most important activities and appeared certain that their outreach efforts had led to greater use of health center services and increased adherence to the national insurance plan. One PAQ committee member reported a fourfold increase in the use of family planning services and an even more dramatic increase in the number of assisted deliveries. Another stated, “We educated the surrounding community and most especially...pregnant women to consider the health center as their first choice for delivering their babies—according to the monitoring we have done, ...our objectives have been attained.”

Similarly, **health center staff and managers** almost universally perceived PAQ members to be playing a useful role in community outreach and education, notwithstanding the workload challenges introduced by the increased demand for services. The community health agents and religious leaders serving on the PAQ committees were described as being especially active in this regard. Respondents credited PAQ educational activities with “helping health centers to improve their credibility” and promoting specific services such as family planning.

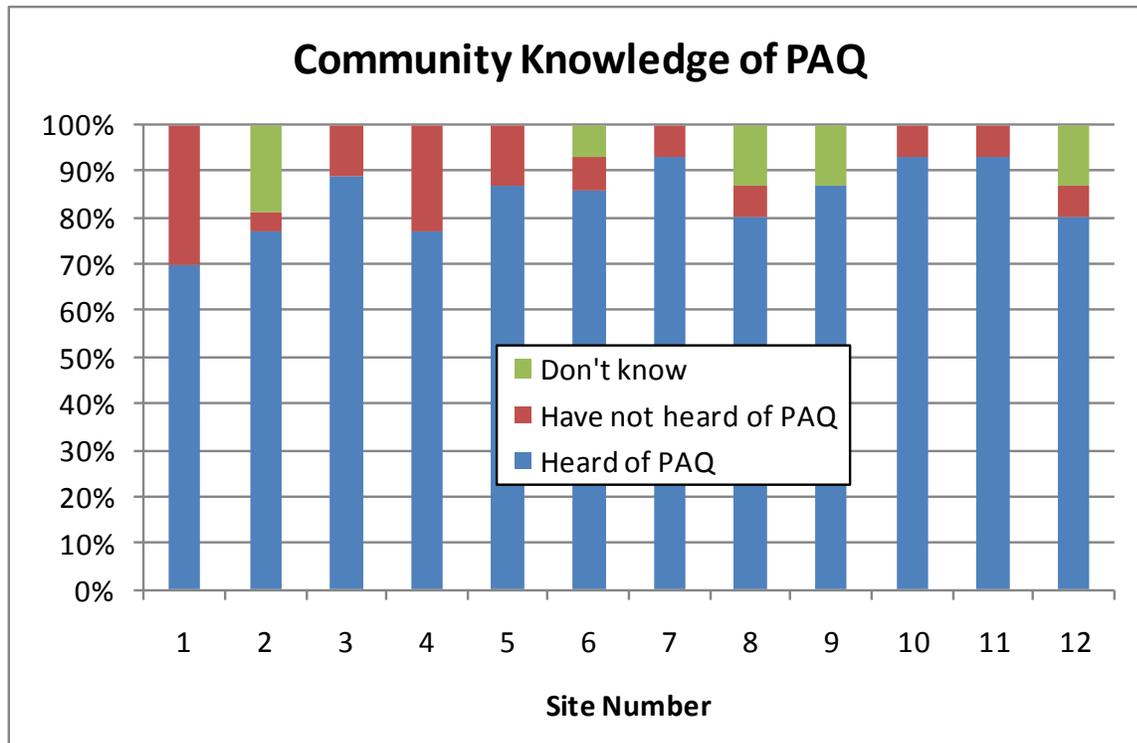
Some health center staff members commented on the PAQ committees’ successful efforts to educate the public about community-based health insurance. One staff member noted that clients had previously “refused to purchase health insurance because the service was so poor,” adding that subsequent improvements in service quality had resulted in “more subscribers.” A health center manager noted that the increased number of insured clients resulting from PAQ outreach efforts had enhanced the health center’s revenue stream, providing funds for recruitment and staff bonuses.

In the focus groups conducted with **sector-level officials**, respondents were asked to identify perceived benefits of the PAQ committees, either for the local health centers or for their communities. In most groups, respondents highlighted the PAQ teams’ community education and outreach efforts as especially noteworthy. Echoing other respondents, both sector and **district representatives** observed that these

efforts had had noticeable results in “mobilizing the population,” but some district officials suggested that additional training for PAQ members would allow for more informed delivery of health messages.

Community members were asked whether they had heard of their local PAQ committee and whether they knew anyone serving on the committee. In the event that the term “PAQ” was unfamiliar to respondents, interviewers also asked community members if they knew a member of the “health center committee to improve quality.” Most community respondents (84%) had heard of the PAQ committees by name or by functional description, while a small proportion (8%) were unsure (see Figure 5).

Figure 5: Community Respondents Familiar with PAQ (%)



When asked to describe the PAQ committees’ key responsibilities, respondents were more likely to cite community education and mobilization than they were to mention health center improvements (88% vs. 44%). Through either first-hand experience or indirect report, community respondents listed a variety of educational topics addressed by PAQ members. As shown in Table 8, education about public health insurance and hygiene were the two topics mentioned most frequently.

Table 8: Community Perceptions of PAQ Outreach Topics

TOPICS (# TIMES CITED)	KEY MESSAGES
Public Health Insurance (57)	-Improved access to care -Affordability
Hygiene (50)	-Personal hygiene -Home environment -Care of children
Vaccinations (34)	-Availability and schedule
Family Planning (33)	-Family planning goals -Information about specific methods
Assisted Delivery (28)	-Healthy birth -Role of traditional birth attendants and community health agents
Use of Health Center and Timely Care (27)	-Avoiding serious illness -Role of traditional healers and health centers
HIV/AIDS and TB (25)	-HIV/AIDS and TB information -HIV testing -Assistance for people with HIV/AIDS and TB
Malaria Prevention (14)	-Use of mosquito nets -Prevention for infants and pregnant women
Prenatal Care (9)	-Importance of early and ongoing prenatal care

4.5. PAQ Sustainability

The majority of assessment participants expressed interest in having the PAQ committees continue after the end of the Twubakane Program. District, sector, and PAQ committee respondents identified three main areas of need to ensure long-term sustainability: (1) funding for PAQ operations, (2) funding for health center improvements recommended by the PAQs, and (3) training to bolster committee members' skills.

4.5.1. Funding for PAQ Operations

Many respondents emphasized the need for PAQs to have an operating budget to cover member transportation, meeting refreshments and office supplies. PAQ committee members reported that they were already taking advantage of four key resources to fund PAQ operations (see Table 9), and most perceived these resources as important vehicles for long-term sustainability: **member contributions**; **external donor support** (e.g., Twubakane Program District Incentive Fund [DIF] grants); **government grants** (e.g., district administration or health center); and **income-generating projects**. Although few of the PAQ-run businesses had yet produced significant revenues, most were viewed as doing well and having the potential to eventually cover transportation costs and other operating expenses.

Table 9: Sources of Funding for PAQ Committee Operating Expenses

TYPE OF FUNDING	PURPOSE(S) OF FUNDING	# COMMITTEES REPORTING
External Donor Support		
Twubakane Program DIF grants (500,000 to 1.3 million Rwandan francs per PAQ committee)	-Operating expenses -Initiation of microprojects	11
Government Support		
District grants and donations	-Office supplies and equipment	11
PAQ-generated Support		
Member contributions (200-500 Rwandan francs per month)	-Operating expenses	9
Income-generating projects (e.g., cafeterias, small animal husbandry, petty trading, office equipment rentals, trash cleanup, agricultural projects)	-Operating expenses -Health insurance premiums for the poor -Special programs	12

District and sector representatives agreed on the importance of a multipronged approach to ensure that PAQ activities are not interrupted, mentioning income-generating activities, NGO funding, sector allocations, donations from other levels of government and health centers, PAQ member contributions, and even in-kind and cash contributions from the general population. One sector representative emphasized the need to use existing resources “as efficiently as possible” and to maximize available resources “rather than waiting for other funds.” A PAQ committee member commented:

We have a pineapple field to generate income. We haven't made any money yet but we expect a good harvest that will make us some profits. Even if Twubakane closes its doors we are capable of continuing to function because we have strength and we have ideas.

4.5.2. Funding for Health Center Improvements

Assessment participants noted the need for larger-scale funding for health center improvements such as increased staffing, equipment, and infrastructure. Respondents described international donors and (to a lesser extent) district and sector government as the primary funding sources for health center improvements (e.g., Belgian Technical Cooperation, IntraHealth International, Joint Learning Initiatives on Children, Medicus Mundo and World Vision). Some district officials reported that they had already provided supplementary funding to address improvements suggested by the PAQ committees.

4.5.3. Training

Respondents recommended that PAQ committee members be offered several types of training to strengthen their ability to perform their tasks. District officials particularly emphasized the need to train PAQ committee members in basic project management skills to ensure the success of PAQ income-generating activities. As one district representative commented, “Managing projects is something new. People need knowledge about...how to work with banks, how to monitor the project, [and] also a little accounting...” In addition, some respondents proposed that funding be sought to send PAQ members on “study tours” within and outside of Rwanda to gather new ideas and gain problem-solving skills.

5. Discussion

Our assessment used primarily qualitative methods (individual interviews and focus groups) to consider whether and how well community-provider partnerships are functioning to improve the quality of care in Rwanda's mostly rural health centers. In general, we found high levels of both community and government awareness of the PAQ committees and their activities. More than four-fifths (84%) of community respondents had heard of the committees, and most sector and district representatives spoke favorably of the PAQ committees' role within the local health care system.

Although the PAQ committees included in the assessment had been operating anywhere from half a year to three years, virtually all of the committees reported an acceptable level of functionality as assessed by meeting frequency. All but one committee had met within the last year (with half holding meetings in the previous month), and all of the committees' executive boards had met at least once in the last quarter.

5.1. PAQ Effectiveness

Meeting frequency is clearly an inadequate proxy for actual effectiveness. However, our interview and focus group data suggest that most PAQ committees have achieved their intended purpose by raising service quality at local health centers. Respondents of all types unhesitatingly linked health center infrastructure and service delivery improvements to PAQ committee activities. This conclusion is supported by Twubakane's 2008 facility assessment, which showed that three-fourths (96/130) of the functional PAQ committees had influenced some type of change at local health centers.

In addition to acknowledging the committees' practical achievements (e.g., acquisition of funds for improvements, construction of toilets and showers), many respondents also noted that the PAQs had been able to exert influence in the more intangible realm of provider and health center accountability by building morale and serving as "the eye of the people." Moreover, Twubakane's 2008 facility assessment showed that most PAQ teams (103/130 or 79%) had participated in community mobilization activities during the year.

Stakeholder perceptions regarding PAQ achievements focused on two health center outcomes (physical infrastructure/environment and service organization/delivery) and two community outcomes (community partnerships and community outreach). Nearly all categories of respondents discussed health center outcomes, although the topic was understandably most relevant to health center personnel and the PAQ committee members themselves. In the community outcome category, PAQ achievements in community outreach and education were almost universally mentioned, while government administrators (sector and district) noted the importance of community partnerships. Although all levels of administration (from the health centers to the districts) discussed the PAQ committees' role as community ambassadors and intermediaries, the design of the questionnaire for community members did not invite many responses on this topic, making it difficult to know whether community members' perceptions regarding partnerships match those of government officials.

PAQ committee members' perceptions of their contributions focused most significantly on changes in the health center environment (notably cleanliness and hygiene), whereas community members were more likely to discuss the PAQ teams' outreach activities. Despite these disparate perceptions, our results suggest that PAQ committee activities frequently address community priorities. For example, almost a fifth of community respondents described long wait times as an access barrier, noting that excessive wait times influenced their decisions about where to seek care. PAQ committee members and health center personnel, in turn, reported that PAQ oversight had helped reduce client wait times attributable to unprofessional provider behavior (e.g., tardy arrivals, long breaks, conducting personal business during work hours). On the other hand, many respondents acknowledged the very real issue of human resource shortages and understaffing. Moreover, comments by some community members suggest that the standard primary care package may not always be well understood, as community members requested cadres of providers who are not typically present at local health centers.

Although administrators credited PAQ community education campaigns with helping health centers reach service delivery and health insurance targets, these efforts, paradoxically, were sometimes described as too effective, drawing in more clients than facilities could handle and exacerbating the problem of long wait times. Understaffing is likely to remain a key structural barrier to care until the number of trained nursing graduates increases and the national budget allows for employment of additional health workers. As an intermediate solution, the government's strategy of training community health workers to attend to common health problems may offset some of the pressure put on the formal health sector.

Nonetheless, many health center staff members who were interviewed voiced appreciation for PAQ team efforts to address staffing issues. Two health centers described PAQ committee successes in lobbying for additional staff, and others commented on the replacement of underperforming staff and resolution of pay scale inequities. Some health center respondents also suggested that the PAQ teams' accountability focus alleviated pressure on managers to confront late and otherwise underperforming colleagues, or gave staff the opportunity to replace managers who were not doing their jobs. These comments suggest that PAQ committees may fill an oversight gap, particularly when formal supervision is inadequate. Although administrators should not be allowed to abdicate their responsibility for staff supervision, PAQ committees may be able to play an important supporting role in ensuring that employees and managers are performing appropriately.

All respondent categories recognized community outreach as an important aspect of PAQ committee duties. Moreover, each group of interviewees gave strikingly similar accounts of the community education topics for which PAQ committees were responsible, information typically disseminated according to national guidelines and sector goals. District officials noted, however, that PAQ members' ability to deliver health messages effectively would be enhanced by further training. In addition to providing health education, some respondents reported that PAQ team members accompanied clients to health centers when they were ill or about to deliver, or they offered other forms of practical support more typically associated with community health agents. The PAQ committees play a valuable adjunct and synergistic role in prompting community members to use services.

5.2. Barriers to Effectiveness

Our findings indicate that the overlapping issues of supervision, training and funding are perceived as the primary impediments to PAQ effectiveness. Although supervisors and PAQ committee members reported an interest in more frequent supervision, supervisors also commented on the lack of funds for travel to the field. All types of respondents agreed on the need for PAQs to have an operating budget to cover not only training costs but transportation to and from meetings and field visits to conduct community outreach.

Respondents' comments about the sometimes sporadic nature of PAQ supervision indicate that the supervisory process could benefit from clarification of supervisory roles and responsibilities. In addition, the supervisory process needs to address the problem of PAQ member turnover, perhaps by creating a "buddy" system where more experienced members provide guidance to new members.

PAQ committee members suggested that they would welcome supervision twice a month, but with a focus on practical skills such as program management and health education. Because PAQ members are volunteers who do not receive financial compensation, the retention of PAQ team members might be enhanced by offering training that strengthens volunteers' sense of effectiveness and their perception that they have the skills needed to perform their work. Both PAQ members and supervisors noted that PAQ participants have wide-ranging "job descriptions" encompassing committee management, health center oversight, infrastructure assessment, community education and mobilization, and data reporting. Some PAQ members expressed concern that they lacked the expertise to handle these tasks.

Some elements of volunteer motivation are already being addressed. For example, the PAQ Manual, which focuses on creating a shared vision and a cohesive team, is likely to contribute to the sense of connectedness among volunteers. In addition, assigning specific tasks to different members of the PAQ committee may be an effective way of showing appreciation for their uniqueness and particular skills. Finally, PAQ members' stated pride in their activities indicates that many participants perceive their work to be rewarding and effective.

5.3. Sustainability

5.3.1. Organizational Structure

At present, there are no term limits for PAQ members, and members leave the committees only by choosing to step down or if they are removed due to poor performance. One respondent suggested that the by-laws for each PAQ committee be modified to include a section on term limits, leaving it up to each committee to determine the amount of time that a member can serve before being reelected or replaced. The by-laws would also specify the number of consecutive terms a PAQ member is allowed to serve, the amount of time that must pass before they can stand for elections again, and the periodicity and timing of elections. This respondent suggested that PAQ teams stagger their elections so that some experienced members are always in place to provide guidance to new members. Some committees might decide that term limits are unnecessary for their PAQ team or for certain members.

5.3.2. Training

To ensure the PAQ committees' sustainability, respondents underscored the importance of providing members with basic training in **organizational management**. Some respondents suggested that the Twubakane Program, as the original sponsors of the PAQ committees, be responsible for developing the organizational management training content and contract with a training firm to provide for future training needs. Training could encompass a broad range of skills, including:

- Writing job descriptions
- Building leadership skills
- Running meetings
- Ensuring transparency
- Ensuring accountability
- Strategic planning
- Budgeting and accounting
- Holding elections
- Program design and management
- Public relations
- Customer service planning
- Financial reporting and analysis
- Programmatic reporting and analysis
- Fundraising
- Conflict management and resolution
- Division of labor

Although many PAQ members emphasized the need to learn about the **health topics** that are the focus of their education and outreach efforts, it is clear that some PAQ committee members may be more suited to function as health educators than others. It may be important for PAQ committees to assess training needs and assign responsibility for outreach to those members who are most comfortable delivering health messages.

5.3.3. Funding

Although some health centers or sector offices already pay for PAQ members' transportation costs, a repeated theme voiced by nearly all respondent categories was the need for a regular source of transportation funds to allow PAQ members to attend meetings and deliver community education. In addition to transportation expenses, numerous respondents requested that PAQ members receive a stipend or per diem for their work, a request that raises a host of sustainability concerns for a model based on voluntary community service. The development of PAQ-operated businesses offers one solution to this dilemma. PAQ-run projects generate income to pay for PAQ operating expenses as well as some community health needs but require considerable training and guidance on program management and accounting to be successful. Some respondents cautioned that the challenges of running a business have the potential to distract PAQ committees from their primary service goals. To avoid this pitfall, respondents suggested that committees develop a well-thought-out business plan, including a feasibility analysis; operating budget; signed partnership agreements; legal documentation of ownership, profit use, and reinvestment strategies; and a clear management structure.

5.4. Assessment Limitations

Several factors exist that limit the conclusions that can be drawn from our data. Due to administrators' competing responsibilities and job demands, many of the interviews with district and sector representatives were relatively brief, and focus groups with these cadres were often small. Nonetheless, most categories of respondents were eager to share their perceptions and opinions regarding the PAQ committees' activities.

In addition, the assessment design does not allow us to present conclusive evidence on the extent of the PAQ committees' influence on health center performance indicators. Because use of prenatal care, assisted delivery and vaccination services increased both prior to and after the committees' initiation, it is unlikely that the PAQ committees were the sole cause of the documented increases in service use over the project period. However, respondents' anecdotal observations suggest that PAQ outreach activities in the three content areas were considerable and probably deserve some credit for the rise in numbers.

Finally, as extensively documented elsewhere, Rwanda's MOH has successfully introduced a number of progressive innovations over the past several years, including national scaling up of community-based health insurance (*mutuelles*), performance-based financing (PBF) and a variety of training and quality

improvement approaches. In this rapidly changing climate, it is difficult to attribute improvements in specific indicators to one intervention without control groups and multivariate analysis.

6. Recommendations

A number of recommendations emerged from our assessment's findings. The recommendations support continuing expansion of the PAQ approach in Rwanda, and they provide guidance for MOH efforts to implement quality assurance measures nationally. We include recommendations that address: (1) improving PAQ committee operations; (2) measuring PAQ impact on the health care system; and (3) ensuring PAQ sustainability.

6.1. PAQ Committee Operations

- Organize meetings within each region for district and sector administrators to develop a common understanding of **appropriate supervisory roles**
- Develop **job descriptions for supervisors**, specifying frequency of supervision and processes for managing and sharing data with other administrative structures
- Train supervisors on ways to support PAQ committee members through **recognition of achievements**
- Maximize volunteer **participation** by matching tasks to the existing skills of PAQ members.

6.2. PAQ Impact on Health Care System

6.2.1. Infrastructure

- Encourage PAQ committees to provide input to health committees on facility **infrastructure maintenance needs**.

6.2.2. Service Organization and Delivery

- Foster collaboration between PAQ committees and health committees such that PAQ committees provide input to health committees on staffing needs for each health center; at a minimum, the plan should outline the catchment area population, number of clients served, current client-provider ratios and projected staffing needs.
- Maintain PAQ committees' **oversight functions** regarding the performance of health care staff, and ensure that processes are in place to allow PAQ teams to share perceived problems with health center managers
- Support PAQ members in continuing to identify **gaps in service delivery**.

6.2.3. Community Partnerships

- Build PAQ committee members' **advocacy skills**
- Encourage the **community health agents** who sit on PAQ committees to exercise leadership and guidance regarding community health priorities.

6.2.4. Community Outreach and Education

- Train and supervise PAQ members to carry out **community outreach and education** activities on selected topics, providing refresher training as needed
- Investigate the need for (and feasibility and sustainability of) producing and distributing **didactic materials**
- Encourage PAQ committees to educate communities on the **health services that are available** in their health center
- Support PAQ members in continuing to encourage citizens to enroll in the *mutuelles* and to identify those who may need financial assistance to pay premiums
- Encourage the **health insurance program managers** appointed to health centers to accompany PAQ members to the field to register interested households.

6.3. Sustainability

6.3.1. Institutionalization and Standardization

- Integrate the PAQ approach into the Community Health Strategies since the approach is included as one mechanism for quality assurance in both the National Quality Assurance Policy and in the National Community Health Policy. Subsequently, review and adopt a PAQ manual and encourage partners supporting quality assurance and community health to support districts and sectors in establishing PAQ committees.
- Facilitate the institutionalization of the PAQ approach to act as a safeguard which verifies, monitors and provides feedback to the district and the sector on the entirety of the community health program. The PAQ team is the most appropriate entity to transparently perform the role of advisor to protect the interests of the community. In addition, the PAQ approach complements other quality assurance mechanisms in the health facilities through the insistence on collaborative health care provision.

6.3.2. Organizational Structure

- Encourage PAQ committees to consider **term limits** and include term limit stipulations in their by-laws
- Consider expansion of PAQ membership to include representatives of **local and sector-level NGOs** working to improve the quality of community health services.

6.3.3. Training

- Establish training procedures for **new PAQ committee members**, exploring options such as annual refresher courses for all interested PAQ members or a “buddy system” for new members
- Develop a **training schedule** and **training curricula**, and determine whether training will be standardized across districts or tailored to local needs
- Develop a strategy to cover the **cost** of training courses
- Determine **who** will provide initial and refresher PAQ training (e.g., government, donor-supported programs, other)
- Maintain the **team building** emphasis of PAQ training courses.

6.3.4. Funding

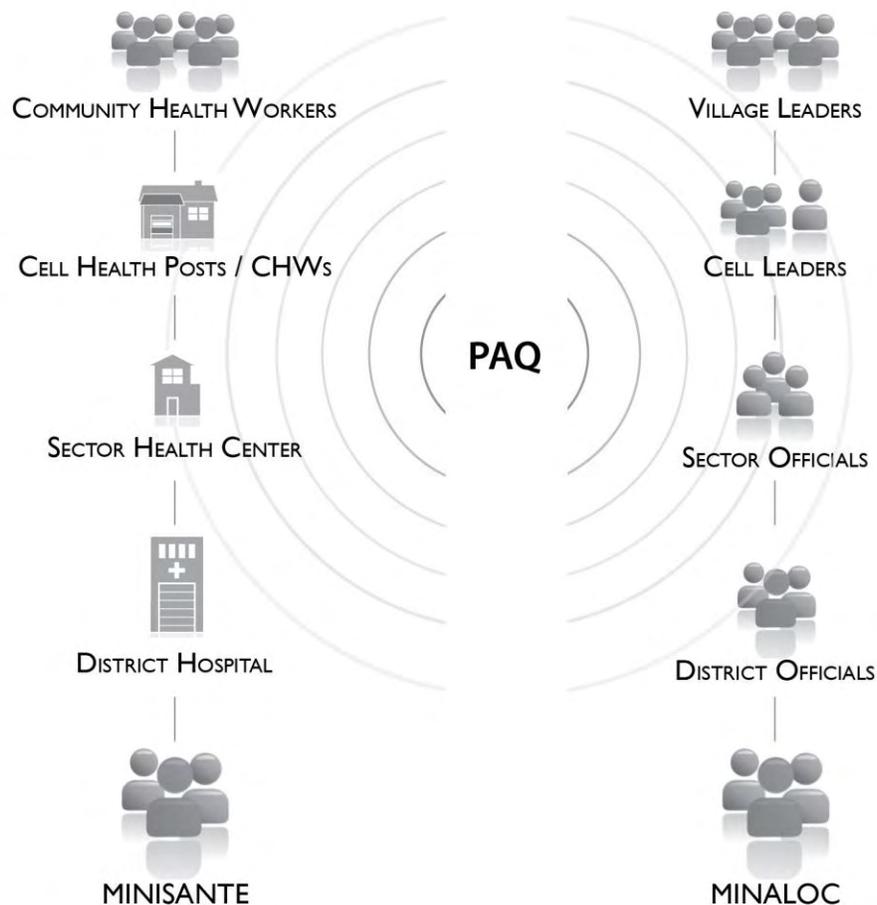
- Assist PAQ committees in generating realistic estimates of their **operating expenses** and projected **financing needs**
- Evaluate the advantages and disadvantages of various **funding mechanisms** to cover PAQ expenses. Options include PAQ-operated businesses, national or district government support, and collaboration with cooperative development partners.

7. Conclusions

The PAQ approach was first introduced in Rwanda in 2001. Since the Twubakane Program began in early 2005, PAQ committees have become operational in nearly all (96%) of the health centers in the 12 Twubakane Program-supported districts. According to the most recent Twubakane assessment, 74% of the committees have succeeded in influencing health center changes and 79% of PAQ teams have participated in community outreach credited with increasing use of health services. In this assessment, participants ranging from the district and sector levels on down to the community level reported an impressively wide range of PAQ activities and suggested that many positive changes had resulted from those activities.

Based on the success of the PAQ approach in the 12 Twubakane districts, it is recommended that the approach be scaled up to a national approach for quality improvement. To sustain the PAQ committees' momentum and deepen community engagement with local health facilities, it will be important that the MOH develop a strategy to ensure that the PAQ approach officially listed as one mechanism for assuring and improving the quality of services, be supported and rolled out. The MOH and partners also will need to work with district and sector leadership to begin to address issues such as PAQ member turnover, training needs and mechanisms for covering operating expenses. Although health centers will continue to be affected by deeper structural problems such as human resource shortages, this assessment's findings indicate that community-based entities such as the PAQ committees have the potential to strengthen health care quality and client satisfaction.

Appendix 1: PAQ Committees' Integrative Role within Health System and Administrative Structure of Rwanda



PAQ Committee members *may* include:

Community Representatives

Community Health Workers
 School representatives
 Church representatives
 Local NGO representatives
 Police
 People living with HIV
 Private sector representatives
 Traditional healers

Health Care Representatives

Health center staff
 Health center managers
 Health Committee Managers
 Health insurance manager

Sector Representatives

Executive secretary
 Manager of social affairs
 National Youth Council Coordinator
 National Women's Council

Appendix 2: PAQ Assessment Questionnaires

4. Quels sont les bénéfices que vous voyez grâce à ce programme ? (changements dans le travail des centres de santé suite au lancement des activités du PAQ, façon de travailler)

a.

b.

c.

5. Comment ? (comparé aux Comité de santé, Performance-based financing, décentralisation des fonds et responsabilités)

a.

b.

c.

III. AVANTAGES ET DÉSAVANTAGES DE L'EQUIPE PAQ (15 MIN)

6. Quels sont les désavantages des équipes PAQ ?

a.

b.

c.

7. Pourquoi ?

a.

b.

c.

GUIDE DE DISCUSSION : Individuel du PAQ
Enquête – PROGRAMME POUR L’AMÉLIORATION DE LA QUALITÉ « PAQ »
Twubakane, December 2008

NUMERO DE QUESTIONNAIRE

SITE

NO.

DATE

DD

YY

START TIME

HR

MIN

END TIME

HR

MIN

DATA COLLECTOR

RESPONDANT POSITION

SITE

I. BACKGROUND (15 MIN)

1. Comment avez vous été sélectionné pour être membre de équipe PAQ ? [Mwatoranijwe mute kugira ngo mube umunyamuryango wa PAQ ?]

2. Quelles sont vos responsabilités au sein de l'équipe PAQ ? [Ni izihe nshingano ufite muri PAQ ?]

3. Donnez des exemples du travail fait pour l'équipe PAQ ? [Mwaduha ingero z'ibikorwa byakozwe na PAQ ?]

SUPERVISION (8 min)GUKURIKIRANA IBIKORWA

3. Who supervises the PAQ? [Ni nde ukurikirana ibikorwa bya PAQ?]

- a. Encadreur [Ukurikirana ibikorwa] b. Rép. Affaires Sociale [Ushinzwe imibereho myiza] c. autre [Undi]

4. Sur quelle fréquence ils vous visitent? (noter le plus souvent) [Ni kuruhe rugero babasura ? (Vuga kenshi babikora)]

- a. Chaque semaine b. Chaque mois c. Chaque trimestre
d. Chaque six mois e. Chaque an f. Jamais

5. Qu'on fait vos superviseurs pour assister au travail de votre équipe ? [Abakurikirana ibikorwa byanyu babafasha iki mu kazi ?]

6. Discuss additional needs for supervision [Mwatubwira ubundi buryo bukenewe bwo gukurikirana ibikorwa byanyu.]

II. SUSTAINABILITY (8 min) UBURAMBE

7. What are the current funding sources which support the PAQ? [Ni hehe PAQ ivana inkunga]

- a. Service Fees [Amafaranga y'akazi] b. GOR [guverinoma] c. World Bank [Banki y'isi]
d. Twubakane e. Other [Ahandi] f. Other [Ahandi]

8. How will the PAQ support itself after the Twubakane project closes? What steps have you taken to ensure sustainability of the PAQ ? [PAQ yanyu yiteguye ite gukomeza ibikorwa byayo mugihe Twubakane ihagaritse ibikorwa byayo. (ni izihe ngamba mwafashe kugirango muzakomeze mukore.)]

III. PROBLEM RESOLUTION (20 MIN) IBISUBIZO BY ' IBIBAZO

9. Quels étaient les problèmes jugés prioritaires pour améliorer la qualité des services que vous avez identifié et résolu pendant votre travail en tant qu'équipe PAQ ? (trois au maximum). [Ni ibihe bibazo byihutitwa PAQ yabashije gukemura kugirango imikorere irusheho kuba myiza.]	10. Comment avez-vous choisi les problèmes prioritaires ? [Ni gute mwahisemo ibyo bibazo.]	11. Pourquoi avez-vous choisi ces problèmes ? [Kuki aribyo mwahisemo ?]	12. What steps did you take to reach your desired outcome? [Ni iki mwakoze kugirango mugere ku inshingano mwari mwihaye?]
a.			
b.			
c.			
d.			

13. Please discuss priority problems you have identified but have been unable to resolve? (trois au maximum). [Mwatubwira bimwe mubibazo byihutirwaga ariko mutabashije gukemura .]	14. What have been your constraints to finding viable solutions? [Ni izihe mbogamizi mwahuye nazo mugushaka ibisubizo by'ibibazo mwari mufite.]
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a.	
b.	
c.	
d.	
e.	

IV. RESULTANTS & RECOMMENDATIONS (15 MIN)

15. What achievements are you most proud of ? Qu'est ce qui fonctionne bien dans cette équipe? [Mubyo mwagezeho ni ibiki mwishimira kurusha ibindi? Muri PAQ yanyu ni iki kigenda neza kurusha ibindi ?]

16. D'après vous, y a t il un changement des attitudes des villageois face aux services de santé ? (droit aux services, appréciation, implication, etc.) Comment pouvons-nous améliorer la participation des membres des communautés ? [Ku bwanyu, mubona hari impinduka kumyumvire y'abaturage kubijyanye ni imikorere y'ibigo nderabuzima? (uburenganzira mu kwivuza, mu gutanga ibitekerezo, kubigiramo uruhare, n'ibindi.) Twakangurira dute abaturage ngo bagire uruhare mu bikorwa by'ubuzima bwabo.]

17. Quelles seraient vos recommandations pour la mise en exécution de vos activités dans les autres secteurs et centres de santé ? Quelles sont les difficultés que votre équipe rencontre à ce moment ci ? [Ni ibihe byifunzo mwatanga kugirango ibikorwa byanyu bigere no muyindi mirenge ndetse no mubindi bigo nderabuzima. PAQ yanyu ifite ibihe bibazo ?]

FILL THE REST OF THE QUESTIONNAIRE IN WITH MEETING AND GROUP DOCUMENTS

V. PARTICIPATION

18. What positions are represented in your PAQ? [Ni bande bagize ikipe PAQ yanyu?]

19.

20.

1			
2			
3			
4			
5			
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24			
25			

19. Qui était présent dans la dernière réunion de l'équipe PAQ ? (*check the box above right*) [Ni bande bari mu nama y'ubushize?]

20. Who participated in this focus group? (*check the box above right*) [Ni bande baje muri iki kiganiro?]

VI. MEETING FREQUENCY

21. Quand est-ce que l'équipe PAQ était établit? [PAQ yanyu yatangiye ryari ?] MM YY
22. How many times has the PAQ committee met in the last year? [Mwakoze inama zingahe za komite umwaka ushize?]
23. Quand est-ce qu'a eu la dernière réunion du comité de l'équipe PAQ ? [Inama yanyuma ya komite ya PAQ yabaye ryari ?]
- | | | | | |
|-------------------------------|---------------------------|-----------------------|-----------------------------|---------------------------|
| a. dans les 30 derniers jours | b. dans les 2 mois passés | c. le trimestre passé | d. entre 4 et 6 mois passés | e. ca fait plus de 6 mois |
|-------------------------------|---------------------------|-----------------------|-----------------------------|---------------------------|
24. Combien de membres étaient-ils présents au cours de la dernière réunion du comite de l'équipe PAQ ? [Ni abanyamuryango bangahe bari muri iyo nama ya komite ?]
25. Who called the last PAQ committee meeting? [Ni nde watumije inama ya komite iheruka?]
-
26. Normalement, qui convoque les réunions du comité de l'équipe PAQ? [Ubusanzwe ninde utumiza inama ya komite ya PAQ ?]
-
27. How many times has the entire PAQ committee met in the last year? [Mwakoze inama rusange zingahe umwaka ushize?]
28. Quand est ce qu'a eu lieu la dernière réunion de toute l'équipe PAQ ? [Inama rusange ya nyuma ya PAQ yabaye ryari ?]
- | | | | | |
|-------------------------------|---------------------------|-----------------------|-----------------------------|---------------------------|
| 1. dans les 30 derniers jours | 2. dans les 2 mois passés | 3. le trimestre passé | 4. entre 4 et 6 mois passés | 5. ca fait plus de 6 mois |
|-------------------------------|---------------------------|-----------------------|-----------------------------|---------------------------|
29. Combien de membres étaient-ils présents au cours de la dernière réunion de toute l'équipe PAQ ? [Iyo nama yarimo abayamuryango bangahe ?]
30. Who called the last PAQ meeting? [Ninde watumije inama rusange iheruka?]
-
31. Normalement, qui convoque les réunions de toute l'équipe PAQ? [Ubusanzwe ninde utumiza inama rusange y'abayamuryango bose ba PAQ ?]
-

GUIDE DE DISCUSSION : Personnel de la Formation Sanitaire Focus Group et Individuel

Enquete – PROGRAMME POUR L’AMÉLIORATION DE LA QUALITÉ « PAQ » Twubakane, Decembre 2008

QUESTIONNAIRE NUMBER	SITE	NO.
DATE	DD	YY
START TIME	HR	MIN
END TIME	HR	MIN

DATA COLLECTOR _____

SITE _____

I. BACKGROUND (5 MIN)

1. Quels sont vos rôles au FOSA. [Ni izihe nshingano zanyu mu kigo nderabuzima ?]

a. Responsable maternelle et infantile [Ushinzwe ababyeyi n’abana]
b. Responsable pour les vaccinations [Ushinzwe inkingo]
c. Responsable pour la consultation [Ushinzwe gusuzuma]
d. Responsable pour la mutuelle [Ushinzwe ubwisungane mu kwivuza]
e. autre [ibindi]

2. Genre

a. masculine [gabo]	b. féminine [gore]
a. masculine [gabo]	b. féminine [gore]
a. masculine [gabo]	b. féminine [gore]
a. masculine [gabo]	b. féminine [gore]
a. masculine [gabo]	b. féminine [gore]

II. ACTIONS DE L’EQUIPE PAQ (15 MIN)

3. Est-ce que vous pouvez donner les exemples des changements à la FOSA résulté des décisions pris par l’équipe PAQ ? Quels changements dans votre travail sont grâce à l’initiative PAQ ? (3 exemples) [Mwatubwira ingero z’ibyahindutse mu kigo nderabuzima biturutse ku ngamba za PAQ ? Ni izihe mpinduka zabaye mu kazi kanyu bitewe na PAQ (Ingero 3)]

Comment est-ce que vous avez répondu ? Pourquoi ? Que faites vous exactement pour faciliter le travail de l’équipe PAQ? (exemples des actions faite) [Ni gute mwaba mwaroroheje akazi ka PAQ ? Ni ibihe bikorwa bifatika mwaba mwarakoze mu urwo rwego rwo korohya akazi ka PAQ ?]

a.
b.

a.
b.

c.

c.

4. Maintenant, est-ce que votre travail est plus facile ou plus difficile suite à l'initiative PAQ ? [Mubona akazi kanyu karoroshye cyangwa karagoranye kuva aho PAQ itangiriye imirimo yayo muri iki kigo nderabuzima cyanyu ?]

5. Comment? [Sobanura]

a.

a.

b.

b.

c.

c.

III. ATTITUDES VER L'EQUIPE PAQ (10 MIN)

6. Comment est-ce que le titulaire peut mieux faciliter le travail de l'équipe PAQ ? (Informations sur les activités réalisées par l'équipe PAQ) How can the linkages between the PAQ and the FOSA be improved ?) [Ni gute umuyabozi w'iki kigo nderabuzima yatuma umurimo w'abagize PAQ wakorwa neza? (Mwaduha amakuru ku mikorere ya PAQ n'ikigo nderabuzima cyanyu?)

7. Qu'est-ce que vous pensez de la PAQ ? Quelles seraient vos recommandations pour la répliation de cet effort dans d'autres centres de santé ? [Mubona mute ibikorwa bya PAQ ? Mwatanga izihe nama kugira ngo PAQ irushaho kunoza imikorere yayo mu bindi bio nderabuzima ?]

GUIDE DE DISCUSSION : Interview Individuel Clients
Enquete – PROGRAMME POUR L’AMÉLIORATION DE LA QUALITÉ « PAQ »
Twubakane, Decembre 2008

QUESTIONNAIRE NUMBER	SITE	NO.
DATE	DD	YY
START TIME	HR	MIN
END TIME	HR	MIN

DATA COLLECTOR _____
 SITE _____

I. BACKGROUND (Umwirondoro) (5 MIN)

- | | | | | |
|--|--|-------------------------------------|-----------------------|--------------------|
| 1. Age du répondant
[Imyaka y’ususbiza] | | 2. Genre du répondant
[Igitsina] | a. homme
[umugabo] | b. femme
[gore] |
|--|--|-------------------------------------|-----------------------|--------------------|

II. FORMATION SANITAIRE (Ikigo nderabuzima) (10 MIN)

- | | | | |
|---|--------------------------------------|-----------------------------------|-----------------------------|
| 3. Fréquentez-vous _____ centre de santé? (insérer le nom du centre) | a. oui [yego] | b. non [oya] | |
| 4. When was the last time you visited the FOSA ? [Ni ryari uheretse kwivuriza kuri iki kigo nderabuzima?] | a. < 3 mois
[mbere y’amezi atatu] | b. <1 an
[mbere y’umwanka] | c. jamais [nta narimwe] |
| 5. Est-ce que vous pensez que l’accès aux services et la qualité des services de santé adéquate ou pas adéquate ? [Ubuvuzi muhabwa kuri iki kigo nderabuzima mubona zikwiriye cyangwa ntikwiriye ?] | a. adéquate
[zirakwiriye] | b. pas adéquate
[ntizikwiriye] | c. ne sais pas [ntacyo nzi] |
| 6. Pourquoi ? [Kubera iki ?] | | | |

7. Pouvez-vous donner les exemples des changements au centre de santé dans les 3 mois précédents? [Mumezi atatu (3) ashize waduha ingero z’ibyahindutse muri iki kigo nderabuzima ?]

a. improved hours [amasaha yarahindutse]	b. improved service [serivisi zarahindutse]	c. improved interaction w/ staff [imikoranire yarahindutse]
d. easier navigation of services [serivisi zitugeraho muboryo bworoshye]	e. better physical environment [tuvurirwa ahantu heza]	f. none [nta nakimwe]
g.	h.	i.

Appendix 3: Informed Consent Statement

- Murahho,
- Nitwa-----
- Nkorera IntraHealth TWUBAKANE, umuryango utegamiye kuri Leta, ukorana n'uturere n'akanyu karimo. Turakora ubushakashatsi ku bijyanye n'ibikorwa by'ubuzima mu baturage. Tugenda tuganira n'abantu mugihugu hose, dukusanya ibitekerezo, kubijyanye n'ibikorwa mu bigo ndera buzima.
- Ibyo turi buganire ni ibanga hagati yacu. Ntazina ryawe cyangwase undi mwirindoro bizagaragara muri raporo yacu.
- Ntabwo ari agahato kuganira natwe, ariko mubitwemereye, byadufasha kumenya uburyo twavugurura ibikorwa IntraHealth TWUBAKANE iha ibigo nderabuzima.
- Hari ibibazo ndibukubaze, uransubiza ibyo uzi ibyo utazi urabyihorera.
- Ikaganiro kiramara kiramara nk'iminota makumyabiri (20).
- Niba hari icyo ushaka kumbaza mbere y'uko dutangira ikiganiro wakimbaza.

MURAKOZE