



Twubakane

Decentralization and Health Program

Twubakane Fourth Year Annual Report

...Let's Build Together



“Abishyize hamwe nta kibananira”

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ACRONYMS

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

TWUBAKANE IMPLEMENTING PARTNERS

IntraHealth International (*lead partner*)

RALGA

RTI International

Pro-Femmes Twese Hamwe

Tulane University

Government of Rwanda

EngenderHealth

Ministry of Local Government

VNG

Ministry of Health

INTRODUCTION

The Twubakane Decentralization and Health Program, implemented by IntraHealth International, RTI International, and Tulane University's Payson Center and other partners, is a five-year USAID-funded program. The Twubakane Program's overall goal is to increase access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels. The program is a partnership between the Government of the United States of America (USG), represented by USAID, and the Government of Rwanda (GOR), represented by the Ministry of Local Government and the Ministry of Health. Twubakane also works in partnership with the Rwandese Association of Local Government Authorities (RALGA), EngenderHealth, VNG (Netherlands International Cooperation Agency) and Pro-Femmes.

The program has continued to combine central-level policy and technical support with hands-on district capacity building to assist in a smooth transition to a highly functioning decentralized system. Launched in March 2005, the Twubakane Program has, over the past four years, responded to a rapidly changing environment and continuously applied evidence and lessons learned to foster sustainable results. Working in close partnership with the GOR at all levels, the Twubakane team has learned that nurturing and supporting political engagement, especially at decentralized levels, is essential in ensuring the availability and use of high-quality services.

Twubakane Program Participating Districts

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

Twubakane, with its unique approach to improving health by supporting decentralization, has demonstrated that high-level and district-level political commitment facilitates sustainable results. Among other factors, the program has noted that the district performance-based contracts (*imihigo*), signed by the district mayors and the president of Rwanda, have had a positive impact on health, contributing to both improved health resources and to visible district-level leadership in health. Twubakane's District Incentive Fund (DIF) grants program has contributed both to district capacity building, and to resource mobilization, supporting the districts in reaching their goals laid out in the *imihigo*.

The Rwandan Government has adopted an integrated and decentralized approach for all health services and at all levels of service. In its support to the GOR, Twubakane works closely with the Ministry of Health (MINISANTE) and other government ministries (Ministry of Local Government—MINALOC—and the Ministry of Economic Planning and Finance—MINECOFIN) and with districts, health facilities and providers. Our approach supports integration of health services in facilities and communities, as well as a multisectoral approach to health. The program's support for an integrated package of services builds on the GOR's national policies and programs and helps districts, sectors, health facilities and communities in implementing the national priorities. Since the program began in 2005, the GOR has made great progress in developing policies and programs that facilitate an integrated and comprehensive package of services, and USAID and other development partners have made resources available to support not just discrete health issues, but overall health system strengthening.

During Twubakane's fourth year, the team continued to work closely with districts and other partners to promote high-quality health services in a sustainable manner. The program built upon the strides made in the first three years, focusing on the ability of districts to manage and implement the District Incentive Fund (DIF) grants and to support the quality of health services, as well as linkages through the community-provider partnership PAQ (*Partenariat pour l'Amélioration de la Qualité*) teams. Twubakane-supported districts demonstrated improved capacity to plan, budget for and manage services, while also recognizing the continued importance and need to build additional capacity of health care providers, health facilities and district authorities.

Twubakane's support to the GOR this year to reach the Millennium Development Goals has led to measurable results. Twubakane-supported districts made additional progress this year in increased use of family planning and improvements in maternal health and child survival. Interventions such as ensuring a full range of contraceptive methods, supporting family planning secondary posts, rolling out high-quality obstetrics care in health centers, supporting home-based management of malaria and the integrated package of community health services, and supporting community-provider partnership teams have all had a positive impact on the health of children, their mothers and communities.

Initial results of the Rwanda Interim Demographic and Health Survey show dramatic improvement in utilization of modern contraceptive methods; these results corroborate our findings from Twubakane-supported districts. In these 12 districts, couple years of protection for modern contraception more than tripled from 2005 (40,766) to 2008 (193,814). The number of deliveries managed by skilled providers also has increased, from 70,124 in 2007 to 92,156 in 2008. The number of children under five successfully treated for malaria in communities also continues to be significant (50,520 in 2008), as does the number of children benefiting from nutritional programs.

PERFORMANCE REVIEW BY COMPONENT

For each component, data related to the Twubakane Program Performance-Monitoring Plan (PMP) is reported for January – December 2008. Data were obtained from all health centers (HCs) and district hospitals receiving Twubakane support, unless otherwise stated. Data were provided from the Rwanda health management information system (HMIS), a rapid facility assessment (RFA) in HCs and hospitals conducted by Twubakane in December 2008, and district authorities as part of a strengths, weakness, opportunities and threats (SWOT) exercise. Some results (trainings and workshops) are reported from the Twubakane Program's training database.

Component 1: Family Planning and Reproductive Health Access and Quality

Repositioning FP: The Twubakane Program continues to support FP repositioning in Rwanda and to ensure that advocacy is translated into action through continued orientation of authorities and local leaders on population and health issues in FP, support for mobilization activities through DIF grants and for implementation of district plans to reach FP objectives laid out in the performance-based contracts between the districts and the President.



Honorable Christine Mukarubuga speaking in Ngororero District during an outreach campaign, November 2008

“Life is becoming more and more expensive, and to respond to the challenges, women must have an opportunity to contribute to the socio-economic life of their families,” noted the Honorable Christine Mukarubuga during a campaign on the role of couples in supporting family planning and HIV/AIDS prevention in November 2008. “This is only possible through family planning.”

The Twubakane Program’s continued collaboration with the Rwanda Parliamentarians’ Network for Population and Development, supported by the Hewlett Foundation, has resulted in ongoing efforts by parliamentarians to speak directly to their constituents about the important

contributions of family planning to their health and development. The Hewlett-supported initiative also has allowed Twubakane to support high-level government commitment to population and FP and to train journalists in FP to improve media coverage, and produce a report on Rwanda’s experience with FP. This report has been cited in numerous other reports and presentations about family planning in Africa. In early 2009, district mayors will participate in an orientation session to encourage greater support of FP.

Twubakane’s participation in the national FP technical working group continued, with support for the development of a national strategy to increase the number of trained health care providers through on-the-job training (OJT) in family planning. Through OJT, trained providers will serve as trainers for their colleagues. To facilitate this training, Twubakane contributed to the finalized version of the national training modules for family planning along with other FP partners (Association Rwandaise pour le Bien-Etre Familial or ARBEF, Capacity Project, GTZ, Population Services International, and MINISANTE). These modules, which include a reference manual for FP training, a trainer’s guide for OJT, and a participant’s OJT guide, were finished in 2008.

The community-provider partnership, or PAQ (*Partenariat pour l’Amélioration de la Qualité*) teams also have played an active role in family planning-related behavior change communication. In all 12 districts, PAQ teams have organized community mobilization and, in many, conducted door-to-door campaigns, to share information about the benefits of family planning. “There is a notable increase in family planning use throughout the district,” said Damas Muhororo, the Mayor of Kayonza District. “We increased the use of family planning from 11% to 21%, thanks, in large part, to Twubakane’s contributions and support to the PAQ teams’ mobilization work at the community level.”

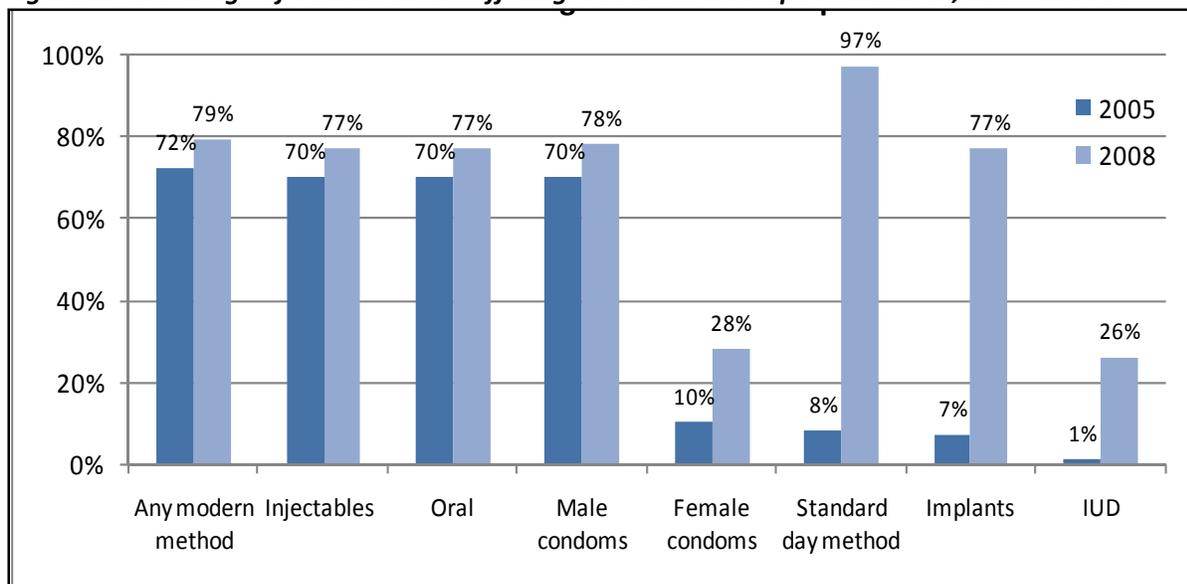
Increasing Access to, Use and Quality of FP: In 2008, the Twubakane Program continued to support a decentralized approach to the rollout of national-level FP training, supporting the trained district-level trainers to provide ongoing training and supportive supervision. As part of the FP training, Twubakane supported continued training and post-training follow-up in long-acting methods to ensure that all HCs are able to offer a full range of short-term *and* long-acting methods (IUDs and implants). Training in long-acting methods began in late 2006, and many HCs requested refresher training and supportive supervision during 2007 and 2008 due to attrition of providers or a desire for enhanced knowledge and skills. Attaining full proficiency in skills has been hampered by occasional shortages of Jadelle implants, an increasingly popular FP method in Rwanda. Twubakane and other FP partners continue to work closely with the USAID DELIVER Project to improve continuous availability of Jadelle in health centers. By

the end of 2008, all public (non Catholic-supported) HCs in the 12 Twubakane-supported districts were offering modern contraceptive methods.

Twubakane continues to collaborate with and transfer responsibility to district staff for supportive supervision of FP services. Twubakane staff members conduct visits monthly to selected sites with district health supervisors, mentoring them in the supportive supervision methodology to increase quality of services.

Data collected for the PMP indicate continued increases in FP availability and utilization. As seen in Figure 1 (below), the percentage of facilities providing modern contraceptives has increased since 2005. While the percentage increase is limited due to the fact that many health centers are Catholic-supported, there has been a significant increase in the percentage of facilities offering IUDs, implants, and the Standard Days Method.

Figure 1. Percentage of health centers offering modern contraceptive methods, 2005 and 2008



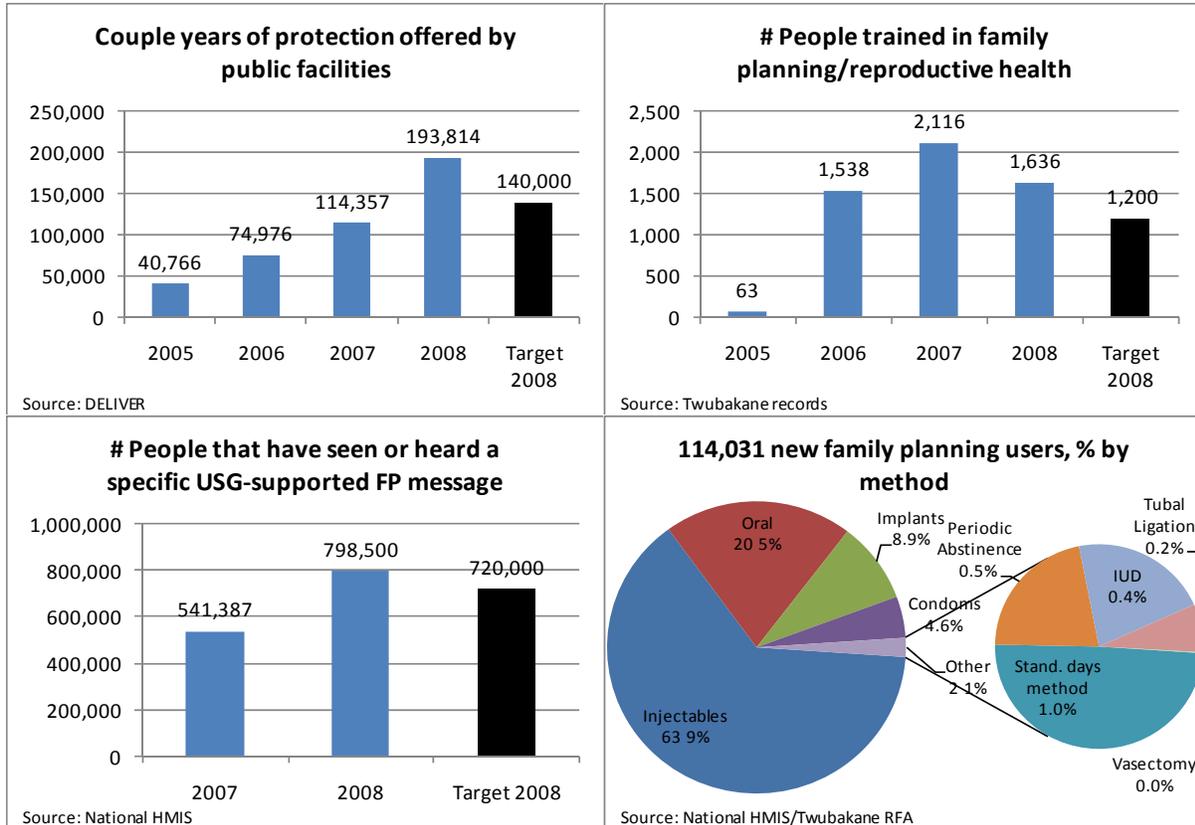
~In 2005, Twubakane supported 110 HCs and 12 district hospitals; in 2006, 127 HCs and 12 district hospitals; in 2007, 131 HCs and 12 district hospitals; and in 2008, 136 HCs and 14 hospitals. For explanations of which facilities provided data for indicators, please see Annex Three.

Figure 2 shows a consistent increase in couple years of protection (CYP) in Twubakane-supported districts, with nearly a five-fold increase in CYP since 2005, and a 70% increase between 2007 and 2008. Couple years of protection, a proxy for measuring contraceptive coverage, is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated from routine data collection on contraceptive commodities distributed and administered to clients. CYP is a way to estimate coverage, providing an indication of the volume of program activity, as well as comparison among the different family planning methods.

In 2008, fewer individuals received training in family planning than in 2007, but the increase in the number of people exposed to FP messages, combined with the increase in CYP, indicates that knowledge and skills from past trainings have been sustained. Data on new FP users was not collected in prior years, so it is not possible to determine precise changes in preferred FP methods. The preferred

method continues to be injectables, followed by oral contraceptives. There is a growing preference for implants (almost 9% in 2008); however, availability of implants continues to be a challenge which may limit the number of new users opting for implants.

Figure 2. Selected family planning results, 2005-2008



Secondary Posts: During 2008, Twubakane continued to establish secondary FP posts for clients of Catholic-based facilities to offer the full range of modern methods of contraception that are not available at the Catholic facilities (see Table 1). Support to these facilities included provision of equipment (such as exam tables and office furniture), supplies and training and supervision of providers. One challenge facing secondary posts is that many providers are “loaned” from neighboring facilities, meaning that services cannot be offered on a daily basis. However, because of this arrangement, providers are also able to refer and counter-refer clients needing additional services, such as child health care, from the neighboring HC. The secondary posts continue to struggle to have sustained support from local leaders and the continuous stocking of consumable products.

Table 1. Family Planning Secondary Posts functioning in December 2008, by district

District	FP Secondary Post
Nyaruguru	Ruheru
	Cyahinda
	Muganza
	Kibeho
	Ruramba
Nyamagabe	Mbuga
	Cyanika
	Rugege
Ruhango	Muyunzwe
	Kizibere (DIF grant-funded)
Kicukiro	Masaka
	Kicukiro
	Gikondo
	Rusheshe
Rwamagana	Munyaga
Kayonza	Rukara
Ngoma	Zaza
	Rukoma -Sake
	Jarama
	Gituku
Muhanga	Muhanga
	Mata
	Mushishiro
	Nyarusange
	Kivumu
	Bwilika

Twubakane continues to work closely with the MINISANTE to ensure ongoing support for FP secondary posts, as some Catholic Church authorities have expressed concerns about the same health care providers working in both the Catholic-supported facility and the FP post. This year, during regular data collection efforts, Twubakane was able to obtain service data from these posts, an improvement over previous years. Twubakane also has worked with the MINISANTE to ensure that data from secondary posts is captured in the national HMIS; the program will begin to regularly collect data from these secondary posts in the coming year.

HIV – FP/RH Integration: This year, Twubakane continued to participate actively in various HIV and FP integration discussions and activities, and provided ongoing support to USG HIV/AIDS clinical partners to develop simplified modules to ensure that providers offering HIV services are able to provide FP counseling. Twubakane and the Capacity Project also continued to include HIV integration in the ongoing training of providers in FP. Through support to secondary FP posts, Twubakane has continued to ensure that individuals and couples that are clients of Catholic-supported facilities, including those who are HIV-positive, have access to a full range of contraceptive methods and FP services. Through on-the-job training in FP, which will begin in within Twubakane-supported districts in January 2009, Twubakane will further contribute to the integration of FP and HIV-related services by ensuring that a team of providers in each health center is capable of providing high-quality FP counseling and services.

Improving Access to Safe Motherhood Services: As in previous years, Twubakane has continued to support the MINISANTE by serving as the secretariat for the safe motherhood technical working group. Collaborating with the MCH Task Force, National Malaria Control Program, TRAC Plus and several partners, including the USAID-funded ACCESS Project, UNICEF, UNFPA and others, Twubakane supported the finalization of the Focused Antenatal Care (FANC) protocols and training modules. Twubakane also contributed to the national quantification of RH commodities effort organized by the USAID-funded DELIVER Project. Using Pile Line software, this effort projected needs for 2008-2010 and covered items such as oxytocin, magnesium sulfate, iron/folic acid and Vitamin A, among others.

Improving maternal health with 2008 DIF grants

Eleven of the Twubakane-supported districts used some of the funds provided through their 2008 DIF grants to equip health care facilities for improved maternal health services, and nine for renovation to improve maternal health services. One of the hospitals that received support through the DIF grants was Kibungo Hospital in Kirehe District, where the maternity ward was fully equipped. Dr. Moise Moissa, head of the maternity ward in the hospital and one of the national EONC trainers, said that the changes in services were remarkable after the training of the staff and reception of new equipment. *“Thanks to our infection prevention procedures, we now have no cases of post-partum infections. We also have almost no stillborn births, thanks to timely case management and prompt referrals from the health centers. The training prepared us, and we now also have everything we need to detect and treat any complications.”* Dr. Moissa also said that there has been a dynamic change in the organization of the maternity ward, and that visitors and patients notice immediately the cleanliness and orderliness of the ward.



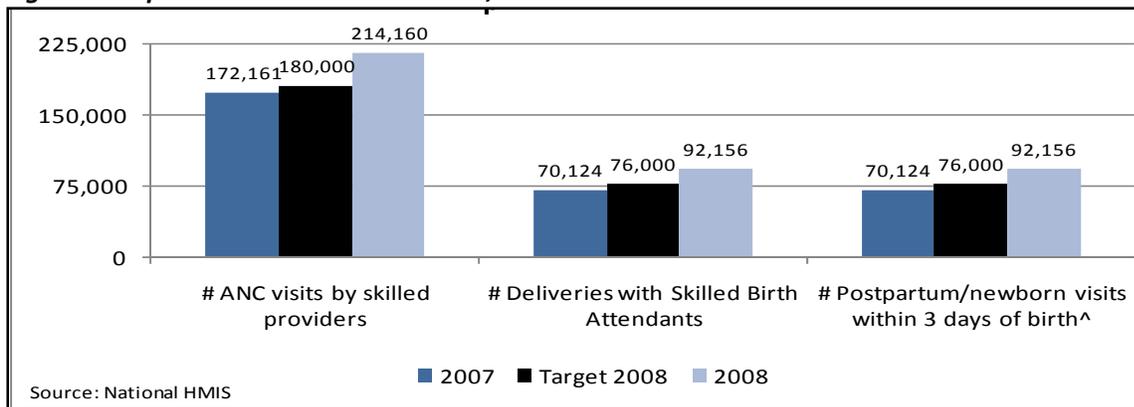
Twubakane continued to support expanded service availability in emergency obstetric and neonatal care (EONC) by helping district hospital-based trainers to train health center providers. This year, expanded emphasis also has been placed on the prevention of fistula, which has been incorporated into the EONC modules. Twubakane collaborated with the USAID-funded ACCESS Project on trainings and other service delivery support activities in Nyamagabe, Kayonza, Ngoma, Rwamagana, Nyarugenge and Gasabo districts. In addition, both projects helped to introduce Kangaroo Mother Care for case management and care of underweight and premature neonates in eight hospitals—Munimi, Kieme, Kaduha, Kibagabaga, Kanombe, Kanombe, Nyanza, Rwamagana, and the CHUK University Hospital of Kigali.

Twubakane also continued to support supervision of health centers by district hospital trainers of EONC. Many positive findings were noted during supervision visits, including widespread and systematic use of partographs to track progress and outcomes during labor, and the practice of Active Management of Third Stage of Labor (AMTSL) to prevent post-partum hemorrhage. In addition, health providers are using improved infection prevention practices however this is still an area needing more intensive support, particularly proper use of sterilization equipment for infection prevention. Additional areas still needing attention included outreach communication from health centers to their communities about the improvements in care, regular consultation of training reference guides, and continuous procurement of needed medical supplies.

Twubakane also conducted refresher trainings for providers in Focused Antenatal Care and in the use of Manual Vacuum Aspiration (MVA). The FANC trainings were provided for 23 providers in Kamonyi and the MVA training was for 28 hospital providers from districts supported by Twubakane and the Capacity Project.

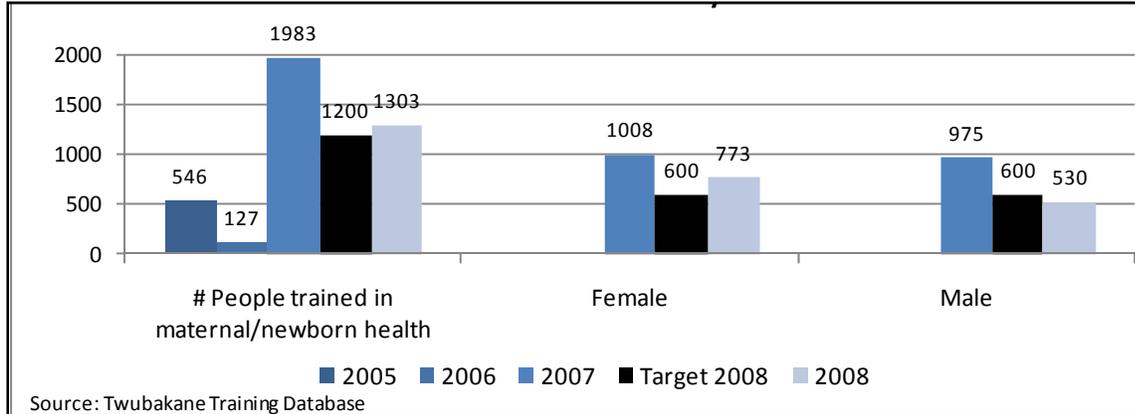
As in 2007, facilities supported by Twubakane exceeded the PMP targets for RH indicators related to antenatal care and deliveries (see Figures 3 and 4). The number of antenatal care visits increased by almost 25%, and the number of babies delivered by a skilled birth attendant increased by 31%. Twubakane also exceeded its training target in maternal and newborn health.

Figure 3. Reproductive health indicators, 2007-2008



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

Figure 4. Numbers of health workers trained in maternal/newborn health, 2005-2008



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

All 12 districts in which the Twubakane Program works now have trained and validated hospital training teams in EONC. Hospital trainers have trained HC maternity ward staff in basic EONC, including management of obstetric emergencies (e.g. shock, eclampsia), AMTSL, and immediate post-partum and neonatal care. Twubakane is continuing to provide supportive supervision to health centers to improve the practice of AMTSL. Challenges with regular supply of oxytocin at the health center level are still affecting the ability of providers to properly perform this practice on a routine basis. Oxytocin was not officially allowed to be used at the HC level according to the previous health policies and standards of care document, but MINISANTE approval was granted to introduce AMTSL pending finalization of the revised policies, norms and protocols document (which allow for AMTSL at the health center level).

There has been an increase in the percentage of HCs providing EONC, but a slight decrease for assisted vaginal deliveries. The introduction of two new hospitals—Kirehe and Munini—contributes to expansion of services; however, they are still in the process of establishing their services, thus the results of hospitals providing comprehensive EONC decreased slightly from 2007. The Twubakane Program continues to organize advocacy activities on the importance of safe motherhood throughout the 12 districts, encouraging local authorities to get involved in promoting facility-based deliveries.

Table 2. Emergency Obstetric and Neonatal Care, 2007-2008

Indicator	Results 2007 <i>Random sample 60 HCs</i>	Results 2008 <i>135 HCs</i>	Target 2008	Data Source
% of health centers that offer essential emergency obstetrical and neonatal care [^]	10%	19%	50%	Twubakane RFA
Parenteral antibiotics	28%	74%		
Parenteral Oxytocic Drugs	27%	65%		
Parenteral Anticonvulsants	30%	70%		
Manual Removal of Placenta	33%	58%		
Manual Removal of Retained Products	22%	62%		
Assisted Vaginal Delivery	25%	21%		
	All 12 District Hospitals	All 14 Hospitals		
% of hospitals that offer comprehensive emergency obstetrical and neonatal care ⁺	83%	71%	90%	Twubakane RFA
Parenteral antibiotics	100%	93%		
Parenteral Oxytocic Drugs	100%	93%		
Parenteral Anticonvulsants	92%	93%		
Manual Removal of Placenta	100%	93%		
Manual Removal of Retained Products	92%	93%		
Assisted Vaginal Delivery	100%	71%		
Blood Transfusion	100%	93%		
Surgery (e.g. Cesarean Section)	100%	86%		
		All 149 Health Facilities		
% of health facilities that offer Active Management of the Third Stage of Labor	n/a	67%	50%	Twubakane RFA
Administration of oxytocin within one minute of birth	n/a	69%		
Performance of controlled cord traction	n/a	79%		
Performance of uterine massage	n/a	77%		

[^] Essential emergency obstetric and neonatal care (EONC) is defined as the availability of six interventions to address complications that arise during deliveries. ⁺ Comprehensive EONC is defined as the availability of eight interventions: the six essential interventions plus Cesarean sections and blood transfusions.

Gender-Based Violence Prevention and Response: Twubakane’s initiative to improve prevention and management of gender-based violence (GBV) in the context of ANC/PMTCT services this year included dissemination of the findings from the readiness assessment conducted in 2007, and initiation of the response phase. At the five service sites in Gasabo, Kicukiro and Nyarugenge districts, follow up activities have begun to implement the assessment’s recommendations with service providers, facilities and the community (focus levels of the assessment). Twubakane also began to develop the GBV/PMTCT training curriculum and clinical protocols for identification and management of GBV. A retreat of legal and political decision makers was organized to define strategies to reinforce the legal and political environment for GBV prevention and care. Twubakane also began to work in partnership with the Rwandan National Police (RNP) to support the police with gender-based violence training and response by officers; in early 2009, Twubakane will work with the RNP to help update and disseminate the standard operating procedures guide for police officers.

Addressing Gender-based Violence

During the decision-makers retreat, Deputy Judith Kanakuze, a member of Rwanda’s parliament, said that the study inspired her and others to improve the national law related to GBV (which was recently passed.)

“Thanks to this study, we got accurate information and data, which guided our deliberations while passing the bill on GBV. Some of the articles were reviewed, others taken to the penal code and we thank IntraHealth and other partners who carried out the study.”

Partnership with Pro-Femmes Twese Hamwe: The Twubakane Program’s collaboration with Pro-Femmes this year focused on strengthening the capacity of Pro-Femmes and its member organizations to work efficiently in the context of decentralization. This year, the grant provided by Twubakane to Pro-Femmes in 2007 was extended through October 2008 to allow for completion of outreach and mobilization activities related to FP and safe motherhood. Pro-Femmes has also worked closely this year with Twubakane on the program’s efforts to improve GBV prevention and response.

Information, Education and Communication/Behavior Change Communications (IEC/BCC): This year, Twubakane contributed to standard communication strategies and messages in collaboration with MINISANTE and other partners using the BEHAVE framework. This framework identifies priority interventions during prenatal, delivery and post partum periods, and the accompanying messages, counseling tools for interpersonal communication, and norms and procedures. Other IEC/BCC activities included radio programs, mass media campaigns (including one financed by Kigali City’s DIF grant) and participation in the USG staff health fair.

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

The Twubakane Program continued its efforts this year to support integrated pediatric care at facility and community levels by supporting rollout of clinical and community integrated management of childhood illness (IMCI), including malaria and malnutrition. Much of this effort dovetailed with those of the MINISANTE’s Community Health Desk as the national integrated community health package was rolled out. Twubakane also continued to provide technical and financial support for community-based nutrition activities.

Malaria – Improving Prevention and Treatment (President’s Malaria Initiative): At a central level, Twubakane continued to support the National Integrated Malaria Control Program (*Programme National Intégré de Lutte contre le Paludisme*, or PNILP) with implementation of PMI activities and participation in meetings with PMI partners as part of the US President’s Malaria Initiative (PMI). These meetings served to devise work plans, agree upon intervention areas and discuss constraints to

implementation. In early 2008, Twubakane also had the honor of participating in visits from Rear Admiral Timothy Ziemer of the PMI, a delegation from the White House, and a delegation from ONE. These visitors observed PMI-funded activities at the Masaka Health Center in Gasabo; all were impressed with Community Health Workers (CHWs) and their enthusiasm to serve their communities. As in years past, Twubakane has also provided input into the development of USG's Malaria Operational Plan (MOP) for Rwanda, this year for the MOP 2009.

During 2008, Twubakane further expanded the number of communities implementing home-based management of fever (HBM) and assisted PNILP with the introduction of Coartem at the community level. This introduction required community orientations and trainings to ensure proper use of the new drug. Twubakane's focus districts for HBM are Gasabo, Kicukiro, Nyarugenge, and Bugesera.¹ Upon completion of their training, community health workers receive "kits" which includes items such as boots, flashlights, umbrellas, bags and wooden boxes to store records and medicines. During 2008, Twubakane trained 4,192 CHWs in HBM in these districts. An important element of the HBM intervention is supportive supervision of CHWs; during 2008, CHWs received quarterly visits and participated in monthly meetings at health centers. This element and overall data quality have been challenges during the expansion and introduction of a new drug.

In late 2007, Twubakane had worked with the ACCESS Project to organize the national Malaria in Pregnancy/Focused Antenatal Care training of trainers. Trainings in 2008 included the treatment and prevention of malaria in pregnancy, as a part of focused antenatal care, and the overall management of anti-malaria drugs and supervision.

Integrated Management of Childhood Illness: In 2008, Twubakane continued to support rollout of clinical IMCI at the HC level by training 184 providers in eleven districts, including seven districts that were trained for the first time (Kamonyi, Kayonza, Kicukiro, Muhanga, Ngoma, Nyamagabe and Nyaruguru). Twubakane also trained 10 district hospital-based physicians in clinical IMCI in 2008, and 16 district hospital-based supervisors in IMCI supervision techniques. As supervision visits were conducted in Ngoma and Kayonza districts, results revealed that seven of 12 HCs in Ngoma and eight of 11 HCs in Kayonza had initiated services. For the health centers that had not yet begun implementing clinical IMCI, there were problems either with overall lack of personnel or transfers of trained personnel.

In Kirehe and Gasabo districts (trained in 2007), joint supervision activities were conducted in February 2008 by district supervisors of the two districts, accompanied by Twubakane staff. The supervision team consulted registers and IMCI case management documents, and conducted direct case management observations. The supervision visit showed that those providers who were practicing IMCI were doing it well, but, in some health centers, IMCI protocols were not being systematically followed due to several factors: insufficient number of staff trained in IMCI, trained staff being transferred elsewhere, and the fact that the performance-based financing (PBF) system did not provide incentives for the correct application of IMCI. The supervision visit provided an opportunity for hands-on support and training. Twubakane also has continued to advocate for review of PBF indicators to ensure that the system supports national priorities such as IMCI.

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

In addition to clinical IMCI, Twubakane continued to assist with introduction of community IMCI in selected districts. In 2008, Twubakane focused on training CHWs in Ruhango District. This district was selected, in part due to its successful implementation of clinical IMCI, supported by Twubakane, and because of its successful launch of HBM activities at the community level (supported by the Global Fund). Twubakane has supported MINISANTE with adaptation of training materials for CHWs, the providers of IMCI at the community level. At the completion of training, each CHW (992 new in 2008) received equipment to help them diagnose and manage diseases. Twubakane also conducted supervision of community health workers trained in community IMCI in collaboration with the team of district hospital supervisors and health center staff; some were visited at home (310 in Ruhango) and some through group meetings (1628 in Ruhango). During such visits/meetings, management tools were checked and questions were asked by community health workers on the items they did not fully understand during the training and the appropriate answers were given.

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

Cold Chain Management: In 2008, Twubakane placed an emphasis on addressing cold chain management in collaboration with the Expanded Program of Immunization (EPI) desk of MINISANTE. An assessment conducted in early 2008 revealed key deficiencies related to refrigerator maintenance and temperature control, vaccine management (spacing in the refrigerator and storing expired vaccines instead of returning them to the district) and proper use of forms to document vaccine administration. In response to these problems, trainings were held to ensure that at least two technicians at health centers were able to properly manage their cold chain. Twubakane has trained 273 technicians in 11 of the 12 supported districts. (Nyarugenge District technicians were not available to participate in the training.) Following the trainings, Twubakane supported districts in conducting supportive supervision; district teams reported notable improvements in the overall management of the immunization program.

Nutrition: Two key outputs from 2008 were contributions to the production of the National Nutrition Strategic Plan and a community nutrition guide in Kinyarwanda. Twubakane has also contributed to implementation of HEARTH in the Eastern Province, where malnutrition is still a priority health problem. Districts selected to implement the HEARTH model include Kayonza, Kirehe, Ngoma and, Rwamagana. By the end of 2008, in Rwamagana District, nine villages (*imidugudu*) covered by Karenge Health Center and eight villages covered by Muyumba Health Center were supporting the management of malnutrition cases at the community level with HEALTH. A total of 110 children under five suffering from moderate to severe malnutrition were treated in the district, with at least two-thirds fully recovering in each zone.

In 2008, Twubakane continued expansion of community-based nutrition programming to an additional 111 villages. A total of 84 health care providers were trained in three districts, Muhanga (29), Kamonyi (23) and Nyamagabe (32) districts; these trained providers trained 315 CHWs in Muhanga (117), Kamonyi (99) and Nyamagabe (99). Each trained CHW received growth monitoring material. Trainings are accompanied by information campaigns to raise awareness of malnutrition and to seek local commitment to preventing and responding to this contributing factor to childhood illness and deaths. Community members and leaders are provided with tools to recognize signs of malnutrition and are encouraged to have young children screened at health centers. In addition, health centers in these areas receive equipment including weighing scales, growth monitoring cards and registers.

In 2008, Twubakane provided technical and financial support to the national Mother and Child Weeks, during which Vitamin A and mebendazole are provided to all children under five, and immunizations are provided to all children under one year, and pregnant women. The week also included promotion of breastfeeding and family planning. Twubakane participated in social mobilization activities during the campaign by supporting radio messages and by providing technical and logistic to support districts and hospitals staff in follow up.

PMP results for child health, malaria and nutrition are presented in the following table. Results for these indicators continue to show improvement. The number of diarrhea cases increased significantly through implementation of the integrated community health package. One decrease, (nutrition) is due to a change in the definition of the indicator to better capture the impact of nutrition activities (please see note under Table 3). Data for children receiving DPT3 immunizations and vitamin A, as well as those being diagnosed with simple malaria in HCs exceeded 2008 targets.

Table 3. Child Health Indicators, 2005-2008

Indicator	Results 2005~	Results 2006~	Results 2007~	Results 2008~	Target 2008	Data Source
CHILD SURVIVAL						
# Diarrhea cases treated	n/a	n/a	39,869	73,510	44,250	HMIS
# Children <12 months who received DPT3 immunizations	105,401	107,176	113,126	118,875	100,000	HMIS
# People trained in child health and nutrition	n/a	285	1,537	1,325	800	Twubakane records
Female	n/a	n/a	695	741	400	
Male	n/a	n/a	843	584	400	
NUTRITION						
# Children <5 who received vitamin A ⁺	n/a	n/a	526,134	1,100,338	500,000	UNICEF, HMIS
Facility and Community Data				615,531		
Campaign Data				484,807		
# Children reached by nutrition programs*	n/a	n/a	606,253	229,546	250,000	HMIS
MALARIA						
# People trained in treatment or prevention of malaria	n/a	1,167	3,415	5,345	3600	Twubakane training database
Female	n/a	n/a	1,561	2,685	1800	
Male	n/a	n/a	1,854	2,660	1800	
# Children <5 diagnosed with simple malaria in health centers (Twubakane's 12 Districts)	n/a	n/a	n/a	174,563	140,000	HMIS
Twubakane's 5 HBM Districts [^]				81,607	50,000	
# Children <5 treated for malaria through HBM (only Twubakane's 5 HBM Districts [^])	n/a	n/a	n/a	50,520	50,000	PNILP reporting forms & HMIS

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

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

* This indicator declined considerably because we changed the definition of the indicator to omit education sessions about nutrition and solely include activities that directly reach the child. Also, the method of calculating the number of children reached by nutrition programs in this report differs from the method used in the quarterly reports in order to avoid multiple counting of the same individuals. (See Annex Three for details.)

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

Component 3: Decentralization Planning, Policy, and Management

MINALOC: Twubakane continued to work in partnership with the MINALOC in 2008 to support the rollout of the Rwanda Decentralization Strategic Framework (RDSF), the Decentralization Implementation Program (DIP), and the Economic Development and Poverty Reduction Strategy (EDPRS). These policy documents guide local government authorities and development partners in supporting implementation of decentralization policies of the central government as well as provide indicators on good governance and decentralization. Some districts elected to use their District Incentive Fund (DIF) grants (see Component 4 for more information) for completion of their five-year District Development Plans (DDPs), especially concerning health-related issues. In 2008, Twubakane supported the MINALOC's district capacity-building needs assessment and provided documentation of district capacities for the 12 Twubakane-supported districts, working as partners of the consultants gathering district level data. Twubakane also collaborated with the assessment consultants in the facilitation of a pilot workshop for the development of the capacity-building plan in Ruhango District. The workshop was successful in bringing together sector and district officials, other stakeholders, and members of the Joint Action Development Forum (JADF) to develop a capacity-building plan that responds to the districts' specific needs. Twubakane also supported the development of capacity-building plans in the 12 Twubakane-supported districts.

Support to Rwanda Association of Local Government Authorities (RALGA): The mandate of RALGA is to strengthen its member organizations, local governments. In July 2008, RALGA celebrated its fifth anniversary. As part of its celebration, RALGA elected a new board of directors and directors of the special commissions, and reviewed RALGA's strategic plan and annual action plan. Twubakane was recognized for its contributions to the institutional strengthening of RALGA. Twubakane partner VNG has continued to provide distance and in-country support to RALGA's capacity-building program officer. In 2008, a VNG consultant supported her and the RALGA team in the development of a capacity-building strategy for RALGA members and local government authorities. This work was in preparation for RALGA to expand its role as a broker to meet members' capacity-building needs by liaising with institutions and development partners. The anti-corruption initiative (ACI) with RALGA that started in 2007 was closed out in mid-2008. As a service to RALGA's stakeholders, a CD-rom of all the ACI activities and materials was created and distributed. In addition, a useful tool for local authorities was created this year in Kinyarwanda on corruption, accountability, transparency and good governance. With Twubakane's assistance, copies were distributed to all 30 districts.

Costing Study: The results of the national costing study were officially disseminated in May 2008. This study, conducted with the National University of Rwanda's School of Public Health (SPH), and in collaboration with MINISANTE, was designed to analyze costs of the minimum package of health

services (MPA) provided at the health center level and the complementary package of health services (CPA) delivered at the district hospital level. The results will contribute to setting service tariffs for 2009.

National Health Accounts (NHA): By mid-2008 the NHA report was completed and disseminated within Rwanda and externally via the Health Systems 2020 project website. Rwanda is one of a few countries with multiple years of NHA data. Thus, the completion of the 2006 NHA exercise allows policymakers and stakeholder's insight into Rwanda's complex health financing system in its entirety and, along with the four past NHA exercises, an opportunity to observe trends. Twubakane worked closely with MINISANTE and the World Bank to establish the terms of reference for a health financing technical working group; these were approved during the Joint Health Sector Review in November 2008. Another priority activity in 2008 was supporting the finalization of a draft of Rwanda's first health financing policy. This policy will contribute to the Economic Development and Poverty Reduction Strategy (EDPRS) and the Health Sector Strategic Plan (HSSP) II.

The results for the program PMP pertaining to these two activities are listed in Table 4. They illustrate the progress that has been made to date in developing and implementing the costing tool. The results indicate that in terms of institutionalizing the NHAs, the MINISANTE has decided to address the larger issue of health financing by establishing a health financing desk within the ministry. This will assist with sustainability and will allow MINISANTE to institutionalize NHA once there is more health financing capacity within the ministry.

Table 4. Process Results in Decentralization, Policy Planning and Management, 2007-2008

Process Results	Results 2007	Results 2008
MINISANTE develops and disseminates a costing tool to be used in the development of a financially viable tariff list for minimum and complementary activity packages.		
Have developed costing tool for the national level (survey of costs) for MPA and CPA.	Completed in 2007	
Implement this tool May-July 07 by doing the survey of costs.	Completed in 2007	
Technical team analyses results and disseminates them to MOH and its partners (NGOs, multilaterals, bilaterals etc.)	Completed in 2007	
MOH may use those results to set costs of products and services.	Rescheduled for 2008	Costing study used as a reference document
On the basis of those costs MOH may adjust tariffs for clients	Rescheduled for 2008	Costing study used as a reference document
If new tariffs are established MOH will require hospitals and HCs to apply them.	Rescheduled for 2008	Completed, with more work and supervision to be done in 2009
The new tariffs are implemented and respected by MOH, private sector, health insurance (<i>mutuelles</i> and private insurance companies) and others.	Rescheduled for 2008	Completed, with more work and supervision to be done in 2009
Timely production, completion and dissemination of National Health Accounts		
Steering committee is created and a Memorandum of Understanding signed by stakeholders	Completed in 2007	
Technical team is trained to conduct the NHA process	Completed in 2007	
Technical team developed the NHA survey design and tools (with pre-testing)	Completed in 2007	
The data collectors are trained to conduct the survey	Completed in 2007	

Process Results	Results 2007	Results 2008
The survey is conducted	Completed in 2007	
The survey results are analyzed and written up in NHA report	Completed in 2007	
Survey results are disseminated in various ways to stakeholders with recommendations for how to institutionalize the NHA	Drafts Disseminated	Completed, and on-going for 2009
Recommendations on how to use NHA (e.g. for planning, for advocacy etc.) are implemented.	On-going	On-going
Introduction of the Institutionalization of National Health Accounts		
Identify appropriate training institutions; e.g.: School of Public Health, and School of Finance and Banking	Completed	
Introduce curriculum and adapt to Rwandan context and requirements	Rescheduled for 2008	Canceled
Train trainers in NHA methodology	Rescheduled for 2008	Canceled
NHA courses being offered	Rescheduled for 2008	Canceled
Health finance desk at MOH created	n/a	On-going – will be finalized and official during 2009
Health finance desk personnel recruited	n/a	Recruitment started
Health finance desk personnel trained and oriented in NHA	n/a	Scheduled for 2009

In addition, Table 5 shows the number of policies Twubakane supported through their development and the number of policies, plus guidelines and manuals Twubakane helped disseminate.

Table 5. Policy Development Supported by Twubakane, 2005-2008

Indicator	Results 2005	Results 2006	Results 2007	Results 2008		Targets 2008	Data Source
# of policies drafted or revised with USG support	13	11	14	22		15	Twubakane records
# of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA, health facilities, and other relevant stakeholders with USG support	2	7	9	9		10	Twubakane records

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

List of policies drafted or revised during 2008

- National Nutrition Strategic Plan
- National Health Accounts
- Health Services Costing Study
- Financial viability review and audits of *mutuelles* offices and FOSA billings
- Health Care Services Norms, Standards, Protocols
- Initial Draft of Health Financing Policy
- District Accountant Training Manual and Guidelines
- Anti-Corruption Guidelines for Local Government and RALGA members
- Decentralization Implementation Plan
- National Community Health Policy National Policies, Norms and Protocols for Family Health
- MoH Joint Health Sector Review and work plan recommendations
- MoH joint action work plan for the health sector (JAWP)
- GESIS / HMIS technical reviews and revision of health indicators
- *Mutuelle* Policy
- *Mutuelle* Management Manual
- Health Facilities Management - Hospital Management manual
- M&E framework and Management Information Systems (MIS) systems and modules for Local Government, with 17 indicators for tracking health service delivery
- District Auditor training manual and guidelines
- Health Corruption vulnerability assessment
- Economic Development and Poverty Reduction Strategy
- Health Sector Strategic Plan (HSSP 2 draft)
- Adaptation of Ubudehe process for management of “indigents” benefitting from *Mutuelles* subscriptions

List of decentralization policies, guidelines, indicators, procedural manuals disseminated during 2008

- Management Information Systems (MIS) framework for Local Government
- Decentralization Implementation Plan (DIP)
- District capacity mapping and resource allocation, FormaDis, and cataloguing of training modules for LGAs
- Health Governance programming and interventions
- District Accountant Training Manual and Guidelines
- District Auditor training manual and guidelines
- Anti-Corruption Guidelines and booklet for Local Government and RALGA members
- Revised Rwandan Association of Local Government Authorities’ capacity-building strategy
- Improved data collection and reporting systems for tax registries / rolls /collection / privatization of public market tax collection

Component 4: District-Level Capacity Building

Twubakane continued support for participatory district capacity building at the national level, in collaboration with RALGA. In each of the 12 Twubakane-supported districts a selection of capacity building activities were implemented or supported, including:

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

Several districts this year also solicited Twubakane’s support for such initiatives as the District Open House and Accountability days and the *PlateForme de la Société Civile* which outlines roles and responsibilities of local governments and civil society. Feedback from Twubakane-supported districts showed they appreciate the program’s combined technical and financial support.

Further building upon the progress in 2007, Twubakane technical staff and field coordinators have noted an even greater improvement in the capacity of the district, sector and health facility staff and officials

to lead and direct their own budget and planning exercises. The location of Twubakane field coordinators within the district offices facilitates districts calling on Twubakane as needed. This year, Twubakane’s ongoing support in the form of coaching and mentoring was much appreciated as evidenced by the numerous public recognitions, calls, emails and testimonials of Twubakane support.

District Incentive Funds (DIF): 2008 was a year of progress for the districts in managing, implementing and reporting on the DIF grants, one of Twubakane’s principal capacity-building tools used to assist districts to budget and plan. In 2008, as in 2007, each district received \$150,000 for activities prioritized by the district for implementation during the year. Only activities included in the District Development Plans and annual action plans required by the GOR were eligible. Districts have shown much improvement since the DIF grants began in 2006. The districts now include discussion of DIF grant activity status during weekly district meetings, consult with ministries regarding activity implementation, are improving their overall tender process for procurement, and executive secretaries regularly monitor sector-level activities. In addition, the activities prioritized by the districts and funded through the DIF grants are increasingly contributing directly to the goals of the Twubakane Program—and the GOR—to improve access to, and use and quality of key family health services. Table 6 (below) provides an overview of the type and number of DIF projects from 2006 to 2008.

It is important to note that the ministers of MINALOC and MINISANTE both supported the DIF grants actively this year by communicating directly with the district mayors about the importance of expeditiously using and reporting on the DIF grant monies. The ministers’ support, as well as intensified hands-on assistance from Twubakane, led to increased DIF spending levels in the last quarter of 2008. Many districts, however, still faced challenges concerning their absorptive capacity for funds and the timely implementation of activities, and all of the 2008 DIF grant contracts, originally scheduled to end on December 31, 2008, had to be extended to the end of January 2009; selected districts needed until March 31st to complete their 2008 projects. Examples of DIF 2008 results by district are included in Annex One.

Table 6. DIF Activity by Category, 2006-2008

Indicator	2006 Results	2007 Results	2008 Results	Data Source
# of DIF grant supported activities that were implemented to improve the local government authorities, Administrative District, and Sector level capacity to provide services, with an emphasis on health services, to its population.	59	56	56	Twubakane Records
District administrative level capacity building activities	13	19	22	Twubakane Records
Activities to support sustainability of <i>mutuelle</i> payments for indigents	8	2	2	Twubakane Records
Improvements to health and public hygiene infrastructure and health equipment supplies	25	24	20	Twubakane Records
Community mobilization and communication activities	4	10	11	Twubakane Records
Health related training of local authorities	1	1	1	Twubakane Records

Several examples of DIF grant projects from 2008 are outlined below.

Participatory DIF grant planning in Ngoma District

Ngoma District held a highly participatory 2008 DIF grant workshop to focus on identification of priority needs and develop projects, headed up by the district's Executive Secretary, Jean Baptiste Bizimungu. Workshop participants, including the district team, sector-level authorities, and hospital and health center directors and managers, unanimously proclaimed the workshop successfully, several saying that they truly felt that their "voices were heard."



An income-generating opportunity for beautifying a neighborhood with 2008 DIF Grant

"We managed to transform the problem of home garbage into an income-generating opportunity for our members, through our collaboration with the district and the Twubakane Program," said Laetitia Uwanyirigira, the coordinator of a Rwandan widows' cooperative. Twizamure, Kinyarwanda for "let's promote ourselves," is one of several community cooperatives working with Gasabo District in the capital of Kigali to manage household organic wastes and produce household energy by making clean burning briquettes from the recycled wastes. The cooperative's work is ensuring the cleanliness of households and neighborhoods in Gasabo District, and has brought a solution to the problem of supplying safe household cooking fuel. The cooperative was supported by the Gasabo District Council through its District Incentive Fund (DIF) grant.



Renovating Munini Hospital with DIF grants

Nyaruguru District was among the few districts that did not have a district hospital two years ago. Through its DIF grant monies, starting in 2006, the district renovated a block of administrative buildings and created Munini Hospital. Felix Sibomana, Nyaruguru's mayor, said that, "Munini hospital will serve the entire population of Nyaruguru District and beyond...our vision is to expand it and make it a hospital with international standards."



Joint Action Development Forums (JADF): During 2008, Twubakane continued support for the district JADF in all program-supported districts. This mechanism assists district government administration and its stakeholders to discuss and coordinate development planning, budgeting, monitoring and evaluation. Twubakane staff provided districts assistance with harmonization of partner interventions and reporting requirements, resource mobilization for the long-term sustainability of JADFs and in Ruhango, an evaluation of field activities implemented by members of the forum. This evaluation form will be standardized in 2009 for use in other districts and provinces throughout Rwanda. Because of their important role in initial support to JADF meetings, some Twubakane staff members have been elected as officials of the JADF committees.

District Auditors Training and Orientation: In early 2008, strengthening the audit process in districts was identified as a need to improve decentralization and overall district functioning. The District Capacity-Building Needs Assessment (described above under MINALOC) noted that the few reports produced by auditors were not analyzed by District Council members, and the offices of the Auditor General and the Ombudsman also both recommended reinforcement of the districts' audit process. In addition, Twubakane field coordinators and the DIF grants management team both noted that more regular, thorough and accurate audits would have a positive impact on the implementation of the Twubakane Program and on decentralization.

To respond to this need, the Twubakane Program collaborated with the Ministry of Finance and Economic Planning (MINECOFIN), the German Development Service (DED) and the Rwandan Institute of Administration and Management (RIAM) to develop a training module for district auditors. The audit training

was designed to increase the capacity of auditors to understand their roles and responsibilities and to strengthen auditors' skills to carry out audit missions and elaborate accurate reports to improve overall district management. In addition, an orientation was developed for district authorities on the principles of auditing as a mechanism for transparency and accountability and the importance of supporting district auditors with their responsibilities.

Twubakane supported the orientation and training of 11 auditors and 8 procurement officers for the 12 Twubakane-supported districts in September 2008. In October 2008, 17 district authorities, in the Eastern Province received orientations and training. In 2009, district authorities from the City of Kigali and Southern Province will receive training. During the last quarter of 2008, Twubakane and DED staff provided follow-up, on-the job supervision and support for the trained district auditors. Participants and other district representatives expressed appreciation of the audit course. Jeremy Kivunanka, the Director of Finance of Kayonza District, said, "I am sure the Auditor General's Report of 2008 in our district will be very different of the previous one," thanks to support received during and after the audit training.

A similar testimonial on the benefit of the training was made by Anastase Nzanzumuhire, the auditor for Kayonza District: "After the training received by Twubakane, I have changed completely because I now understand my importance in the district organization. I have been working in this district since July



Twubakane team member Antoinette Uwimana (left) and Anastase Nzanzumuhire review audit mission reports in Kayonza District's offices

2008, and the District had not had an auditor for six months when I started. The training has helped me to be confident, and to show the difference of my presence in the District." During a supervision visit to Kayonza, Nzanzumuhire very enthusiastically showed off his reports of audits conducted in sectors with suspected management problems, in two health centers and in two schools. After the audit training he approached the district mayor and explained to him the importance of creating a committee which would set strategies and follow up revenue collection and enforcement in the district.

The committee was set up and begun to evaluate the revenue potential in district markets. In November, this activity resulted in recovering approximately 7,500,000 Rwf (or about \$13,636) and 14,000,000 Rwf in debt. Thanks to Nzanzumuhire's good performance, the district decided to give him communication cards and a laptop computer to support his work, and has promised him a motorcycle to help him to carry his audit missions.

Participatory Assessments of Districts' Strengths-Opportunities-Weaknesses-Threats (SWOT): Engaging with public officials to contribute to improved district level planning, budgeting and management is an important aspect of Twubakane's support to districts. To measure progress in this regard, SWOT assessments with district and sector officials were conducted by Twubakane in October 2006, in December 2007 and in February 2009 (see methodology section of Annex Three for a description of the methodology).

Table 7. District-Level Planning, Budgeting and Managing Indicators, 2006-2008

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

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

Table 7 illustrates the increase over 2007 in the percent of districts with at least one oral and one written mechanism for reporting on their financial performance. The results for overall health sector activities reporting remained the same; however there were notable increases in radio messages, newsletters and pamphlets. For the other indicators of progress in district-level planning, budgeting and managing, the targets were realized or came very close.

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

Twubakane continued to support capacity building of district entities and individual public sector officials in order to strengthen districts' financial management and planning practices. In the past year Twubakane exceeded the target for training in management and fiscal management of almost double as many people as targeted (Table 8).

Table 8. Public Sector Capacity Building, 2006-2008

Indicator	Results 2006	Results 2007	Results 2008	Target 2008	Data source
USG ASSISTANCE FOR CAPACITY BUILDING IN PUBLIC SECTOR					
# Sub-national government entities receiving USG assistance to improve their performance	12	12	12	12	Twubakane records
# Sub-national governments receiving USG assistance to increase their annual own-source revenues	12	12	13	12	Twubakane records
# of local non-governmental and public sector associations supported with USG assistance	101	144	148	150	Twubakane records
PAQ teams	99	130	134		
RALGA	1	1	1		
Pro-femmes	1	1	1		
JADFs	n/a	12	12		
# Individuals who received USG-assisted training, including management skills and fiscal management, to strengthen local government and/or decentralization.	2,114	4,450	1859	1000	Twubakane records and RALGA
Female		1,018	1097	500	
Male		3,432	762	500	

Indicator	Results 2006	Results 2007	Results 2008	Target 2008	Data source
ANTI-CORRUPTION					
# of USG-supported anti-corruption measures implemented	6	10	14	10	RALGA
# of government officials receiving USG-supported anti-corruption training	n/a	216	250	300	RALGA
Female		52	125	150	
Male		164	125	150	

Component 5: Health Facilities Management and *Mutuelles*

Revision of Health Care Policies, Norms and Standards: A significant undertaking of the MINISANTE, which began in 2006, is the revision and updating of policies, norms and protocol for health care services and the minimum and complementary packages of activities. Twubakane has provided both local and international technical assistance since the process began, and has collaborated with many development partners to ensure consensus on the documents' content. In 2008, this exercise continued to face challenges, particularly concerning follow-up to finalize the process and ensure buy-in of stakeholders. An initial draft of the document was reviewed in early 2008, and workshop was held in July 2008, during which MINISANTE desks and partners reviewed content. After this review, it was determined that additional content was needed, especially concerning task-shifting and school health. By the end of 2008, this content had been incorporated, and final review by the MINISANTE and partners is pending. Twubakane has continued to reiterate its support to field-test and finalize this key health sector document.

Table 9. Service Delivery Points, 2005-2008

Indicator	Results 2005	Results 2006	Results 2007	Results 2008	Target 2008	Data Source
# Service Delivery Points (SDP) with USG support	139	143	164	210	174	Twubakane Records and Twubakane RFA
Hospitals	12	12	12	14		
Health Centers	110	127	131	136		
Dispensaries & Health Posts	17	4	7	34		
FP Secondary Posts	0	0	14	26		

One of the PMP indicators for Twubakane is the number of HCs providing services included in the MPA for Family Health. The percentage of HCs providing the full MPA will continue to improve as the norms, standards and protocols are finalized and disseminated, new facilities (e.g., 2 hospitals and other HCs) are equipped and capacity is built with support from MINISANTE, districts, donors and other projects. Table 10 presents data on the percentage of HCs providing the services in Rwanda's MPA. This year, the percentage increased of HCs providing prenatal consultations, deliveries, post-natal care, FP and IMCI services. There is still a challenge with the provision of pre-nuptial consultations. If that particular service was not considered, most HCs would offer the full package of activities. Other services showing a decrease are post-abortion care and growth monitoring.

Table 10. Health Centers Providing Services in Minimum Package of Activities (MPA) for Family Health, 2005 and 2008

Indicator	2005 Results All 110 HCs	2008 Results 135 HCs	Target 2008	Data Source
% health centers providing MPA	n/a	2%	20%	Twubakane RFA
Prenuptial consultations	9%	13%		Twubakane RFA
Prenatal consultations	93%	97%		Twubakane RFA
Infant Delivery	83%	96%		Twubakane RFA
Post-natal consultations	45%	82%		Twubakane RFA
Postabortion Care	60%	57%		Twubakane RFA
Family Planning	72%	79%		Twubakane RFA
Vaccinations	91%	100%		Twubakane RFA
Growth Monitoring	81%	96%		Twubakane RFA
VCT	n/a	93%		Twubakane RFA
Clinical IMCI	n/a	100%		Twubakane RFA
Epidemiological surveillance	n/a	89%		Twubakane RFA
Hygiene	n/a	82%		Twubakane RFA

Health Care Financing—*Mutuelles*: Twubakane continued to work this year to support the *mutuelles* system on a national level through close collaboration with the MINISANTE's *Mutuelles* Technical Support Unit, or *Cellule d'Appui Technique aux Mutuelles de Santé*. Twubakane, with collaborators GTZ, BIT-STEP, Belgian Technical Cooperation (BTC), the Global Fund and the British Department for International Development (DFID), met regularly in a technical working group to discuss national-level implementation and share experiences. Twubakane also supported the *mutuelles* technical working group to update and finalize the *Mutuelles* Management Manual.

Twubakane continued to support *mutuelles* managers and management committees in the 12 program-supported districts, and conducted supervision visits designed to improve management capacity of *mutuelles* managers through on-the-job training and advice. *Mutuelles* supervision reports, which were submitted by the Twubakane Program to the district mayors, with copies to the Ministry of Health, pointed out financial management problems and potential embezzlement of funds in several *mutuelle* sections; in some of the *mutuelle* sections, managers were interrogated by the police to report on financial management indiscrepancies. In November and December 2008, the GOR undertook a nationwide audit of the *mutuelles* program; results of the audit are scheduled to be presented in early 2009.

In 2008, Twubakane also conducted an assessment of the financial viability of *mutuelles*, which showed that about 70% of the *mutuelles* sections in the Twubakane-supported districts risked bankruptcy in 2008 due to management problems or insufficient funding to pay health facilities' bills. The assessment was presented during a national *mutuelles* workshop in Rubavu in September 2008. During this workshop, the MINISANTE and development partners called for a nationwide audit of *mutuelles*.

During 2008, the Twubakane routine data collection at districts' *mutuelles* units showed that the health facilities included in the Twubakane zone had slightly fewer *mutuelles* members than the targets set for 2008 (see Table 11). Across the 12 districts, an estimated 72% of the district populations are enrolled in *mutuelles* at HCs supported by Twubakane. On average, there was slightly less than one visit (0.96) to a health center per *mutuelle* member per year.

Table 11. Mutuelles Membership, 2007-2008

Indicator	Results 2007	Results 2008	Target 2008	Data source
# People covered with health financing arrangements (in Twubakane Districts)	2,376,986	2,320,493	2,549,808	Districts' <i>mutuelles</i> units and Twubakane RFA
% Population in the districts supported by Twubakane that are enrolled in <i>mutuelles</i> (Pop=3,399,744+)	72%+	68%	75%	Districts' <i>mutuelles</i> units and Twubakane RFA
Utilization Rate of health services by <i>Mutuelles</i> Members (average number of visits per <i>mutuelle</i> member per year) *	n/a	0.96	1	Districts' <i>mutuelles</i> units and Twubakane RFA

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

* While Twubakane had intended to report on the rate of utilization of health services by *mutuelles* members in 2007, that data proved inaccessible for too many facilities. In 2008, data was more readily accessible; however data was not available in most instances for the end of the year. For missing months of data for each health center, estimations were made based on the average number of monthly visits during the rest of the year.

Health Facilities Management: Through its management support to hospitals and health centers, Twubakane strives to increase the capacity of health facilities to better manage their resources and to provide high-quality health services. This year, the MINISANTE and partners collaborated closely on health facility strengthening initiatives, and worked together to develop health facility management manuals, one for hospitals and another for health centers. The manuals are currently being revised and finalized to ensure that they are practical and well-adapted to the Rwandan context. The manuals focus on key health facility management areas, including financial management and accounting, resource and equipment management, drugs, maintenance and human resource management.

In 2008, Twubakane conducted a health facility management assessment and shared results with the MINISANTE and other partners. The assessment reviewed management practices related to management responsibilities, obligations and cycles of health facilities; strategic planning and budgeting processes; strengths and weaknesses of financial and administrative management (including human resources) and accounting; health information systems, data collection and utilization; and the organization, patient flow and delivery of health care services.

This year, Twubakane also supported district health officials by assisting hospitals to develop strategic plans, and to help health centers to develop their own strategic plans. Several tools were used to support the health facility strategic planning process, including participatory SWOT analyses, review of basic package of indicators and forms to collect information on personnel, materials, services and budgeting. Hospital and health center personnel prioritized activities and budgets based on key objectives and through participative discussions and consensus to determine their main activities. Emphasis was being placed on producing simple and realistic plans, focusing on benefits to the population served, and feasibility given available and often limited resources. In addition, Twubakane staff is ensuring the alignment of health plans with DDPs, national goals outlined through the Economic Development and Poverty Reduction Strategy, Vision 2020 and performance-based contract targets set on an annual basis.

Table 12. Facilities Receiving Assistance for Health Financing Management, by District

District	Hospital	Health Centers
2008		
Kayonza	Gahini	12 HCs
Ngoma	Kibungo	12 HCs
Nyarugenge	Muhima	7 HCs
Ruhango	Gitwe	13 HCs
2007		
Gasabo	Kibagabaga	None
Nyamagabe	Kigeme	13 HCs

Situation analyses at the facilities identified priority areas for strategic planning, including quality of care, human resource management, overall equipment needs, improvements in infrastructure, hygiene, general communication about services and community outreach. Following development of strategic plans by each of the hospitals and HCs, Twubakane will provide support to develop operational plans (all facilities) and business plans (hospitals only).

Jean Claude Nteziryayo, the manager of Mwendo Health Center in Nyarugenge District, confided, during a Twubakane-supported support visit, “I never was able to take a class in planning and management while I was in nursing school, and now that I am responsible for a health center, I am recognizing that this is a weakness.” After the orientation workshop on strategic and operational planning, the health center managers, including Nteziryayo, said that they had a much clearer understanding of the planning process, and that the workshop would help them develop their own plans, therefore improving their management capacity. The managers of the various services in Muhima Hospital also said that the Twubakane-supported workshop on strategic and operational planning gave them a new-found confidence in their management capacity, whereas before the workshop, they saw themselves more as technicians and health care providers.

Component 6: Community Engagement and Oversight

Over the last year, an important focus of Twubakane has been support to MINISANTE and the Community Health Desk with the roll out of Rwanda’s integrated community health strategy through participation in workshops to finalize management tools, to integrate CHIS indicators into the community PBF system and to conduct a national training on the CHW Trainers’ Guide. Twubakane has concentrated its support of the national roll out in the districts of Ruhango in the Eastern Province and the three districts of Kigali, Kicukiro, Gasabo, and Nyarugenge.

During 2008, 183 CHWs were trained in Ruhango specifically in the integrated community health package; another round of training is scheduled for early 2009 to complete coverage of the district. Twubakane has also provided orientations on the community health package in other districts (Rwamagana, Muhanga, Nyamagabe, Kirehe and Nyaruguru) as well during the past year; over 660 CHWs were oriented. (Please see Component 2 above for more information on trainings of and support for community health workers.) Also in Ruhango, 91 PAQ members were oriented to enable stronger support for this initiative via PAQ teams.

Partenariat pour l’Amélioration de la Qualité (PAQ): Since 2006, the PAQ approach has been officially identified by the MINISANTE as a best practice in quality assurance and an approach that should be

supported in all of the country's HCs. PAQ teams bring together HC managers and health care providers with local leaders and community representatives in an effort to identify and address barriers to quality and to use of services, therefore improving service quality and increasing community participation in planning and management of health care and health care facilities at the local level.

During 2008, the focus of Twubakane shifted from establishing PAQ teams at each HC to institutionalizing the teams to improve their sustainability. PAQ supervisors from the district and hospital are in place and providing advice and support to the PAQ teams. Given the new HCs that have been created since the Twubakane Program began, 96% of all HCs in all 12 districts now have functional PAQ teams. During this past year, information exchange meetings were held to review activities, challenges and sustainability strategies. As an outcome of these meetings, Twubakane visited PAQ teams needing support to revitalize their membership and activities. In addition, quarterly coordination meetings were initiated to allow PAQ teams in each district to better coordinate their efforts and identify solutions to challenges.

As shown in Table 13, 96% of the HCs visited during data collection for the 2008 RFA had a PAQ. Indicative of their active functioning, 91% of the HCs had a PAQ that reported having met at least once in the past six months and 84% of the HCs had a PAQ that had met in the past three months.

Table 13. Community Engagement in Health Centers through PAQs

Indicator	2005 Results All 110 HCs	2007 Results Random Sample of 60 HCs	2008 Results All 136 HCs	Target 2008	Data Source
% of health centers that have established a mechanism for communities to provide input on quality of services (PAQ)	10%	100%	96%	100%	Twubakane RFA
% of health centers with an active mechanism for communities to provide input on quality of services	n/a	80%	91%	90%	Twubakane RFA
<u>Most recent PAQ meeting:</u>					
In the last 3 months		68%	84%		
4-6 months ago		12%	7%		
More than six months ago		20%	9%		
% of health centers with a PAQ that has influenced at least on change in the health center in the previous year	n/a	n/a	88%	80%	Twubakane RFA
% of health centers with a PAQ that has undertaken community mobilization activities in the previous year	n/a	n/a	93%	80%	Twubakane RFA

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

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

An important role of PAQ teams has been their ability to influence changes at the health centers and of health services based on input from PAQ team members and negotiations with HC management. As was described in Component 2, Twubakane was fortunate to accompany visitors to Rwanda by ONE in July 2008. The health center visited—Masaka Health Center in Kicukiro District has a strong PAQ team. The manager of the HC, Sister Goriatti, shared her thoughts on the PAQ approach with the visitors from ONE.



“We no longer have any problems in mobilizing our communities for immunization, antenatal care visits or other services,” she said. *“Our monthly PAQ team meetings give us a chance to sit down together and do a monthly plan for outreach activities with the local authorities. The PAQ approach has made my work a lot easier, and also made me proud of the good work and great results.* The graphs below show some of the outcomes of PAQs during 2008.

There were 96 out of 130 PAQ teams (74%) that have influenced some kind of change to health services or infrastructure. Of those, 64 influenced improvements to the quality of services (e.g., interaction with clients, respect of health care norms, etc.); 62 influenced improvements to hygiene and sanitation within health centers; 51 influenced infrastructure improvements to health facilities; and 50 influenced the restructuring of staff (e.g., recruitment, removing of ineffectual personnel, etc.).

Fostering sustainability of the PAQ approach

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

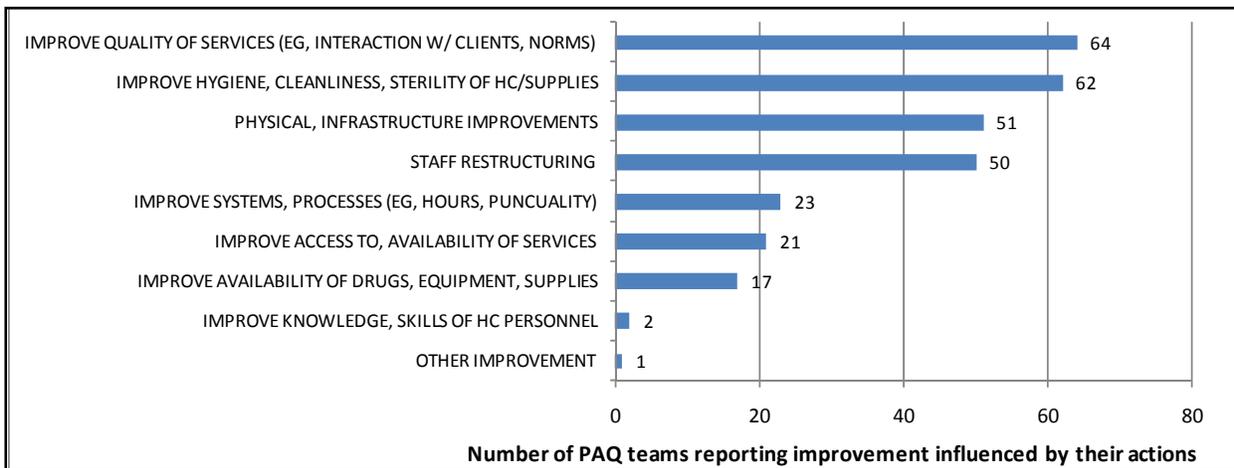


PAQs team and hygiene

In Nyaruguru District, the PAQ team of Coko Health Center supported community health workers in learning how to install and use a new handwashing system, and in learning about the *Sur'Eau* water purification product. The PAQ team continues to support community outreach and education about clean water and hygiene. One CHW said, *“The PAQ team helped us get organized, and helped convince local authorities that we play an important role in promoting disease prevention and family health. This inspires us—and makes our work easier.”*

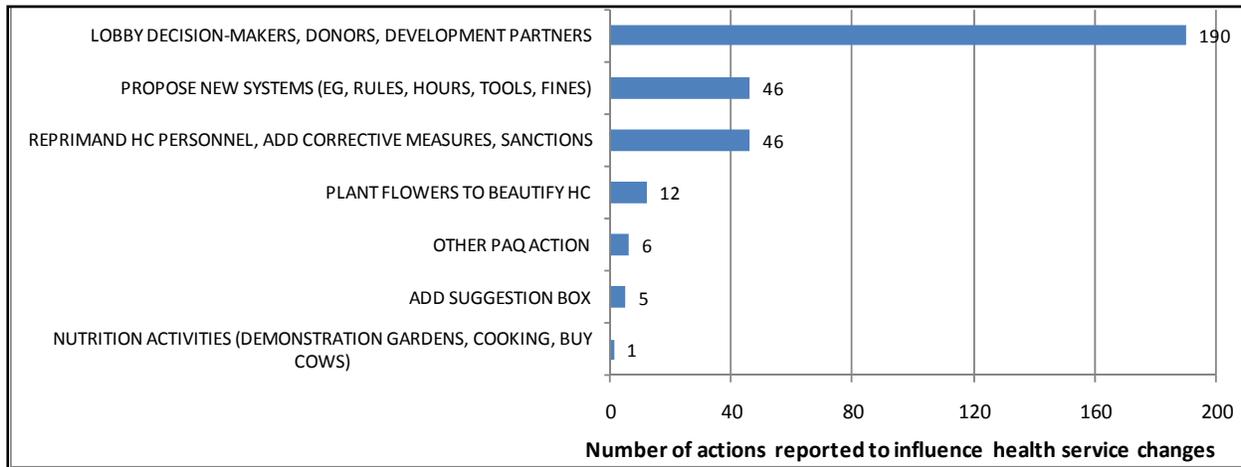


Figure 5. Improvements to Health Services Influenced by PAQ Teams, All Twubakane Districts



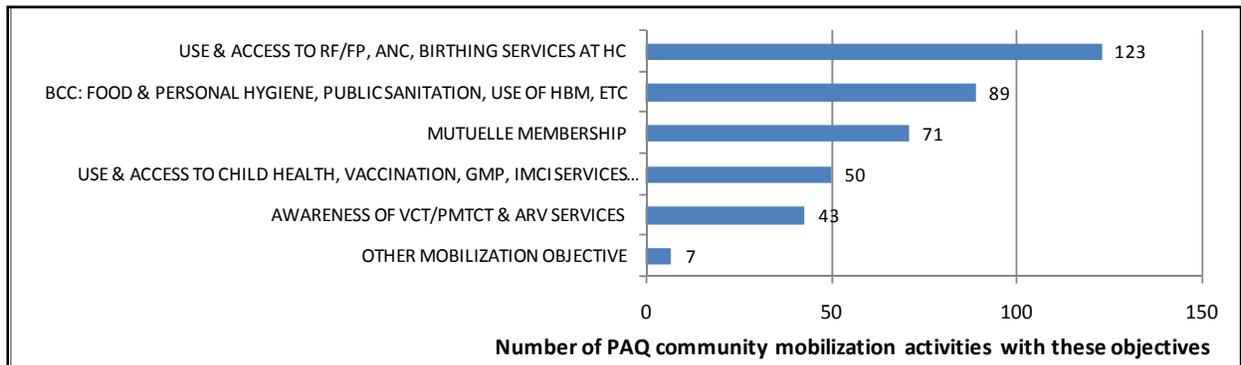
The specific actions undertaken by the PAQ teams to influence these changes include lobbying for directives or advocating for funds from administrative decision-makers, donors, and other development partners; making specific proposals to implement new rules and systems; and putting in place corrective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

Figure 6. Actions taken by PAQ Teams to Improve Health Care Services, All Twubakane Districts



Many of the actions undertaken by PAQ teams during 2008 to mobilize the community were focused on increasing use of health services for FP and safe motherhood (e.g., delivery at a HC vs. at home) and education about personal and food hygiene. In order to mobilize community members, PAQ teams mostly relied on group sensitization activities, household visits, and team members serving as good examples to the community.

Figure 7. Types of PAQ community mobilization objectives, All Twubakane Districts



Most PAQ teams said they encountered important challenges and obstacles to their efforts. Lack of financial means and meeting space were by far the most frequently mentioned, followed by limited member participation, motivation, or time, and lack of knowledge of the PAQ strategy and community health policies. To address these challenges, some actions that PAQ teams undertook were to set up income-generating activities, request individual member contributions and set up member support funds, and replace absent or inactive members.

An evaluation of PAQ teams in December 2008 provided valuable information for further implementation of this Twubakane component as well as for MINISANTE. The qualitative evaluation of the PAQ approach included in-depth interviews and focus groups of national authorities, local authorities, health center staff, PAQ team members, and community members.

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

CHIS in Kicukiro

The manager of Busanza Health Center in Kicukiro District, Providence Uwineza, said, *“Before we started with the CHIS, there was no information that came from the communities to the health centers and the local authorities to make them aware of the real problems within communities. Now, every time that the CHIS reports are submitted, the trained CHWs get together with the sector-level authorities and all of the heads of social affairs from the cells to discuss the results. We have seen so many positive things happen, including changes in nutritional status of children, and more people coming for family planning. For us, we really appreciate this new system that Twubakane helped us set up, and we consider it an innovation that we will keep going...”*

Table 14. Strategic Information Management

Indicator	2005 Results All 110 HCs	2007 Results Random Sample of 60 HCs	2008 Results All 136 HCs	Target 2008	Data Source
# People trained in Strategic Information Management (Community Health Information System)	100	30	317	400	Twubakane training database
Male	n/a	9	171	200	
Female	n/a	21	146	200	

During 2008, through funding from USAID’s Last Mile Initiative, under an agreement with Systems, Research and Applications (SRA), a US-based organization, Twubakane staff and IntraHealth/Chapel Hill-based staff developed a platform that can be used to support health data collection at the community level. SRA received funding from USAID/Washington for a pilot test of telecommunications to support the community-based health information system (CHIS) and requested that IntraHealth International be the in-country implementor. Unfortunately, due to challenges with the changing information technology environment in Rwanda and the numerous donors and partners working on such information collection systems, the planned pilot of the system was not executed. However, the foundation system exists that would allow CHWs to collect and enter information into a cellular phone or personal digital assistant (PDA). Should future funding and in-country support be identified, the foundation system could be updated and adapted to the indicators. The development of the foundation system was based on the paper data collection system used by CHWs in two districts: Kicukiro and Kirehe.

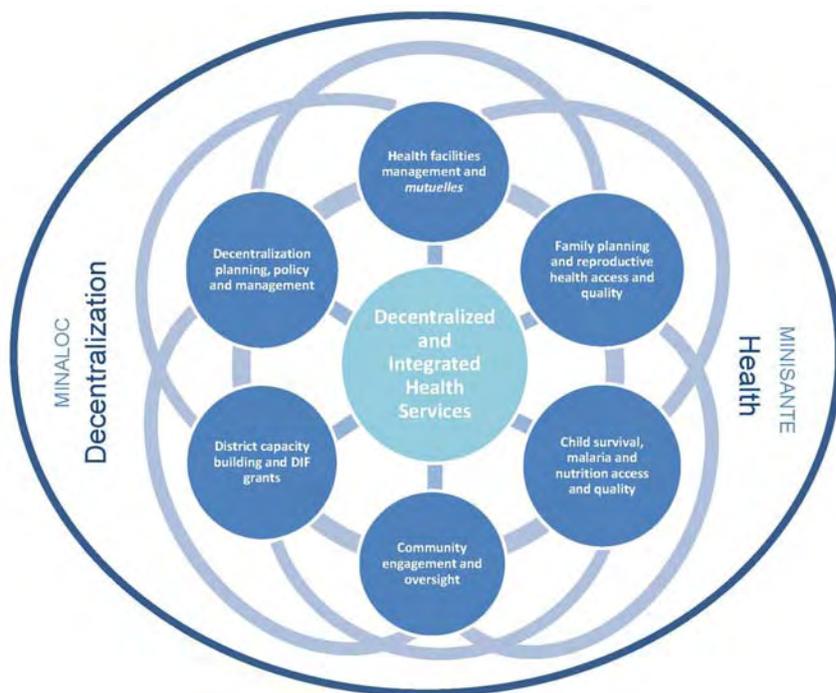
TWUBAKANE’S SYNERGISTIC SUPPORT FOR IMPROVED DECENTRALIZATION AND HEALTH

The Twubakane Program’s approach to improved decentralization and health is based on the notion of synergy, that the combination of the program components has an impact beyond that of the individual elements. As noted in previous reports, and throughout this annual report, the Twubakane staff work as a team in close collaboration with our GOR counterparts, and a variety of other partners, at all levels in fostering an integrated approach, both within the health sector, and among health, decentralization and good governance, and overall social and economic development.

Examples of synergies among the Twubakane Program components include the following:

- Community-provider partnership (PAQ) teams not only encourage community participation and ownership; *in addition*, the work of the PAQ teams has had positive influences on good governance, community health and improved maternal, child and reproductive health.
- District Incentive Funds provide much-needed resources to the districts and promote good governance and capacity building; *in addition*, DIF grants impact the quality of services through investments in medical equipment and supplies, health facility renovations, PAQ teams and community mobilization.
- Family planning and reproductive health efforts have had an impact of the health of women, as well as their children and families; *in addition*, attention to family planning and reproductive health has galvanized district authorities and other local leaders to care about health as a social and economic development issue—and to direct local resources to promote health and ensure high-quality services.
- Community health workers offer vital—and often urgent—services to the communities in which they serve; *in addition*, in close collaboration with the PAQ teams, CHWs have become empowered community representatives with a voice in health management and governance issues at the local level. Furthermore, as many beneficiaries have noted, the availability of health services at the community level has saved time and money for community members.
- Strengthening the management of health facilities and *mutuelles* has contributed to more cost-effective use of resources; *in addition*, district authorities better understand the investments needed for quality health care services and the role *mutuelles* play in allowing citizen access to these health care services.
- Decentralization policies and programs have contributed to increased availability of resources at the local level and empowered local government authorities; *in addition*, the successful implementation of the decentralization plan is contributing to local leadership and services, including health services that are more responsive to the needs of the population.

Figure 8. Twubakane Program’s synergistic health and decentralization components



INTERNAL PROGRAM PROCESS MILESTONES

Field Offices

In response to heavy workloads and growing demand for the support of field coordinators, Twubakane hired and posted four additional assistant field coordinators in early 2008. These additional positions allow the field coordinators, most of whom cover two to three districts, to focus on coordination between the Twubakane office and operations in Kigali and our local program activities. The assistants have participated actively in Joint Action Development Forums, *mutuelles* supervision and data management, and other district coordination mechanisms to ensure that Twubakane's support is coordinated with that of other development partners in each district. As in the past, field coordinators and their assistants continued to support DIF grants by monitoring implementation of DIF-supported activities, and actively participating in the district Joint Action Forums. In addition, field coordination teams continued supporting (initiating, organizing, monitoring) activities from all components given their location within the districts. District-level authorities continued to express their appreciation of the coordinators' hands-on support and presence in the districts.

Monitoring and Evaluation (M&E)

Twubakane M&E activities continued in 2008 to be focused on an ongoing process of data collection and analysis in order to report quarterly and annually on program performance, and to inform implementation decisions. Using the revised PMP indicators from January 2007, the updated PMP system was put into use. To comply with USAID's Operational Plan requirements, the Twubakane M&E team collected data on all performance indicators, the main source of which was the national HMIS. Other data sources included district mini-surveys and Twubakane project records.

Annual Retreat

As in previous years, Twubakane held an all-team retreat in early November 2008. This retreat focused on planning for the fifth and final year of the program. To help facilitate such an effort, the Twubakane senior team used a reflection-planning process, whereby team members were able to assess the degree to which activities implemented produced desired results in 2008 and to recognize program achievements and areas for documentation, as well as prioritize for 2009.

ANNEXES

Annex One: Activities Completed with 2008 District Incentive Funds (DIF) Grants

SOUTHERN PROVINCE

KAMONYI		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Capacity building of the district in planning, budgeting and data processing equipment; <i>as verified by preparation of action plan 2009, the Medium Term Expenditure Framework (MTEF) 2009-2011, the study trip of the planning committee, approved budget of 2009, revised budget of 2008, annual plan and performance contract (Imihigo) 2009.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. Action plan, budget, and performance contract for January to June 2009 developed and approved. 22 desktop computers, 10 laptop computers, and 21 printers purchased and distributed by the district to health centers and administrative sectors.
2	Purchase and supply of medical equipment for Musambira, Kamonyi, Gihara, Mugina health centers and Remera Rukoma Hospital; <i>as verified by their purchase, delivery, and the use of the equipment.</i>	100% of health facilities equipment and materials has been purchased and delivered to the health centers; this includes: 5 delivery tables, 9 microscopes, 6 delivery kits, 9 tension-meters, and 10 stethoscopes.
3	Capacity building of cell officials and technicians of Kayenzi and Kigese health centers in case management and best practices on managing cases of malnutrition amongst the local population; <i>as verified by planting of vegetables and the fruit trees, the small animal breeding and 13 cows of improved and crossed race as well as the training of the recipients.</i>	District organized and provided training to 11 coordinators and 11 executive secretaries from cells, health center technicians and 311 malnourished individuals on nutrition protocols and methods for improving nutritional quality within the cells and at the health centers of Kigese and Kayenzi. 11 associations for malnourished persons have been created, each benefiting from a small grant to finance an income generation project oriented towards setting up agriculture and livestock projects which will enable vulnerable households to improve their nutrition; The two health centers of Kayenzi and Kigese have received financial support for their agriculture and livestock projects in order to maintain nutritional education for the malnourished population; Inter-sector study tour was carried out in well-performing sectors for 44 individuals (four per association); technicians from several district sectors and health centers participated; Agricultural products purchased and distributed to members of the associations for the malnourished (2,500 kg fertilizer, 48 kg seeds, 315 hoes, 315 shovels, 315 watering cans, and 315 mattocks).
4	Capacity building of the district in the reduction of malnutrition by the purchase of a manufacturing tool that produces tubes for the growing and production of mushrooms; <i>as verified by the purchase, the installation and the operation of the machine.</i>	This activity was replaced by the purchase and distribution of medical equipment and supplies for several health facilities within the District of Kamonyi.

MUHANGA		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Capacity building of six PAQ teams of the district health centers in the conception, planning and execution of income generating activities; <i>as verified by the signed agreements for income generating projects and financing, for a total of 1.800.000 RWF.</i>	6 PAQ teams have received 300,000 FRW each to finance income-generating projects.
2	Capacity building for the District in planning, budgeting and use of ICT equipment for local government activities management and improved service delivery; <i>as verified by: the production of the MTEF (Medium Term Expenditure Framework) 2009-2011; the annual action plan 2009 and the IMIHIGO performance contract 2009; the purchase and distribution of 12 lap top computers and 20 modems for the directors of the technical units and executive secretaries of the Sectors of the District.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. Action plan, budget, and performance contract for January to June 2009 developed and approved. Evaluation of the district's performance contract, <i>imihigo</i> , has taken place in the sectors. Thirteen laptops, 14 printers, 20 modems, one projector, and 20 flash disks have been purchased and delivered for the District to distribute to the staff of admin Sector offices.
3	Capacity building of district staff in monitoring and evaluation, reporting techniques, leadership skills; <i>as verified by: a series of training sessions of eight unit directors at the district level and 12 executive secretaries from the sector, and a series of conference-debates.</i>	Training for the district staff in monitoring and evaluation and in reporting techniques completed, in collaboration with RIAM (Rwanda Institute of Administration and Management).
4	Capacity building of district in media campaigns and developing public messages on decentralization, good governance and health service delivery programs; inter-district partnership with Ruhango District; <i>as verified by: the production and broadcasting of a weekly radio show on decentralization and health issues, on the local community Salus radio.</i>	Contract was signed and executed between the district and the local radio station (SALUS) of the National University of Rwanda to broadcast 15-minute shows on decentralization and health twice a month.
5	Renovation of health post of Gasagara, the health centers of Rutobwe and Buramba and the maternity ward of Kabgayi Hospital; <i>as verified by the completion of the Gasagara second health facility building initiated by the local population of the Rongi Sector; the renovation and coating of the old building of Rutobwe health center; the set up of the consultation room for children in Buramba health center; and renovation of the maternity ward of Kabgayi hospital; technical control of the buildings.</i>	Renovation of Rutobwe health center complete. Renovation of the operating room of the maternity ward of Kabgayi hospital complete. Renovation of Gasagara health posts is ongoing and will be completed with cost-share contribution.
6	Purchase and supply of medical equipment for health centers, secondary health facility and office furniture for the <i>mutuelles</i> office and Kabgayi Hospital; <i>as verified by their purchase, delivery by suppliers, distribution and the use of the equipment.</i>	69 units of medical and nonmedical supplies and equipment purchased and distributed among the Gasovu, Shyogwe, Gitarama, Nyabinoni, Kabgayi, Nyabikenke, Birehe, Gasagara Nyarusange and Gitega health centers; office furniture purchased and delivered to the <i>mutuelles</i> office and Kabgayi Hospital.

NYAMAGABE		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Capacity building of the district staff in planning processes, such as: preparation of district marketing profile; revision of the MTEF 3 year budget cycle; evaluation of performance contracts and indicators; preparation of the 2009 annual action plan; organization of JADFs and roll out of the JAF at the sector level; <i>as verified by the production the District profile, the 2008-2010 MTEF, the 2009 action plan, the reporting on the performance evaluation, and the minutes of the JAF sessions.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. JADF meetings are taking place on a regular basis at the District level (four quarterly meetings). Joint Action Development Forum (JADF) established in 17 of the district's sectors and meetings are taking place. Action Plan and performance contract for January to July 2009 developed and approved. Evaluation of the performance contract took place in June and in November 2008. District's marketing plan developed and will soon be distributed. 22 modems and 4-months internet service purchased to facilitate communication between the sector technical staff, the 17 executive secretaries, the district's four executive council members, and the District's ICT director.
2	Purchase of medical equipment for hospitals and health centers; <i>as verified by their purchase, delivery, and the use of the equipment.</i>	100% of medical equipment and supplies purchased and distributed to two health facilities, the Kigeme Hospital and the new Kibumbwe health center; this activity supports part of the "Umurenge Vision 2020" flagship project of the Kibumbwe sector.
3	Renovations of the buildings of two health centers (Ngara and Nyarwungo) and the Burarama health post; <i>as verified by the technical inspection by the District technical and infrastructure services, and technical control visits of the buildings of the health centers and health secondary facility.</i>	Renovations of the buildings of the Nyarwungo health center and the fence of the Ngara health center 100% complete. Renovation of the Bugarama secondary health facility will no longer take place due to budgetary constraints.
4	Support local income-generating activities and strengthening the economic viability of poor households, through a pig breeding program in eight sectors; <i>as verified by the signed and certified list of beneficiaries, household visits, and technical reports of the district.</i>	This project has been replaced with the purchase of cattle, due to the outbreak of an epidemic that affects pigs, and pigs that have been quarantined. In-lieu, sixty-four cows have been purchased and distributed to 64 vulnerable households in eight of the District's sectors.
NYARUGURU		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Purchase and supply of medical equipment for Munini Hospital; <i>as verified by the purchase, delivery, and use of the equipment.</i>	Medical equipment for operating room purchased and delivered; this includes one anesthesia unit / device; one surgical aspirator; one operating table; three high-power microscopes, and medical supplies. Hospital is now operational and the first surgical operation took place in the night of February 10, 2009. As of the first quarter of 2009, 25 C-sections had been carried out at this hospital.

2	Production of the urban planning documents of the district (Kibeho – main town); <i>as verified by: the production of a zoning plan for the city; the plans for the road network and drainage plan (gutters, culverts, storm-water drainage system, etc...); the site planning specifications of the roadway system (roads and gutters); the budgets and cost estimates of the public works; and the site / cadastral surveys of planned and zoned lots.</i>	Cadastral site maps and field notes of urban planning site surveys and the result of the study with initial zoning boundaries prepared and submitted to the district. Socio-economic study ongoing, will evaluate status of current land ownership, property taxes and other local commercial taxes and revenues of individuals currently living on the sites; plan for integrating the local population into the urban planning process is underway.
3	Capacity building of district staff in regular budgeting and planning processes; <i>as verified by revision and preparation of the MTEF 2008-2009 year budget cycle; preparation of the 2009 annual action plan; the reporting on evaluation of performance contracts and indicators; and the minutes of the JAF sessions.</i>	Four sessions of the Joint Action Development Forum (JADF) organized at the district level; two sessions organized at the sectors' level. Medium Term Expenditure Framework (MTEF) 2009-2011 revised and approved by the district council in November 2008. The Action Plan and the Performance Contract for January to June 2009 have been developed and approved. The evaluation of the performance contracts has taken place four times in the 14 sectors of the District. A study tour of the members of the national parliament to the District took place for an exchange of ideas with technicians, elected officials and health officials about the roles and functions of local government and improving service delivery. .
4	Support to PAQ teams of the district's health centers in the conception, planning and implementation of income-generating activities; <i>as verified by: the minutes of PAQ meetings with public and administrative authorities; the signed agreements and MoUs for income generating projects and financing for the monitoring and supervision of PAQ activities.</i>	13 PAQ teams benefited from funds to finance income-generating project. The funds were provided in a shared partnership, with the administrative sectors contributing 13%, health facilities 7%, and the district 80% (through the DIF grant).
RUHANGO		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Purchase and supply of medical equipment, particularly for emergency obstetrics and neonatal care, for the district hospital and health centers; <i>as verified by their purchase, delivery, and the use of the equipment.</i>	20 units of medical and nonmedical supplies and equipment purchased and distributed.
2	Support for 8 PAQ teams of the district's eight health centers in the conception, planning and execution of income-generating activities; <i>as verified by the signed agreements for income-generating projects and financing, and the implementation of activities.</i>	8 PAQ teams (Nyarurama, Kigoma, Karambi, Kizibere, Ruhango, Muremure, Gitwe and Munyunzwe) each received funds ranging between 1,100,000 FRW and 1,260,000 FRW to finance income-generating projects.
3	Nutrition promotion in the schools of Byimana and Bukomero and promotion of hygiene in the Byimana sector; <i>as verified by the installation of the vegetable gardens, the breeding of the smaller live-stock, and the plantation of the fruit trees.</i>	Eight female members of the Bonezubuzima organization trained as trainers to promote better nutrition among children infected with or affected by HIV/AIDS. These women have trained 150 people living with HIV and/or supporting others living with HIV.

4	Strengthening of the staff in health posts on family planning methods; <i>as verified by the purchase and the delivery of the medical and non medical equipment and their use.</i>	Medical and nonmedical supplies and equipment purchased and delivered to health posts to strengthen their capacity to provide family planning services.
5	Institutional capacity building of local cooperatives in the sectors Mwendo, Kabagali and Ruhango; <i>as verified by the census of the co-operatives on the villages' level, the federation of the co-operative movements, the election of the management boards of the co-operatives and a study trip at the national level.</i>	Members of cooperatives in three sectors (Mwendo, Kabagari and Ruhango) trained on the principles and policies pertaining to cooperatives, and project management skills.
6	Capacity building of district staff in budget and planning processes; <i>as verified by the production the Medium Term Expenditure Framework (MTEF 2009-2011) year budget cycle, the 2008 budget revision, the preparation of 2009 action plan and 2009 performance contract.</i>	MTEF 2009-2010 (Medium Term Expenditure Framework) revised and approved. Action plan, budget and performance contract for January and June 2009 developed and approved. Evaluation of district's performance contract, <i>imihigo</i> , completed.
7	Capacity building of the district in media campaigns and developing public messages on decentralization, good governance and health service delivery programs; inter-district partnership with Muhanga District; <i>as verified by: the production and broadcasting of a weekly radio show on decentralization and health issues, on the local community Salus radio.</i>	Contract signed and executed between the district and the local radio station (SALUS) of the National University of Rwanda to broadcast 15-minute shows on decentralization and health twice a month.
8	Updating of the database of district taxpayers for improved and increased collection of local taxes; <i>as verified by the training of the census takers, the data-gathering and a data bank up to date of the taxpayers of Ruhango District.</i>	Data gathering complete and data entering ongoing; the updated tax roll and registry will be used for the March 2009 tax collection season.

EASTERN PROVINCE

KAYONZA		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Renovation of Gahini and Kabarondo health centers, Kabare health post and the district pharmacy; <i>as verified by renovation of the maternity wards of Gahini and Kabarondo health centers, the transformation of the former Kabare sector's building into a health post in Kabare and the renovation and transformation of Nyamirama health post into new district pharmacy.</i>	Renovation of the district's pharmacy 100% complete, including five offices and one storage room for pharmaceuticals. 60% of the renovation on Karengye and Gahini health centers has been completed and 90% on Kabare secondary health facility. A contractual arrangement is being devised to ensure that the remaining renovation works take place in compliance with the DIF agreement.
2	Solar energy installation in Ruramira and Rutare health centers and Kageyo health post; <i>as verified by the purchase, delivery and use of solar energy equipment.</i>	Installation of solar energy has been completed for: (1) the Kageyo health facility (where 16 solar panels of 120 kWh each have been installed so that all rooms are now powered 24 hours a day); (2) for the Rutare health center (where 18 solar panels of 120 kWh were installed so that all rooms are powered with 40 light bulbs and 10 outlets, 24 hours a day); (3) panels could not be installed for the Ruramira health center due to budgetary constraints, and the unanticipated high cost of the solar panels.

3	Support for 6 PAQ teams of the district health centers in the conception, planning and execution of income-generating activities; <i>as verified by the signed agreements for income-generating projects and financing, and the implementation of activities.</i>	6 PAQ teams (Rukara, Gahini, Mukarange, Nyamirama, Ndengo et Kabarondo) grouped together into a cooperative and each benefited from funds to finance income-generating projects, consisting mostly of agriculture, livestock, and small business initiatives.
4	Purchase and distribution of management tools and registers for the <i>mutuelles</i> offices; <i>as verified by the purchase, delivery and use of membership cards, family cards, registers, bank and cash ledgers.</i>	1,000 registers delivered to district <i>mutuelles</i> offices.
KIREHE		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Purchase of medical equipment for the health centers of Gahara, Gashongora, Bukora, and Ntaruka and two health posts (Rwantonde and Nyabitare); <i>as verified by their purchase, delivery, and the use of the equipment.</i>	69 units of various medical and nonmedical material and equipment purchased; delivered in first quarter of 2009 to Rwantonde and Nyabitare health posts, and to Gahara, Gashongora, Bukora, Kabuye and Ntaruka health centers.
2	Renovation of existing buildings to create two health posts, Rwantonde and Nyabitare; <i>as verified by the technical inspection and control visits by the district technical and infrastructure services, and the improved use and functioning of the buildings of the health outpost.</i>	100 % of the renovation of Nyabitare health post has been completed and the facility is currently operational. 100% of the renovation of the Rwantonde health post has been completed.
3	Capacity building of district staff in planning processes, such as: revision of the DDP; revision of the MTEF 3 year budget cycle; preparation and evaluation of indicators; preparation of the 2009 annual action plan and performance contracts; <i>as verified by the production and distribution of the District Development Plan (DDP), the 2008-2010 MTEF, the 2009 annual action plan and performance contract.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. January to June 2009 action plan, budget, and performance contract, <i>imihigo</i> , developed and approved.
4	Renovations of district office building – phase II, for improved functioning and service delivery; <i>as verified by the completion of renovation and the technical inspection of building renovations.</i>	Renovation is ongoing and 85% has been completed. A contractual arrangement is being devised to ensure that the remaining renovation works take place in compliance with the DIF agreement.
NGOMA		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Capacity building of 10 administrative sectors to improve quality of service delivery; <i>as verified by the purchase and distribution of office furniture, the signed delivery forms and the regular monitoring of the use of the equipment.</i>	44 office tables with drawer, 10 modern office tables, 40 chairs, 10 rolling chairs, 30 visitor chairs, and 50 modern metal cabinets were purchased and delivered to the district office and to its 10 sector offices. Multipurpose / conference room of the district renovated.

2	Capacity building of district staff in planning processes, such as: revision of the DDP; revision of the MTEF 3 year budget cycle; preparation and evaluation of indicators; preparation of the 2009 annual action plan and performance contracts; <i>as verified by the production and distribution of the District Development Plan (DDP), the 2008-2010 MTEF, the 2009 annual action plan and performance contract.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. Action plan and the performance contract for January to June 2009 developed and approved. District Development Plan updated.
3	Purchase of nonmedical materials (beds, cloths, mattress and curtains) for use in health facilities; <i>as verified by the purchase, delivery and the use of this material.</i>	100 beds with mattresses, 100 bed sheets, 100 blankets, and 1,843 meters of curtain fabric purchased and delivered to district's health centers.
4	Purchase of medical equipment for health post of Nyagasozi; <i>as verified by their purchase, delivery, and the use of the equipment.</i>	29 units of various medical and nonmedical material and equipment purchased and delivered to Nyagasozi health post.
5	Renovation of maternity ward of the health center of Jarama; <i>as verified by the technical inspection and control visits by the District technical and infrastructure services, and the improved use and functioning of the buildings of the secondary health facility.</i>	100% of the renovation has been completed. A preliminary building construction inspection has taken place, and a permanent inspection will take place in one year.
6	Sensitizing the population on family planning through the religious / faith based organizations and district officials ; <i>as verified by the material of training produced as well as the list of the participants in the meetings of mobilization indicating the number of men and women.</i>	444 people, (on the average 31 people per sector), mostly elected health officials from local administrative entities and the cells, trained on family planning and contraceptive methods; they are responsible for raising the awareness of the local population in the district's 14 admin sectors on family planning options, opportunities and choices.
RWAMAGANA		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Purchase and supply of medical equipment for Murehe, Fumbwe and Gahengeri health posts and 10 health centers; <i>as verified by the purchase, the delivery, and the use of the medical equipment.</i>	100% of the medical equipment and supplies purchased and delivered to the various health facilities.
2	Renovation of Karenghe health center, of Nyagasambu and Musha health centers, and of Murehe health post; <i>as verified by the renovation of the roof of the Karenghe health center, the showers and latrines of Nyagasambu and Musha health centers and of Murehe health post.</i>	100% of the renovation has been completed.
3	Support for 5 PAQ teams of the district health centers in the conception, planning and execution of income-generating activities; <i>as verified by the signed agreements for income-generating projects and financing.</i>	6 PAQ teams (from Muyumbu, Rubona, Ruhunda, Karenghe, Nzige and Rwamagana) have benefited from funds to finance income-generating activities, which mostly consist of agriculture and livestock projects.

4	Technical support to and capacity building of district technicians for revisions to the 2008 budget exercise and the evaluation of 2008 performance contracts (Imihigo); <i>as verified by carrying out and documenting a two-day workshop for the revision and validation of the 2008 budget and four workshops for the quarterly evaluations of the District's performance contracts.</i>	MTEF (Medium Term Expenditure Framework) 2009-2011 revised and approved. 2009 action plan and performance contracts developed and approved. Quarterly evaluation of the District's performance contract, <i>imihigo</i> , taking place in the first quarter of 2009.
5	Purchase of office equipment and material for district to increase efficiency and service delivery, supporting district capacity-building plans; <i>as verified by the delivery and the use of the material and the equipment.</i>	7 office desks, 3 computer tables, 17 chairs, and 1 executive desk, table, and sofa set purchased and delivered to the district offices.
6	Improved communications through the publication of the Rwamagana District newsletter; <i>as verified by the printing and distribution of at least 700 copies of the district newsletter per quarter.</i>	Production capacity of the District's newspaper strengthened through the purchase of equipment (including a laptop, a printer, and a digital camera) as well as other necessary materials (ink, paper, etc); two editions of the newsletter printed and distributed.
7	Renovation of the office of the Karenge administrative sector and the offices of the cells of Cyanya and Fumbwe; <i>as verified by the repair of the roofing, patching of walls and painting buildings.</i>	100% of the renovation has been completed.

KIGALI CITY

GASABO		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Capacity building of the district in its budget and planning processes for the 2009-2011 cycle; <i>as verified by the production of the 2009 annual action plan, preparation of the 2009 District procurement plan, revision of the Medium Term Expenditure Framework (MTEF 2009-2011) year budget cycle; preparation of the 2009 annual budget; the reporting on and evaluation of the 2008 performance contracts and indicators, the preparation of 2009 performance contracts, the district marketing profile and strategic plan of the unites.</i>	MTEF (Medium Term Expenditure Framework) 2009-2010 revised and approved, and the district's procurement and action plan and performance contract for January to June 2009 have been developed and approved. Evaluation of the performance contracts has taken place; district was ranked the 5th best performing district of the country's 30 districts. District's marketing profile developed. Strategic plans of the District's sector activity units (education, health, agriculture, etc) developed.
2	Strengthening the use of family planning methods at the community level by training and capacity building of local authorities at the cell level on national family planning policies and priorities; <i>as verified by carrying out a two-day training session for 501 local authorities, and the production of a training report.</i>	318 elected health officials from the cells (130 men and 188 women) in eight sectors have been trained on family planning methods; training took place in eight instead of planned 15 sectors due to budgetary constraints.
3	Purchase and supply of medical equipment for Rusororo health post and Nyacyonga and Kayanga health centers; <i>as verified by their purchase, delivery, and the use of the equipment.</i>	60 units of various medical material and equipment purchased and delivered to the Nyacyonga, Jali, Kayanga, Rusororo and Gatsata health centers/posts.

4	Renovation of the Gihogwe health post; <i>as verified by the conversion and stuccoing of the administrative building of the ex-cell of Gihogwe into a medical building, and by the technical inspection and control visits by the District technical and infrastructure services, and the improved use and functioning of the buildings of the health outpost.</i>	100% of the renovation has been completed.
5	Rehabilitation of the public market of Kimironko (Phase II), and improvement of hygienic conditions; <i>as verified by the installation of the sanitation facilities, electric / lighting, and the painting of the walls of the market.</i>	100% of the renovation has been completed.
KICUKIRO		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Implementation of district baseline socio-economic survey; <i>as verified by the filled in data collection forms, the socio-economic data of the District population entered into a data base, and the updating of the district marketing profile.</i>	Socioeconomic survey and the data collection completed; information was collected on 58,389 households in all the 328 villages of Kicukiro District. Analysis and the dissemination of the results to be implemented by the National Institute of Statistics of Rwanda in early 2009.
2	Expansion of the community-based family planning strategies and activities in four additional administrative sectors of Kicukiro District; <i>as verified by the technical reports of starting up activities at the 4 new sites and the purchase of the required materials.</i>	A network of elected health officials has widened and committed itself to raise the awareness of various target groups on family planning issues; 700 women were identified and targeted by the awareness campaign and now use a variety of family planning methods.
3	Capacity building for 5 PAQ teams of the district health centers in the conception, planning and execution of income generating activities; <i>as verified by the training of 125 PAQ members in project and operational planning and the signed agreements for income-generating projects and financing.</i>	The district's PAQ teams have identified and financed two new projects: <ul style="list-style-type: none"> - 100% of the renovation of the latrine of Gikondo health center has been completed; - 100% of the renovation of retaining wall of Kabuga Health Center has been completed.
4	Improved hygiene and reduction of oral-fecal illnesses in Kigarama Sector, through the renovation of a bloc of latrines at the public market; <i>as verified by the construction and reception reports, and the use of the latrines by the public / patrons of the market.</i>	100 community health workers and elected health officials in Kigarama Sector trained on hygiene-promoting behavior, and on prevention of oral-fecal transmission. Public latrines of the Kigarama market renovated.
5	Capacity building of 10 administrative sectors and three health centers (Busanza, Gahanga and Kabuga / Betsaida) of Kicukiro in their ability to provide and monitor quality health care service delivery; <i>as verified by the purchase and distribution of 10 computers, the signed delivery forms and the regular monitoring of the use of the equipment.</i>	13 sets of IT equipment purchased and delivered; each consisting of one desktop computer, monitors, inverters, and printers; the units are used by tax collectors in each of the 10 sectors, and for the health center staff of Gahanga, Busanza, and Betsaida.

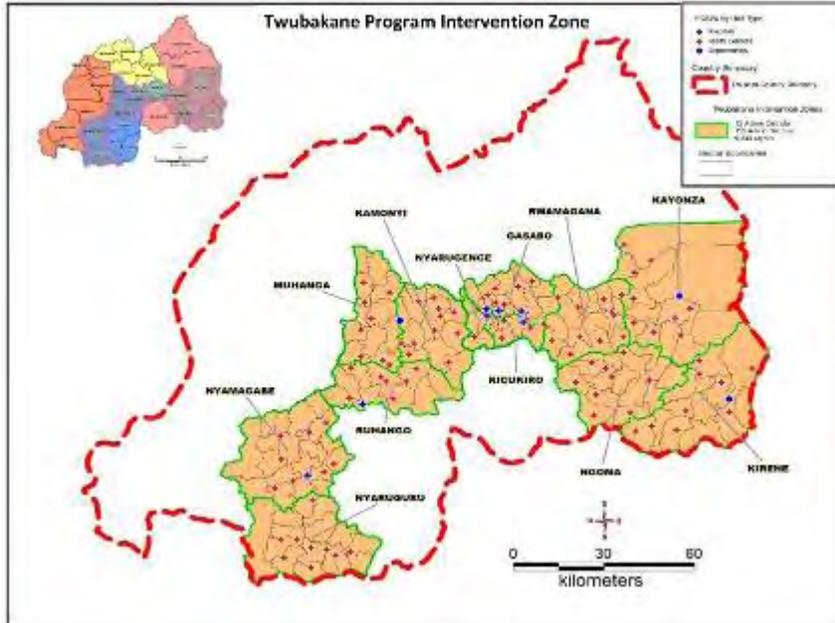
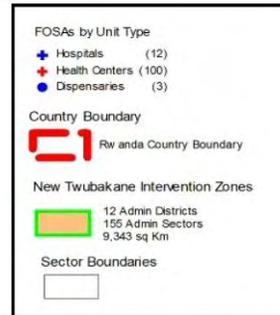
KIGALI CITY		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Strengthening of the City's capacity to plan and coordinate health activities throughout the city and the three districts of Kigali; <i>as verified by the set up of a functional forum of various partners and stakeholders of the city of Kigali operating in the health field & sector; the effective partnership between the city of Kigali and the partners as well as the minutes of the quarterly meetings of the forum.</i>	Health forum held that brought together 81 partners, stakeholders and district health technicians of the City of Kigali and its three districts managing health projects and activities; recommendations and a strategy for harmonized health sector planning and supervision of activities was proposed.
2	Orientation sessions of the population of Kigali city on family planning methods and options; <i>as verified by the production and the broadcasting of educative messages and the public educational spectacle shown by theatrical troop URUNANA at the stadium.</i>	Educative messages on family planning methods have been broadcasted on the Rwandan national radio. Public educational theater spectacle was produced and performed at the Kigali stadium by the theatrical troop Urunana Development Communication; attracted a crowd of 3,000 people.
3	Capacity building of Kigali City team in planning processes for the 2009-2011 budget & planning cycle; <i>as verified by planning workshops the production of the Medium Term Expenditure Framework (MTEF 2009-2011) and the performance contract 2009.</i>	Workshop held November 21-23, 2008, for technical staff of the three districts of Kigali and of Kigali City, including members of the City Council, to produce and approve the MTEF (Medium Term Expenditure Framework) 2009-2011 operations budget.
NYARUGENGE		
	Activities Planned for 2008 DIF Grants	Activities Implemented with 2008 DIF Grants
1	Implementation of district baseline socio-economic survey; <i>as verified by the filled in data collection forms; the socio-economic data of the District population entered into database; the updating of the district marketing profile and the data processing software installed and used in every administrative sector of the district.</i>	Socioeconomic survey and data collection completed. Analysis and the dissemination of the results to be implemented by the National Institute of Statistics of Rwanda in early 2009.
2	Renovation of Mwendo health center; <i>as verified by: the replacement and repairs of the existing fence of the compound and repairs of the main gate of the fence; strengthening the security of the compound and equipment of the health center.</i>	Contract management problems between the district and the contractor caused delay in the renovation works. 50% of the targeted renovation has been completed. A contractual arrangement is being devised to ensure that the remaining renovation works take place in compliance with the DIF agreements.

Annex Two: Twubakane's Intervention Zone

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

Source = MINALOC and Rwanda Census Data, March 2006

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



Annex Three: Monitoring and Evaluation Methodology and Indicator Definitions

Throughout the year Twubakane M&E activities focused on the ongoing data collection and analysis needed for reports of quarterly program performance. Twubakane uses indicators set in January 2007, when the PMP indicators were changed in accordance with the USG's 'Investing in People' indicators as well as additional indicators used for program monitoring.

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

It should be noted that during the course of the year, HCs have been added in districts. Hence, there may be fewer HCs reporting results early in the year than toward the end of the year. Also, due to administrative restructuring in Rwanda in 2006, a small number of the HCs in the Twubakane intervention zone changed.

METHODOLOGY

Data Collection

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

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

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

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

therefore, results for many indicators are based on 135 HCs. A final RFA will be repeated at the end of the project.

At the district level, an annual survey of districts was conducted with district officials to obtain data for several indicators about district-level planning, budgeting and managing. This SWOT self-assessment was first conducted in October 2006 in all Twubakane districts with the participation of district and sector officials. These were district mayors, executive secretaries, vice mayors, directors and sector executive secretaries. In 2007, the data collection tool was shortened and simplified to limit the time required for the officials to implement the assessment. The same data collection tool was used in March 2008. This year, as in previous years, all 12 districts were included in the assessment, and in each district a group of district officials was asked to rate district performance in public reporting of health sector activities and financial performance and to demonstrate that they engage the population in preparing district plans and activities. This exercise coincided with a district planning process; Twubakane staff members who actively support this annual district planning process used this opportunity to administer the SWOT questionnaire to district officials. It should be noted that for several indicators that were to be reported in this annual report, data could not be collected due to its unavailability, including data on # of women receiving AMTSL.

Data Analysis

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

For a few indicators which have remained constant in the project from 2005 to 2008, there is baseline data from 2005. However, comparisons between 2005 and 2007 or 2008 need to be made cautiously as the administrative restructuring in Rwanda in 2006 slightly changed Twubakane's intervention zone.

Indicators: Definitions and Means of Calculation

FAMILY PLANNING/ REPRODUCTIVE HEALTH

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

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

People that have seen or heard a specific USG supported FP message: # individuals in the target population that have seen or heard a FP message. It is calculated by adding: # of new FP clients at health centers, hospitals, and FP secondary posts + # people who have been exposed to FP education/sensitization at health facilities and in the community. Data source: HMIS monthly forms.

of new family planning users by method: # of new family planning users at hospitals, health centers, and FP secondary posts disaggregated by family planning method. Data source: HMIS monthly forms and Twubakane RFA.

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

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

of postpartum/ newborn visits within 3 days of birth: # postpartum/newborn visits within 3 days of birth (includes all skilled attendant deliveries plus all facility or outreach postpartum/newborn visits within 3 days for mothers/newborns who did not have SBA delivery). Data Source: HMIS monthly forms.

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

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

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

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

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

CHILD SURVIVAL

Diarrhea Cases Treated: # cases of child diarrhea treated with oral rehydration therapy (zinc is not used in Rwanda). All cases of diarrhea in children <5 treated at health centers and hospitals are counted

as they would typically include ORT. If data was available on cases were treated through community based distribution of ORT that would also be included. Data source: HMIS monthly forms.

Children <12 months who received DPT3 Immunizations: # children less than 12 months who received DPT3 in a given year. Data Source: HMIS monthly forms.

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

NUTRITION

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

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

MALARIA

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

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

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

DECENTRALIZATION, POLICY PLANNING AND MANAGEMENT

MINISANTE develops and disseminates a costing tool to be used in the development of a financially viable tariff list for minimum and complementary activity: MINISANTE will be using a budgeting

process that uses unit costs for the minimum package of activities (MPA) in health centers and complementary package of activities (CPA) in hospitals. Unit costs must be based on rational data that should be based on at least one of the following: National Health Accounts, USAID costing study, or MBB and must include some kind of cost-of-living-adjustment. Data source: Documentation and oral descriptions of achievements of the various steps processes.

Timely production, completion and dissemination of National Health Accounts: Steps necessary for the production, completion, and dissemination of National Health Accounts include NHA survey conducted, NHA survey report produced, and NHA survey results disseminated to stakeholders. The timing of the production, completion and dissemination of the NHA will be recorded on the timeline set by MINISANTE in collaboration with Twubakane. Data source: Documentation and oral descriptions of achievements of the various steps processes.

Introduction of the Institutionalization of National Health Accounts: Steps necessary to institutionalize NHA: Opening of training facilities offering NHA courses to policy makers, officials, and technicians and Establishment of a health finance desk unit within the MOH staffed by at least 5 full-time personnel. Data source: Documentation and oral descriptions of achievements of the various steps processes.

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

of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA, health facilities, and other relevant stakeholders with USG support: # of decentralization policies, guidelines, indicators, procedural manuals disseminated to LGA (local government authorities), technical civil servants, health facilities, and other relevant stakeholders with assistance from Twubakane. Data Source: Quarterly reports and other documentation.

DISTRICT LEVEL PLANNING, BUDGETING, AND MANAGING

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

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

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

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

USG ASSISTANCE FOR CAPACITY BUILDING IN PUBLIC SECTOR

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

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

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

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

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

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

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

HEALTH FACILITIES MANAGEMENT AND *MUTUELLES*

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

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

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

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

Utilization rate of health services by *mutuelles* members: average # of visits per *mutuelle* member per year. Data Source: RFA.

COMMUNITY ENGAGEMENT AND OVERSIGHT

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

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

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

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

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

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