TWUBAKANE
Decentralization and Health Program
Rwanda

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ACRONYMS

AD	Administrative District
ANC	Ante-Natal Care
ARBEF	*Association Rwandaise du Bien-Etre de la Famille*
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CDF	Community Development Fund
COP	Chief of Party
CPA	Complementary Package of Activities
CPI	Client Provider Interaction
CPR	Contraceptive Prevalence Rate
CS	Child Survival
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
DIF	District Incentive Funds
DIP	Decentralization Implementation Policy
ESP	*Ecole de Santé Publique*
FBO	Faith-Based Organization
FP	Family Planning
GBV	Gender-Based Violence
GOR	Government of Rwanda
HC	Health Center
HD	Health District
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Presumptive Treatment
ISP	Integrated Strategic Plan
ITN	Insecticide Treated Net
LTPM	Long-Term and Permanent Methods
MAP	Men as Partners
MCH	Maternal and Child Health
MEWS	Malaria Early Warning System
MINALOC	Ministry of Local Administration
MINISANTE	Ministry of Health
MPA	Minimum Package of Activities
MTEF	Medium Term Expenditure Framework
NGO	Nongovernmental Organization
NHA	National Health Accounts
ORS	Oral Rehydration Salts
PAQ	*Partenariat pour l'Amélioration de la Qualité*
PNILP	*Programme National Intégré de Lutte Contre le Paludisme*
PPH	Preventing Post-partum Hemorrhage
PRSP	Poverty Reduction Strategy Paper
RALGA	Rwandese Association of Local Government Authorities
RH	Reproductive Health
SM	Safe Motherhood
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VNG	*Vereniging van nederlandse Gemeenten*

IR	Intermediate Result	WHO	World Health Organization

EXECUTIVE SUMMARY

TWUBAKANE'S FIRST YEAR: ADAPTING TO CHANGE

The five-year USAID-funded Twubakane Decentralization and Health Program has the overall goal of increasing 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. Initially funded at $24 million, the Program received an additional $99, 966 to support the national Health Management Information System Assessment. Twubakane's cost-share and leveraging will add at least $3.6 million of associated cash and in-kind programming, for a total program effort of more than $27.6 million.

This first year of the program was a year of significant change for the Government of Rwanda, with the launch of an administrative reform and redistricting process in early July 2005, a process that has and continues to have a major impact on all levels of government. In addition to territorial reform and redistricting, this new phase of decentralization involves new roles and responsibilities at all levels. The Ministry of Health, along with other sectoral ministries, has significantly reduced central-level staff as capacity is shifted to decentralized levels. Also, under the new administrative system, health districts have been incorporated into the districts as departments of health and social services, and health officials responsible for district-level service delivery and management will report directly to locally elected officials.

During the first year of this five-year effort, the Twubakane Program was successfully launched, with offices established in Kigali and in the participating provinces of Gikongoro, Gitarama and Kibungo.

A baseline Rapid Facilities Assessment was conducted in health facilities in the program zone, key central-level support was offered to the Ministry of Health and competency-based trainings of health care providers were organized, contributing to improved quality of care.

With the Government of Rwanda embarking on major decentralization and administrative reform, the Twubakane Program found itself in a unique position to provide timely support not only to initiate and support key health-related interventions but also to provide solicited and timely support to the Government of Rwanda during the new phase of decentralization and administrative reform. This support included highly appreciated central-level technical assistance for the development of a new fiscal decentralization policy.

Pursuant to the GOR reform, the Twubakane Program, in collaboration with USAID and the GOR, identified its new adapted intervention zone, moving from four provinces to 12 districts.

The Twubakane Program's successes—and challenges—in Year One have been based on being able to adapt to an ever-changing environment. Starting the Program in a time of change and reform has necessitated launching activities at both the central and decentralized levels while, at the same time, responding to and supporting the changes.

1. INTRODUCTION

The Twubakane Decentralization and Health Program is a five-year, $24.1-million USAID/Rwanda-funded initiative with the overall goal of increasing access to and the quality and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels.

The Program is a partnership between the Government of the United States of America, represented by USAID, and the Government of Rwanda, represented by the Ministry of Local Government and the Ministry of Health. The program is implemented by IntraHealth International, RTI International and Tulane University in partnership with the implementation agencies of the Government of Rwanda. 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 six integrated components:

1) Family planning and reproductive health
2) Child survival, malaria and nutrition
3) Decentralization policy, planning and management
4) District-level capacity building
5) Health facilities management and mutuelles
6) Community engagement and oversight.

Twubakane's overall strategy focuses on improving capacity to offer services at decentralized levels, but also includes selective support for improving health *and* decentralization policies, protocols and strategies guidelines at the central level. Rather than developing Twubakane-branded materials, we work closely with ministries and other partners to invest in nationally adopted manuals and programs, and then support the use of these materials in the districts supported by the program.

Twubakane was originally designed to work in four provinces: Gikongoro, Gitarama, Kibungo and the city of Kigali. Pursuant to the Government of Rwanda's redistricting and territorial reform, the Twubakane Program, in collaboration with USAID and partner ministries, proposed focusing its activities in 12 of the 30 districts in Rwanda (which closely align with the four former provinces).

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

The program supports USAID/Rwanda in achieving the overall goal of its Integrated Strategic Plan: to increase economic growth and improve well-being in Rwanda. This project specifically targets SO 6: "increased use of community health services" and SO 5: IR 5.1, "reinforced capacity for implementing decentralization in target districts." The Twubakane Program contributes to USAID/Rwanda's Integrated Strategic Plan's cross-cutting themes of gender equity, information and communication technology and human resource and institutional capacity development.

The program also supports the Government of Rwanda's goals and objectives, including those articulated in the GOR's Health Sector Policy and Strategic Plans (2005-2009) and the Decentralization Strategy (2004–2008).

Our program name, "Twubakane," means "Let's build together" in the Kinyarwanda language. As the name implies, this program provides an opportunity for many partners—the Government of Rwanda, USAID, members of our team, public and private sectors, health care providers and communities—to join forces to build a solid base for an effective decentralized health care system in Rwanda.

2. TWUBAKANE'S YEAR ONE ACCOMPLISHMENTS

The Twubakane Program cooperative agreement was awarded to IntraHealth International and its partners in January 2005, and the official launch ceremony organized by USAID in collaboration with the Government of Rwanda was held in early March 2005.

Since March 2005, the Program, in close collaboration with ministries, civil society organizations and other development partners, has been able to realize a number of achievements at both decentralized and central levels.

Key Program Accomplishments in Year One

- Establishment of Program team and offices, including three field offices
- Team-building partners' workshop
- Functional central-level Steering Committee
- Baseline Rapid Facility Assessment in Program zones
- Participatory planning workshops with administrative and health districts and provincial authorities and National Planning Retreat with MINISANTE and MINALOC
- Collaboration and coordination with other development partners to provide technical assistance to the central level Ministry of Health for policies, strategies and protocols for: family planning, mutuelles, nutrition, malaria, maternal health, child health and health communications
- Central-level technical assistance and support for fiscal decentralization policy
- Central-level technical assistance and support for health financing, including National Health Accounts
- Improved quality of family planning and malaria services through competency-based training of health care providers
- Improved management of community-based insurance schemes, mutuelles, through competency-based training in mutuelles management

During its first year of implementation, the Twubakane Program found itself in a unique position to not only initiate and support key health-related interventions but also to provide solicited and timely support to the Government of Rwanda during the new phase of decentralization and administrative reform.

The Program's innovative participatory planning workshops at the provincial and district levels brought together representatives of all administrative districts, health districts and civil society organizations to discuss health and decentralization in a new way—generating great enthusiasm (and creating great expectations) not only for the Twubakane Program but also for the concept of decentralized health. The inclusion in the workshops of civil society organizations, which traditionally have low participation rates in district-level planning and

budgeting exercises, provoked discussion during the forums on how to define "civil society." It also encouraged participants to consider how and why these organizations should be active in a decentralized local governance system. The plans generated during these workshops were then validated at the local level in a participatory manner. Considerable effort went into ensuring the sectoral integration of the Twubakane action plans, and making sure that the activities align with the ministry strategic plans.

"*The project came at the right time,*" said Paul Jabo, the head of the local fiscal governance unit at MINALOC. "*Now, the link between the administration and health is obligatory, and the mayors are responsible for the lives of their citizens...and Twubakane is there to support the process*." He explained that the Twubakane Program's preliminary field work, especially bringing together administrative and health officials for joint planning, demonstrated that "*[illegible]*

The Government of Rwanda launched an administrative reform and redistricting process in early July 2005, and is proceeding quickly for implementation before the March 2006 local government elections. The GOR's objectives of the reform are to better mobilize populations to take part in decision making, strengthen accountability and transparency, increase sensitivity and capacity of the administration to adapt to the local level, develop planning and financial management capacity at local levels and improve efficiency and effectiveness in planning, supervision and service delivery.

The territorial reform involves moving from 12 provinces to four provinces plus the City of Kigali, and moving from 106 administrative districts to 30. The number of sectors will go from 1,545 to 418. In addition to changes to the sizes and boundaries of these entities, the reform involves new roles and responsibilities at each level, with the central level focusing on policy development and capacity building, the provincial level on monitoring and evaluation, the district level on coordination and the sector level on service delivery. Under the new administrative system, health districts have been incorporated into the districts as departments of health and social services, and health officials responsible for district-level service delivery and management will report directly to locally elected officials.

"*The Twubakane Project is an important tool for health care service delivery...strengthening providers' capacity and empowering communities,*" shared Dr. Claude Sekabaraga, the Director of the MINISANTE's Policy Formulation and Capacity-building Unit and Twubakane's focal point at the MINISANTE. He noted that Twubakane is bringing important contributions to "*the goal*

In response to the reform, although progress was made through targeted technical assistance and support at the health facility and community levels, and we have laid the ground work for implementation, the Program has had to delay some key interventions, particularly the District Incentive Funds grants allocation and disbursement and accompanying local government capacity-building activities.

The Twubakane Program team, to ensure that the Program is, indeed, well positioned to adapt to and support this new phase of decentralization, held internal strategic planning

reviews in January 2006 to re-evaluate overall strategies, work plans, budgets and organizational charts. Themes addressed include: adapting local government capacity-building interventions to ensure adequate attention to and support of health at the local level, ensuring that the Program's central-level support is focused and does not distract resources from support to decentralized levels and reviewing allocation of resources to ensure optimal results.

In addition, the Program has recently identified its new adapted intervention zone, moving from four provinces to 12 districts, and has re-evaluated the location of field offices. The National Steering Committee's composition also will need to be revised to adjust to the new zone and new levels of interventions.

The Twubakane Program's successes—and challenges—in Year One have been based on adapting to an ever-changing environment. Starting the Program in a time of change and reform has necessitated launching activities at both the central and decentralized levels while, at the same time, responding to and supporting the changes.

2.1 Twubakane Program National Steering Committee

The role of the National Steering Committee is to follow the programmatic and strategic orientation and activities of the program, and to provide technical and management guidance to ensure the ongoing relevance and impact of its work. The Committee, composed of the Secretaries General of the MINISANTE, MINALOC and MINECOFIN, and representatives of USAID, the four provinces and the Twubakane Program team, met on four occasions in 2005.

During the last meeting of the Steering Committee, held in November 2005, the committee authorized Twubakane's proposal of shifting its coverage zone to 12 districts. Subsequent to the new phase of decentralization, the composition of the national Steering Committee will be revised. In addition, to conform to the reform, the Twubakane Program also proposes collaborating with the 12 districts to establish district-level coordination committees.

2.2 Participatory Planning

As described in this year's quarterly reports, to create the foundation for constructive working relationships with administrative and health districts and provincial teams, to initiative planning and to ensure that the Twubakane Program is planned and implemented in a highly participatory and fully decentralized manner, the Program team organized initial workshops to ensure a common understanding about the Twubakane Program purpose and goals, the roles of the program team, expectations of the various actors and agreements about program management—and to begin the process of developing action plans for the Twubakane Program at decentralized levels. Following each of the provincial-level workshops, representatives from health and administrative districts continued to work, with support from Twubakane and provincial-level staff, to further elaborate and finalize their work plans.

At the national level, the Twubakane Program held a National Planning Retreat July 5—6, 2005 in Kibuye. Participants included representatives of the program provinces, the central-level ministries of Health and of Local Administration (MINISANTE and MINALOC), civil society, USAID/Rwanda and the Twubakane team. The goals of the retreat were to reach consensus on approaches to ensure that the partnership between the Twubakane Program, Government of Rwanda partners and the civil society is effective and functional, and to define the contribution of the Twubakane Program and ensure that a strategy for effective implementation is in place. Objectives were: 1) to share information about the Twubakane Program, 2) to develop a framework and mechanism for working together, 3) to develop an understanding of roles and responsibilities to strengthen central level capacity and 4) to develop activity plans to initiate Twubakane Program activities at the central level. Following the workshop, the Program met with MINISANTE and MINALOC colleagues to prepare work plans for central level support to the ministries. In addition, participatory planning continued with our partner RALGA, the Rwandan Association of Local Government Authorities.

2.3 Twubakane's Field Offices

The Twubakane Program Field Coordinators were officially posted in July 2005. They play pivotal roles in the program, acting as liaison agents between the Twubakane office and operations in Kigali and our program activities at the local level. The Twubakane Program has reviewed the role and posting of the field coordinators in light of the administrative reform and redistricting. Twubakane hopes to negotiate with newly posted district officials to ensure that field coordinators can continue to work within administrative offices of the Government of Rwanda to encourage daily interaction between the program and government authorities (including health officials). The provinces formerly provided office space and some resources for the project field coordinators. Twubakane now plans to post the field coordinators to specific districts, with each coordinator covering three to four districts in the new local government configuration. We also are exploring the possibility of hiring additional district-level coordinators to offer hands-on support to each of the 12 districts.

3. PEFORMANCE REVIEW BY PROGRAM COMPONENT

3.1 Component 1: Family Planning/Reproductive Health Access and Quality

The objective of Component 1 is to increase access to and the quality and utilization of family planning and reproductive health services in health facilities and communities.

Component 1: Family Planning/Reproductive Health
Key Program Accomplishments in Year One

- Improved quality of family planning services through competency-based training of health care providers—with a total of 63 providers trained—and follow-up formative supervision
- Active participation in Family Planning working group, including support to finalize the National Family Planning Sub-policy and the National Family Planning Strategy for Rwanda, revisions of national family planning norms and training modules, collaboration on production of IEC materials and planning for national debate to reposition family planning
- Collaboration with the DELIVER Project to support formative supervision of contraceptive logistics management in Twubakane-supported sites
- Increased access to a range of family planning methods through the procurement of 19,500 cycles beads to support the Standard Days Method, in collaboration with Georgetown University Institute of Reproductive Health Awareness Project
- Support to development of the National Strategy to Reduce Maternal and Neonatal Mortality.

3.1.1 Family Planning Technical Working Group Participation

"*We are privileged to benefit from this first training supported by Twubakane. We heard echoes that where IntraHealth/PRIME II supported training, the services improved and the contraceptive prevalence increased. Now we have the chance to have the same training team. The ball is in our court,*" said Dr. Karara Charles, the head doctor of the Remera Rukoma Health District, during the opening ceremony of the training in his district. One of the participants, Marguerite Mukankangura, a nurse at the Mugina Health Center, said, after the training, "*This is the first time in my professional life that I have participated in such a participatory*

This year, the Technical Working Group for Family Planning, spearheaded by GTZ-Health, was particularly effective in ensuring development partner collaboration on family planning, a priority for the MINISANTE and Government of Rwanda. Throughout the year, the group met on a regular basis to review and finalize a national strategy for family planning, including coordinated training modules and roll-out plans, advocacy, contraceptive security and behavior change communication (BCC) initiatives. The Twubakane Program contributed significantly to the development of the national strategy, and provided technical assistance to update

training modules and coordinate production of BCC materials. The working group also is planning a national debate on family planning, to be presided over by the President of the Republic, in early 2006.

3.1.2 Quality Improvement through Competency-based Training on Family Planning

As noted above, a significant achievement in 2005 was Twubakane's support to competency-based family planning in program zones. The Program's FP/RH team supported family planning trainings for a total of 63 service providers in program zones during Year One. Trainings will continue in Year Two to ensure that health care providers in all 12 program-supported districts have the opportunity to participate. All trainings are followed up with supportive formative supervision.

3.1.3 Strategy to Reduce Maternal and Neonatal Mortality

At the Ministry of Health's request, Twubakane offered technical assistance to the workshop that developed the National Strategy to Reduce Maternal Morbidity and Mortality in April 2005. During the workshop, which included representatives from the Ministry of Health, UNFPA, WHO, UNICEF, CARE International and the *Centre Hospitalier de Kigali*, participants developed a draft strategy to accelerate a reduction in maternal and neonatal mortality in Rwanda. The strategy document includes review of the problem and causes in Rwanda, strategic orientation, activities, monitoring and evaluation systems and definitions of roles and responsibilities of various actors.

The Twubakane Program also is supporting the Ministry's review and revision of the Minimum Package of Activities offered in health facilities, and will promote the inclusion of active management of the third stage of labor for the prevention of post-partum hemorrhaging and expanded postabortion care at the health center level. These additional activities are expected to have a major impact on the reduction of maternal mortality in Rwanda.

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

The objective of Component 2 is to increase access to and the quality and utilization of child health, malaria and nutrition services in health facilities and communities.

Component 2: Child Survival, Malaria and Nutrition
Key Program Accomplishments in Year One

- Support to the National Child Health Assessment
- Development of protocols and eight training modules for clinical Integrated Management of Childhood Illness (IMCI) in collaboration with the MINISANTE and the World Health Organization
- Improved quality of ante-natal consultations and intermittent and presumptive treatment of malaria in pregnancy through competency-based training of health care providers—with a total of 546 providers, including 250 in Twubakane-supported sites, trained—and follow-up formative supervision conducted
- Active participation in the Roll Back Malaria partners group and financial support for key activities
- Support to finalize the national PROFILES application, a nutrition advocacy tool, and, in collaboration with the GOR, UNICEF, WFP, FAO, AED/FANTA and Concern, plan for a national and district-level nutrition advocacy day
- Technical and financial support for social mobilization for National Vitamin A and

3.2.1 PROFILES Nutrition Advocacy Model & Support to the Ministry of Health

As a part of its support of and advocacy for increased official attention to nutrition, the Twubakane program is supporting application of PROFILES in Rwanda. The overall goal of the PROFILES application is to develop and implement nutrition advocacy strategy with the use of the best epidemiological data available at the national and the international levels. In July 2005, the Twubakane Program assisted and participated in the workshop held to finalize the national PROFILES application. Twubakane is an active member of the PROFILES/Rwanda technical committee, which is coordinated by the Ministry of Health's Maternal and Child Health Unit (now transformed into a special ministry Maternal and Child Health Task Force). As part of the PROFILES technical committee, Twubakane is actively collaborating with other partners to plan national and district-level nutrition advocacy workshops, and to organize provincial level nutrition advocacy workshops in the program's target provinces and districts. Twubakane and the PROFILES technical committee are also preparing a National Nutrition Advocacy Day to be held in early 2006.

"I found PROFILES very important because it's a much-needed tool for advocacy. It will help decision makers understand the importance of nutrition, and orient our nutrition plan—thanks to projections supported by the numbers," said Dassan Hategekimana, a professional in charge of nutrition at the MINISANTE. Christine Kaligirwa, UNICEF's Nutrition Project Officer, added: *"I personally appreciated the organizers of the workshop, included the MINISANTE, UNICEF and Twubakane, who offered technical support. We also appreciated Twubakane's support of the*

In addition, Twubakane supported and reviewed the draft National Nutrition Plan that was released by the Ministry of Health in July 2005. The Twubakane program also contributed technical and financial support to the MINISANTE to launch a national Vitamin A and Mebendazole supplementation program.

3.2.2 Support to Roll Back Malaria/PNILP

The Twubakane Program is USAID's primary implementing partner supporting the National Malaria Control Program (*Programme National Intégré de Lutte contre le Paludisme*, or PNILP). In this role, Twubakane provides technical and financial support to the Roll Back Malaria/PNILP coordinating office. In 2005 Twubakane began its support by offering technical assistance and funding for the training of health care providers from the program's target provinces in the PNILP-approved provision of intermittent presumptive treatment (IPT) for pregnant women. The Twubakane Program also supported the PNILP through technical and financial assistance for formative supervision of health care providers trained in IPT and focused ante-natal care and malaria epidemiological surveillance in Gitarama, Kibungo and Gikongoro provinces.

Twubakane's child survival/malaria team also assisted in the organization of a Roll Back Malaria partners' meeting to prepare a PNILP presentation on anti-malaria drugs resistance for the International Symposium on Infectious Diseases held in Kigali in August 2005. During that meeting, a malaria treatment policy shift to Coartem was planned for 2006, and the Malaria Early Warning System (MEWS) and the home-based management strategy implemented in six health districts were also discussed. The PNILP has requested assistance from Twubakane to start home-based management of malaria in the (former) Health Districts of Kabgayi and Kibungo in 2006.

In 2005, the Twubakane Program made plans to support the PNILP in establishing an urban malaria vector control program based on water treatment in the city park and on the ground of the Hospital King Faycal.

3.2.3 Integrated Management of Childhood Illness

The Integrated Management of Childhood Illness (IMCI) is an approach to reducing child mortality that was developed in 1996 by the World Health Organization and UNICEF. Rwanda's Ministry of Health officially adopted IMCI as its approach to reducing child mortality in 1999, and re-validated it as a national strategy in 2000, but strategic implementation was delayed until 2005. A national consensus on IMCI interventions was obtained during the International Symposium on Infectious Diseases held in July 2005. In September 2005, the Twubakane Program provided technical and financial assistance to the Ministry of Health's IMCI desk to hold a workshop focusing on tools elaboration and training modules adaptation for clinical IMCI. In addition to addressing the five major causes of childhood illness and death in Rwanda—pneumonia, diarrhea, malaria, measles and

malnutrition—the workshop participants also integrated HIV/AIDS prevention, care and treatment into the tools and training manuals developed.

In 2005, Twubakane also held preliminary consultations with USAID's BASICS child survival program regarding plans to support a community IMCI initiative in program zones in 2006.

3.3 Component 3: Decentralization Planning, Policy and Management

The objective of Component 3 is to strengthen central-level capacity to develop, support and monitor decentralization policies and programs, with an emphasis on health services.

Component 3: Decentralization Planning, Policy and Management
Key Program Accomplishments in Year One

- Technical assistance to MINISANTE on health financing
- Technical assistance and support for fiscal decentralization policy
- Support to the Rwandan Association of Local Government Authorities' capacity-building strategy to respond to the new phase of decentralization
- Participation in MINALOC partners' working groups to coordinate donor support of decentralization
- Support to the MINISANTE's National Health Management Information System Assessment (ongoing, to be finalized in April 2006)

3.3.1 Technical Assistance to Rwanda Association of Local Government Authorities (RALGA)

RALGA has the mandate to strengthen its members—the Local Governments in Rwanda—and advocate for their interests. If the districts are to play their envisioned developmental roles and become effective instruments of service delivery, the capacity of local authorities has to be enhanced and continually developed. RALGA provides a strategic and critical link to enhance partnership between central government (MINALOC and others) and civil society and a means for institutionalization of project activities (with a strengthened RALGA continuing to serve its members long after the end of Twubakane). Working in close association with VNG International, Twubakane is focusing on building RALGA's capacity to serve its members by improving channels of communication with districts and developing RALGA's ability to advocate for reforms needed by its members. Twubakane is supporting RALGA with a full-time local staff member, hired by VNG International, and short-term technical assistance. RALGA is expected to strengthen its functions of service delivery to its members and monitor local development. Twubakane's collaboration with VNG International is building on the agency's current support to RALGA (funded by Swedish International Development Agency, SIDA), which includes general backstopping, strategic planning, communication strategies and capacity building.

An important part of the assistance was focused on supporting the development of a strategy to prepare RALGA members for adjusting to the new territorial and administrative reforms. This was needed because by dissolving the 106 Administrative Districts RALGA's membership was automatically abolished. A temporary board was formed for the interim period, and the new members (representatives of the 30 Districts and the City of Kigali) will be recruited in 2006.

3.3.2 Technical Assistance to MINISANTE on Health Financing

Twubakane provided continued support to the MINISANTE for the preparation of the Ministry of Health MTEF 2006-2008, including both recurrent and development budgets. Documents were prepared and submitted to the Ministry of Finance and Economic Planning. Technical assistance was provided, and documents and data gathered to support the MINISANTE Marginal Budgeting for Bottlenecks (MBB) for the World Bank mission and workshops. NHA 2002 and NHA 2003 documents were reviewed and edited by Twubakane staff.

In 2006, Twubakane will move forward with more precise MPA and CPA costing, building on the work of the National University of Rwanda's School of Public Health. Costing should include planned data as well as an analysis of the time medical personnel spend per health intervention. This information will be useful for costing purposes—and provide benchmarks for measuring performance and making performance-based payments. At the same time, Twubakane will continue to explore the feasibility of adapting a planning model for providing essential health services that will permit the costing and budgeting of essential service packages at different levels (e.g., by different population groups; by geographic area; by type of facility; by type of ownership of facilities).

3.3.3 Fiscal Decentralization Policy Support

Refining and redefining the Rwanda fiscal decentralization policies and strategies became increasingly important during the transition period to the new administrative and territorial reform. Expanding districts' resource base, resource mobilization mechanisms, debt relief, local tax schemes and laws, and establishing a sustainable local finance system are key in assuring successful implementation of the entire decentralization strategy. In response to requests from the MINALOC to support the decentralization policies and programs, in December 2005, Twubakane provided technical assistance to the MINALOC's Local Government Finance Unit to refine and redefine Rwanda's fiscal decentralization policies, strategies and procedures manuals. A draft of the revised fiscal decentralization policy was presented to MINALOC, MINECOFIN, the Rwanda Revenue Authority and development partners for feedback in December. Other donors and development partners (through the cluster group) were given the opportunity to comment and provide input.

3.3.4 Health Management Information System Assessment

As an integral part of supporting improvement of Rwanda's national Health Management Information System (HMIS), the Twubakane Program is providing technical assistance and financial support for the Ministry of Health's Health Management Information System analysis.

The Government of Rwanda's efforts to improve health care, combat HIV/AIDS and malaria and decentralize health services to the district level have increased the need for more complete, accurate information at all levels of the health care system. An improved and integrated HMIS is necessary to support the Government's sector-wide approach to managing and coordinating internal and external interventions in the health care system. To assess and improve the HMIS, the MINISANTE requested support to conduct an in-depth analysis of the health information systems to identify all actors, their information needs and the extent to which those needs are and are not being met by existing systems.

The Twubakane Program, in consultation with USAID, responded to this request, and the assessment was launched in November 2005 and will be completed by May 2006. The assessment team, headed up by an RTI International consultant, is working in close collaboration with the HMIS Steering Committee, heading up by the Secretary General of the Ministry of Health. The assessment is financed by USAID/Rwanda through the Twubakane Program.

Initial qualitative findings of the assessment include:

1) There is confusion regarding HMIS-related roles and responsibilities at the district and hospital levels.
2) Newly appointed supervisors are often unsure of how to perform data verification and supervision.
3) Data analysis at all levels is minimal and usually dependent on the motivation and efforts of the specific health facility director.
4) Minimal feedback is given at all levels, and currently, since the reform, there is no feedback from districts to health centers.
5) Vertical and discrete data collection systems for HIV/AIDS information exist.

The final report of the analysis will include specific prioritized recommendations, with estimated costs, for optimizing, enhancing and harmonizing existing systems, and implementing realistic solutions to meet information needs at all levels.

3.4 Component 4: District-level Capacity Building

The objective of Component 4 is to strengthen the capacity of districts/sectors to plan, budget, mobilize resources and manage services, with an emphasis on health services.

Component 4: District-level Capacity Building
Key Program Accomplishments in Year One

- Technical assistance to RALGA to prepare for district-level capacity building
- Participatory planning workshops with administrative and health districts and provincial authorities
- Support for reinforced collaboration between administrative districts and health districts, and assistance in including health sector activities into Medium Term Expenditure Frameworks (MTEF).

3.4.2 District Incentive Funds

As discussed with USAID, the MINALOC and MINISANTE, Twubakane has delayed programming and disbursement of the District Incentive Funds (DIF) due to recent administrative reforms and redistricting. Criteria for the selection of projects, management of funds, accounting procedures, etc., have been developed, and the Program plans on orienting district councils, newly elected officials and other officials on the DIF following the elections. Because the number of districts in which Twubakane works is being revised due to redistricting, the planned DIF allocations also are being revised.

The original planned allocation of the DIF was a total of $180,000 per administrative district in 35 administrative districts. Pursuant to redistricting, the DIF allocation will become approximately $500,000 per district in each of the 12 districts.

The use of the DIF to support health services and activities will be facilitated by the recent merging of health districts and administrative districts as a part of the administrative reform. District Coordination Committees will be established to coordinate and orient Twubakane-supported interventions, including the District Incentive Funds, in each of the 12 districts.

3.5 Component 5: Health Facilities Management and Mutuelles

The objective of Component 5 is to strengthen capacity of health facilities, including health

Component 5: Health Facilities Management and Mutuelles
Key Program Accomplishments in Year One

- Technical assistance to develop and revise mutuelles management tools for mutuelles
- Provided technical assistance to the MINISANTE on developing the legal framework for the operations and functioning of mutuelles in Rwanda, with a focus on mobility across districts of mutuelles membership and potential mandatory participation in a national health insurance scheme
- Support to training of national trainers for mutuelles management, in collaboration with other partners
- Technical assistance and training for *mutuelle* managers and *mutuelle* committees in the (former) Provinces of Gikongoro and Gitarama, and in Kigali.

centers and hospitals, to better manage resources and to promote and improve the functioning of *mutuelles.*

3.5.1 Health Facilities Management

During July and August 2005, Twubakane undertook a series of assessments of the tools and management capabilities of health facilities in target districts. Particular attention is being paid to tools that health care workers currently use for the day-to-day operations and management of the health facilities. Most of these tools are paper records that require considerable time and effort for health care workers to fill out and maintain. The main intention of the review is to determine the most efficient and practical way for health care workers to administratively manage health centers and share necessary information with the district that then shares information with central level managers and policy makers. Health facility management tools can be useful as long as the benefits (added value) outweigh the costs (extra time and money).

Twubakane staff has begun to plan for, in collaboration with the MINISANTE, models and tools to further the processes of planning, records management, financing options, care models, business planning and cost structures.

3.5.2 Mutuelles

Throughout the year, the Twubakane team has participated actively as a member of the mutuelles technical working group. As noted in previous reports, a productive and collaborative relationship has been established among the MINISANTE mutuelles group, the GTZ, BIT/STEP and Twubakane—an impressive example of how development partner collaboration can work in Rwanda. Activities were planned, and policies and procedures were developed in concert with all the key players.

During the year, Twubakane also carried out field surveys and evaluations of the status of mutuelles programs and subscriptions rates in each of the project Provinces and districts; many troublesome practices were inventoried and identified in the field that jeopardize the functioning of mutuelles; these issues have been presented to MINISANTE and other key development partners working on the mutuelles programs. Major problems include: quality of health care and subscription rates; inability of subscribers to pay off bank loans that financed last year's subscription fees; how to finance the inclusion of "indigents" in mutuelles programs; the need for better tracking and management tools of mutuelles members; and the need for better subscription procedures and campaigns.

In September, Twubakane contributed to the organization and funding of a mutuelles technical working group seminar, held to discuss harmonizing the subscription (open season) period; review the

A member of the Byimana Health Center Mutuelle expressed the views of many members, and the overall goal of the mutuelles program, when she declared: *"Mutuelles can be a solution for access to health services. Before becoming a member, I would spend sometimes even more than 10,000 frw. Now, I am not afraid to come to the health center right away when I am sick or when my children are sick.*

critical factors that affect mutuelles subscription fees and quality of health care services; examine how health care prevention programs can be beneficial to mutuelle members and health centers; and review the cost implications of including HIV/AIDS patients in mutuelles programs.

Twubakane also supported the development and diffusion of announcements and public/community radio broadcasts on mutuelles, and the advantages of subscribing. At the provincial and district level, Twubakane staff supported advocacy and awareness-raising campaigns for local officials to re-invigorate the mutuelles programs and encourage citizens (both new subscribers and renewal of former subscribers) to subscribe.

3.6 Component 6: Community Engagement and Oversight

The objective of Component 6 is to increase community access to, participation in and ownership of health services.

Component 6: Community Engagement and Oversight
Key Program Accomplishments in Year One

- Conducted initial visits and campaigns to orient authorities and health facilities on the Community-Provider Partnership (*Partenariat pour l'Amélioration de la Qualité*, or PAQ) approach
- Supported development of national Community-Based Services and Community Health policies and programs (ongoing)
- Supported development of national Community-Based Information System Strategy
- Supported developed of National Health Communications Strategy
- Assisted in development of behavior communication change strategies and materials

3.6.1 Community Participation

Twubakane's community participation team is collaborating closely with the MINISANTE's MCH Unit Community Health Desk to support the development of policies and strategies to provide guidance and standardize specific aspects of community health programs, including community-based distribution and services and the roles of community health workers (called *animateurs*, or *agents de santé communautaire*, in Rwanda).

Through our community-provider partnership approach (called *Partenariat pour l'Amélioration de la Qualité*, or PAQ), Twubakane is supporting increased civil society participation in the planning and management of health care and health care facilities at the local level, and making sure that each of the Twubakane technical teams considers the best ways of integrating health care activities at the community level. In 2005, Twubakane staff members worked closely with the field coordinators to assess the status and functioning of the 11 PAQ committees that we have worked with in Gitarama and Kibungo Provinces. These PAQ committees, established with support from IntraHealth through the PRIME II project, are alive and well—and the community-provider partnerships continue to

Local authorities responded positively to the concept of the Community-Provider Partnership teams as an opportunity to enhance community involvement in health service delivery. "*The PAQ approach is coming at the opportune time in this phase of decentralization and will contribute, without a doubt, to supporting integrated planning of health activities in the districts and especially the quality of services; it is time that the communities play their role in planning, monitoring and evaluation [of] health activities*," said David Makuza, the Vice Mayor in charge of social affairs in the Rwamagana District. "*Our PAQ teams can help make sure that this happens*." Rodrigue Munyentwali, head of health and family in the District of Nyamagabe noted that "*our*

thrive. Some of the PAQ committees, however, require additional support and monitoring. The review of the current operations of PAQ committees has provided information on how to extend the PAQ work to other communities in target zones.

3.6.2 National Health Communications Strategy

Twubakane is a member of the informal technical working group on health communications; the MINISANTE asked for Twubakane support to revise and update a national strategic document developed in 1999 on health communications. Twubakane supported the finalization of this national strategy by engaging an international consultant who worked with the MINISANTE's (former) Epidemiology Unit's health communications desk, the MINISANTE communications advisor, Twubakane's Communications Coordinator and other partners in November. The anticipated result is a useful—and widely used—national Health Communications Strategy. Dissemination is planned for the second quarter of 2006.

4. MONITORING AND EVALUATION

4.1 Performance Management Plan (PMP)

The Twubakane Performance Management Plan (PMP), which was developed and revised over the course of the year in collaboration with USAID/Rwanda and other partners, can be found in Annex 1.

4.2 Rapid Facilities Assessment

Twubakane's baseline Rapid Facilities Assessment was planned to gather information from health facilities, both district hospitals and health centers, on health care provider performance, services offered, financial management, mutuelles and client satisfaction. As planned, the Twubakane team, in collaboration with the Ministry of Health, and as approved by the Ministry of Finance and Economic Planning, conducted the assessment in the target districts in September—October 2005. Data collection tools included overall health center data collection, health center management, overall hospital data collection, hospital management and client satisfaction exit survey.

All public and several private health facilities in project zones were visited—a total of 139 public and private health centers and hospitals.

Key findings of the assessment related to infrastructure, equipment and supplies include:

- Although most health facilities have the equipment necessary to offer the Minimum Package of Activities, only 65% of facilities have a separate waiting room, and only 52% have a separate delivery room.
- A total of 67% of health facilities visited have running water; 42% have electricity. Only 21% possess an electrical generator.
- Only 59.5% of health facilities have a functioning refrigerator for conserving vaccines.
- Only 37% of health facilities have a means of communication (radio or telephone).
- Materials to assure basic prevention of infections within health centers are not widely available, and 27% of health centers visited had neither soap nor a disinfectant solution for the providers to wash their hands between clients.

In terms of services offered:

- Only 2.5% of health facilities offer a minimum package of family health services, including growth monitoring/promotion, family planning, pre-nuptial consultations, pre- and post-natal consultations, safe delivery, postabortion care and immunizations.
- A mere 12% of facilities offer immunizations every day.
- Only 56% of facilities offer family planning services on a daily basis.
- The full range of family planning methods/modern contraception is not widely available; none of the health centers visited offers the full range of methods. Methods

offered include: oral contraceptives (in 70% of health centers), condoms (70%), injectables (70%), feminine condoms (10%), Standard Days Method/cycle beads (8%), Norplant (7%) and IUD (1%).

- Nutritional education/counseling and growth monitoring/promotion is offered in 78% of health facilities, but only 43% offer case management for malnutrition. A full 97% of facilities provide oral rehydration therapy, and 95% treat acute respiratory infections, but only 65% of facilities provide presumptive treatment of malaria in children with fever.

In addition to these findings, the assessment collected information to assess the quality of care offered and coverage rates.

The Rapid Facility Assessment report will be available in early 2006. Dissemination of findings will be organized at national and district levels beginning in March 2006.

District Capacity Assessment: The planned District Capacity Assessment to determine baseline data and the capacity-building needs of administrative and health districts has been postponed and will take place at a to-be-determined date following the redistricting and establishment of new districts.

5. CHALLENGES AND OPPORTUNITIES

The following are challenges that have emerged during this first year of implementation, issues that the Twubakane Program also views as opportunities for improving and tailoring our interventions and strategic approach.

- Understanding, closely following and responding to the Government of Rwanda's continuing current administrative reform and redistricting presents ongoing challenges, especially given the rapidity of the reform process. The reform, including the incorporation of health districts into the administrative districts, is leading to the creation of fully integrated and viable local government entities, ultimately facilitating decentralization. As described above, this new phase of decentralization contributes to the overall achievement of our program capacity to support decentralized health services. Twubakane has continued to be flexible, to the extent possible, to support the Government in this courageous reform. We have had to delay some key activities, including our baseline District Capacity Assessment and participatory district SWOT (Strengths-Weaknesses-Opportunities-Threats) analyses. In addition, donor collaboration in supporting the reform process has been challenging, as different development partners have adopted different approaches to responding and getting involved in the process.

- In light of the uncertainties and massive change brought on by re-districting, Twubakane has had to delay the disbursement of its District Incentive Funds until the new structures have taken root and elected officials are in place. This resulted in under-spending of the $1.1 million budgeted for the DIF in Year One of the project.

- The harmonization of health and administrative districts should simplify and contribute significantly to the implementation and results of the Twubakane Program. Twubakane staff will have 12 integrated district teams to work with at the decentralized level, instead of the challenge of merging the work of 11 health districts and 35 administrative districts. The fact that Twubakane's planning process, from the onset of the project, promoted and required close collaboration between the former separate administrative and health districts has allowed the program to quickly adapt to and support this new configuration.

- The Ministry of Health, with support from the Belgian Cooperation, World Bank, Cortaid and, mostly recently, USAID, has adopted a national strategy to institute performance-based finding, or a contractual approach, to encourage and reward health facility performance. This approach, which has had impressive results in pilot areas in Rwanda, is based on rewarding outputs—or high performance on key indicators—rather than funding merely inputs. Various partners have suggested that Twubakane fund direct contracts with health facilities. Twubakane is currently supporting the approach by contributing to capacity development and district and health facility levels, but does not plan on contracting with individual health facilities in 2006. Twubakane will explore the

possibility of supporting districts in using the District Incentive Funds for performance-based financing starting in 2007.

- The Ministry of Health has expressed the need to develop a specific guide for managing health services at decentralized levels. In light of the changes that have occurred in the structure of the health system, and the new roles and responsibilities specifically at district and sector levels, the Twubakane Program feels that such a guide would be a useful tool for the Ministry and its development partners.

- The composition of Twubakane's National Steering Committee will need to be revised in light of the administrative reform, particularly the replacement of provincial-level representatives with other decentralized government representatives. It is necessary that both the MINSANTE and the MINALOC participate actively in the Steering Committee and are regularly represented by the Secretaries General in the committee meetings to facilitate inter-ministerial programming. Twubakane also will propose Twubakane District Coordination Committees in each of the 12 districts to facilitate District Incentive Fund Management and overall collaboration with the district teams. This—and overall program modification in light of the reform—will be discussed during the next Steering Committee meeting, scheduled for March 2006.

- Supporting participatory planning and assisting in developing work plans has been a time-consuming and laborious process. Completing central level work plans and local level work plans has continued in an integrated fashion, and current plans will need to be revised, based on redistricting, following the local elections in February 2006. The capacity of the new administrative Districts and Sectors will have to be assessed and new roles and responsibilities defined for the local officials that will be managing sectoral programs.

6. PROSPECTS AND PLANS FOR YEAR TWO

The Twubakane Program anticipates that Year Two will provide opportunities to quickly move forward to support the new local government entities, health facilities and communities. Our priority for the first quarter of 2006 is supporting the newly created districts in their planning and budgeting process. This capacity-building support will not only assist the new districts by helping them to quickly become functional, but also will pave the way for the program to begin allocation of the District Incentive Funds.

In 2006, the Twubakane Program expects to make great strides in supporting the Ministry of Health, in collaboration with other partners, to support: health sector decentralization and financing, and expand the access to, and the quality and utilization of key family health services. The Program also will continue to support the Ministry of Local Governance in the full implementation of the administrative reform and the empowerment of local governments. A program priority throughout the year will be supporting all staff members of the newly created districts in understanding and executing their new roles and responsibilities in the context of decentralization.

Plans for the second year of implementation, by component, include the following:

Component 1: Twubakane will continue to support expanded coverage of family planning through competency-based trainings and formative supervision, with a special focus on expanding access to and use of long-term contraceptive methods. Family planning also will be supported by the roll-out of community-based distribution and services, and support to community health. The program also will continue to actively participate in the Technical Working Group for Family Planning and support advocacy efforts at the both the national level and within program districts. In 2006, special attention will be given to maternal health, as the Twubakane will advocate expanding the minimum package of activities offered at the health center level to ensure greater access to safe delivery and emergency obstetrical care, including the prevention of post-partum hemorrhages through active management of the third stage of labor. The Twubakane Program also will seek to create a new Technical Working Group to support maternal health in Rwanda.

Component 2: To support child survival, nutrition and malaria control efforts, Twubakane will support the roll-out of clinical IMCI in collaboration with other partners. The program also will continue its support to the National Malaria Control Program, specifically in application of home-based management of malaria and vector control in program zones. Twubakane will support the MINISANTE in reviewing and developing a new National Community Health Strategy and Community Health Information System. Twubakane will pilot-test the strategy and system in select districts beginning in mid-2006 and support national roll-out. Twubakane also will support the review and revision of the national nutrition policy and strategy. This nutrition strategy will be pilot tested in select districts where

Twubakane. In addition, Twubakane will continue to work on implementing the HEARTH positive deviance model throughout its operational areas. The program will continue to support implementation of home-based management (HBM) of malaria in its operational zones. Twubakane also will support training in clinical IMCI. In cooperation with the BASICS, Twubakane will support community-based IMCI programs in its zones.

Component 3: In 2006, Twubakane will continue, in collaboration with other partners, to support the MINALOC in the GOR's decentralization and administrative reform process. Assistance will be provided to finalize the new fiscal decentralization policy and develop district-level financial procedures management manuals. To support health sector decentralization, the Twubakane Program plans to collaborate with other partners, at the request of the MINISANTE, to develop a guide for management of health at the district levels, a guide that describes roles and responsibilities of the Districts, Sectors, hospitals and health centers in managing health care services. Improved health sector financing will be supported through continued technical assistance and funding for cost surveys and mutuelles management and a review of the role of National Health Accounts in Rwanda's management of health sector financing. Twubakane also will continue its collaboration with RALGA to support sustainable capacity-building activities for local government entities, with a special focus on good governance, transparency and anti-corruption initiatives. Collaboration with the NGO network Pro-Femmes in 2006 will focus on gender-sensitive initiatives to support the full participation of Rwandan NGOs in the administrative reform and decentralization process.

Component 4: Due to the extensive reforms in late 2005 and early 2006, Twubakane was not able to advance significantly in its planned district-level capacity building in its first year of implementation. To build district capacity in 2006, Twubakane will initially support the newly created districts in their planning and budgeting processes. Following the elections and orientation processes, Twubakane will work with the 12 program districts to conduct participatory Strengths-Weaknesses-Opportunities-Threats (SWOT) analyses. Following the SWOT analyses, the Twubakane Program will focus it support on helping districts to elaborate and implement resource mobilization strategies. Twubakane also will support improved planning, budgeting and management of health services in the 12 program-supported districts through the implementation and support of District Incentive Funds and application of the MINISANTE's district health management guide.

Component 5: Twubakane will support the application of the new law and policy governing mutuelles, with a focus on improved management of mutuelles and increased involvement of mutuelles in health promotion and prevention of illness in program zones. In the 12 Twubakane program districts, district hospitals and health centers will benefit from a series of support activities focused on the development and application of models and tools to further the processes of planning, records management, financing options, care models, business planning and cost structures. Twubakane also will follow up on the national HMIS assessment by supporting implementation of the assessment recommendations in program zones.

Component 6: To foster increased community participation in and oversight of health, the Twubakane Program, in 2006, will support the development of the MINISANTE's new community health policy and strategy to clarify the role of community-based health agents and the management of health services at the community level. Twubakane also will support the development of a new policy and strategy for community-based information systems. In program-supported zones, Twubakane will continue to support the establishment of provider-community partnerships through support to existing and establishment of new *Partenariat pour l'Amélioration de la Qualité*, or PAQ, committees. In addition, the Program will support the application of the new community health strategy and community-based information system in the 12 program-supported districts, including the established of community-based distribution of key family health commodities in program zones.

District Name	Province Name	Number of Admin Sectors	Area Sq Km	Perimeter Km	Population Yr 2002
KAYONZA	EST	12	1,813.21	196.93	220,802
NGOMA	EST	14	871.80	163.03	232,165
KIREHE	EST	12	1,190.28	191.43	229,468
RWAMAGANA	EST	15	685.17	135.58	209,423
		53	**4,560.46**	**686.97**	**891,858**
NYAMAGABE	SUD	19	1,095.43	204.05	284,852
MUHANGA	SUD	12	650.78	179.21	340,369
KAMONYI	SUD	12	658.64	169.80	292,772
NYARUGURU	SUD	15	1,014.97	188.63	233,815
RUHANGO	SUD	9	629.74	163.68	210,000
		67	**4,049.56**	**905.37**	**1,361,808**
GASABO	VILLE DE KIGALI	15	431.24	110.16	318,569
KICUKIRO	VILLE DE KIGALI	10	167.50	82.34	204,962
NYARUGENGE	VILLE DE KIGALI	10	134.59	106.31	236,990
		35	**733.32**	**298.82**	**760,521**
12	3	**155**	**9,343.34**	**1,891.16**	**3,014,187**

FOSAs_Scenario5 by Unit_Type

- Hospitals (12)
- Health Centers (100)
- Dispensaries (3)

Country Boundary

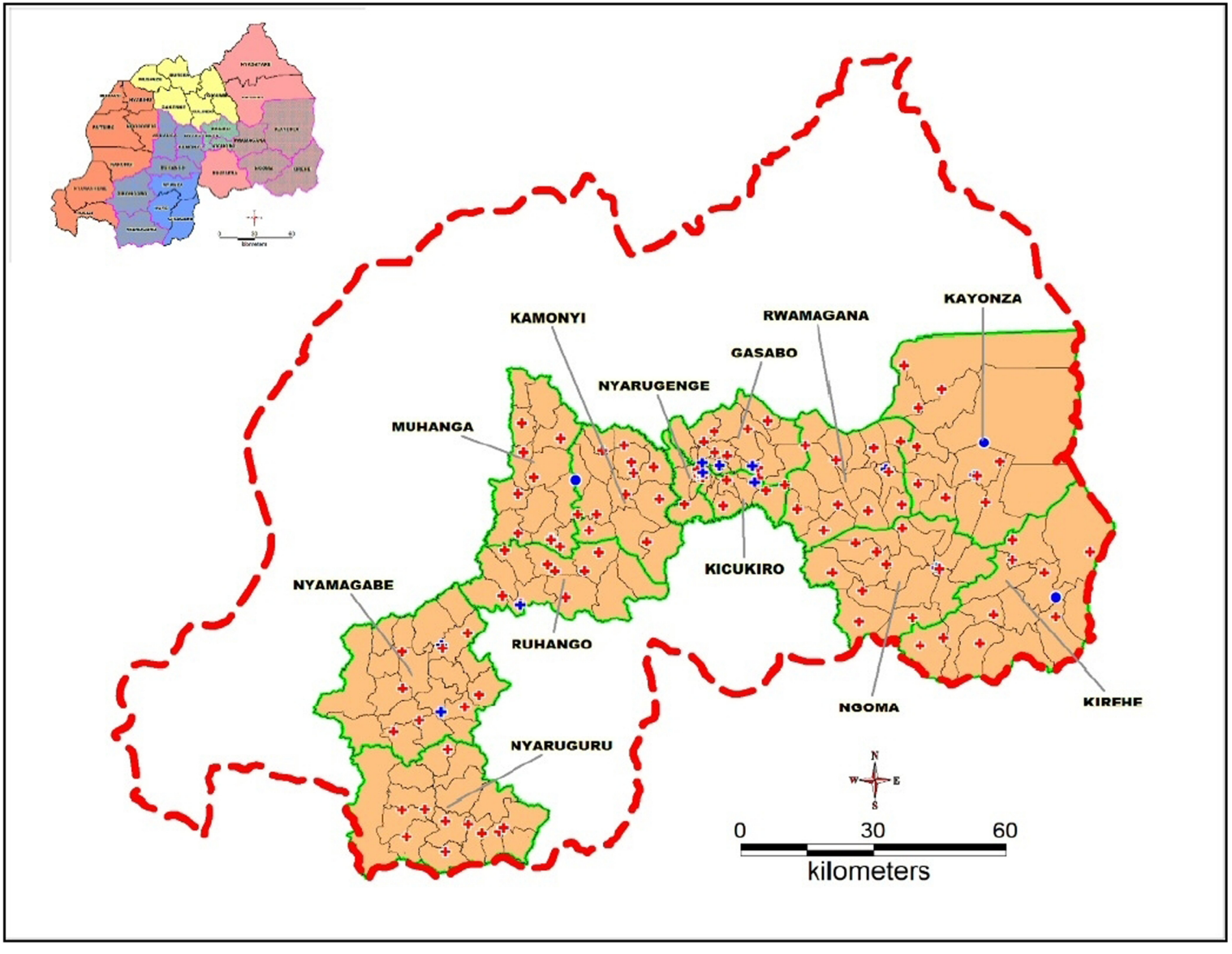
Rw anda Country Boundary

Twubkane_new_districts_S5

Scenario 5

12 Admin Districts
155 Admin Sectors
9,343 sq Km

Scenario 5 Twubakane Work Zones (Proposed at the November 16, 2005 Steering Committee Meeting)



Twubakane Annual Report, Annex 2

TWUBAKANE PROGRAM PERFORMANCE MANAGEMENT PLAN, revised 2006

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
Component One: FP/RH Access and Quality										
Increase access to and the quality and utilization of family planning and reproductive health services in health facilities and communities	6.2 6.3	1	Contraceptive prevalence rate (in target districts)	DHS, HMIS	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	13.8% In Twubakane original program zone (DHS 2005)		15%(average for program zones) 23,8%		20% (average for program zones)
		2	Couple years of protection offered by public facilities (in target districts)	HMIS	Annual review of HMIS data for facilities	22 420 (in public facilities in Twubakane's original program zone)	27,000	35,000	42,000	50,000
		3	Percent of facilities (health center level) providing minimum package of activities (MPA) according to national norms, standards	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	2.5%	7%	15%	30%	50%
		4	Number/percentage of health facilities offering full range of contraceptive methods (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	0%	15%	30%	45%	60%
		5	Percentage of health centers that offer quality emergency obstetrical care	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	0%	5%	30%	50%	70%

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
		6	Percentage of ANC clients with 4 visits (in target districts)	Rapid Facility Assessment, HMIS	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	10% (national) DHS 2000 3% (RFA 2005)	7%	15%	20%	25%
		7	Percent of health facilities with no contraceptive stock-outs in previous 12 months in target districts (segregate data: public facilities versus private/Catholic facilities)	Rapid Facility Assessment, HMIS	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	* 96.3% (Public facilities) * 100% (Private facilities)	98%	99%	99.5%	100%
Component Two: Child Survival, Malaria, and Nutrition Access and Quality										
Increase access to and the quality and utilization of child health, malaria and nutrition services in health facilities and communities	6.1, 6.3	8	Percentage of children under five and pregnant women using insecticide-treated nets in target communities Replaces USAID indicator: Percentage of households with insecticide-treated nets (ITNs)	DHS	DHS 2005, baseline Annual	13% for U5, 17.2% for pregnant women Nationally DHS 2005		30% for U5, 30% for pregnant women		50% for U5, 50% for pregnant women
		9	Percentage of children who have received DTP3 immunizations in target provinces/districts	DHS, HMIS, EPI data	EPI program: Y1 and Y5 with annual monitoring	National 87%; 87,9% in Twubakane old zone	89%	90% (to be recalculated based on new districts)	90%	90%
		10	Percentage of pregnant women given iron at ANC in target districts	HMIS, Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	21%	25%	30%	35%	40%

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
		11	Number/percentage of districts implementing community-based IMCI programs/interventions	Rapid Community Assessment	Rapid Facility/Community Assessment Y1 and Y5 with bi-annual monitoring	0%	10%	40%	70%	90%
		12	Percentage of health facilities with functional cold chains able to store vaccines at facility level in target districts	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with Annual Monitoring	59.6%	70%	80%	90%	100%
Component Three: Decentralization Policy, Planning and Management										
Strengthen central-level capacity to develop, support and monitor decentralization policies and programs, with an emphasis on health services	5.1 6.1	13	Establishment of Joint Action Planning process that is addressing the technical & policy issues of decentralizing health sector (between MINALOC and MINISANTE)	Document Review	On-going monitoring and review of completion	0		Integrated health program established		Integrated Health Program operational and used by MINALOC MINISANTE
		14	Contribute to a fully-costed Health Sector Strategy, sustainable Health Financing Strategy (National Health, MPA, CPA)	Document review	On-going monitoring and review of completion and dissemination process	0		Achieved, disseminated in target districts; Twubakane cost and sustainable health finance inputs completed, incorporated into MINISANTE Strategies		Used nationally

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
		15	Number of reform activities that RALGA is engaged in to support its members. (for example, a) legal representation, b) code of conduct, c) workshops, d) resource mobilization, e) lobbying and advocacy, f) capacity building through training, g) replication of best practices)	RALGA	Annual monitoring	TBD		12		20
		16	Timely production, completion and dissemination of annual National Health Accounts	MINISANTE	Annual monitoring			Previous year's National Health Accounts available and disseminated		Previous year's National Health Accounts available, disseminated
Component Four: District Level Planning, Budgeting and Managing										
Strengthen capacity of districts (sectors?) to plan, budget, mobilize resources and manage services, with an emphasis on health services	5.1 6.1 6.2	17	Community Development Plans documenting community and civil society participation (for example, # of meetings with civil society participation, list of civil society participants)	District assessment	Annual Monitoring	TBD (presumed 0)		30%		80%
		18	Number of ADs that have functional mechanisms in place for public reporting on health sector activities	District assessment	Annual Monitoring	TBD		30%		60%
		19	Number of ADs that have functional mechanisms in place for public reporting on their financial performance	District assessment	Annual Monitoring	TBD		30%		60%

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
		20	Percentage of district sector plans and budgets documented to reflect citizen input	District assessment	Annual Monitoring	TBD		30%		60%
		21	Number/percentage ADs that are operating without debt (based on review of previous year's financial performance)	District assessment	Annual Monitoring	50% (National, according to MINALOC/ Netherlands, 2003 assessment)		60%		80%
		22	Number of ADs that increase the percentage of locally mobilized resources in their annual health sector budget.	District assessment	Annual Monitoring	0		40%		70%
		23	Number/percentage of districts with annual and MTEF plans that include a full range of health activities (prevention, cure, infrastructure, equipment, etc.)	District assessment	Annual Monitoring	0		50%		90%

Component Five: Health Facilities Management and Mutuelles

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
Strengthen capacity of health facilities, including health centers and hospitals, to better manage resources and promote and improve the functioning of mutuelle	6.1	24	Percentage of district hospitals with budget that include diverse funding streams and have action plans to improve their financial viability.	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 Review financial management and record keeping bi-annually	22%	35%	50%	75%	100%
		25	Percentage of health centers with budgets that include diverse funding streams and have action plans to improve their financial viability	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 Review of financial management and record keeping bi-annually	23%	25%	30%	60%	90%
		26	Percentage of health facilities that demonstrate the use of HMIS data for decision making (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5, Annual monitoring	89.30%	92.00%	95%	98%	100%
		27	Percentage of mutuelle members who have used health facilities services in the past year (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5, Annual monitoring	49%	50%	60%	70%	80%
		28	Percentage of mutuelles that have conducted activities to promote preventive health care (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5, Annual monitoring	0%	10%	35%	70%	90%

Objective	IR	#	Performance Indicators	Data Collection		Baseline (2005)	Target			
				Source	Method and Schedule		2006	Mid-Term (June 2007)	2008	End (Dec 2009)
		29	Percent of functioning mutuelles that enroll more than 50% of the catchment population (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 Annual monitoring	29%	40%	75%	77%	80%
Component Six: Community Engagement and Oversight										
Increase community access to, participation in, and ownership of health services	6.2, 6.3, 6.4	30	Number/percentage of health centers that support CBD in at least three commodities (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	2.5%	5%	20%	40%	60%
		31	Percent of health facilities that collect community health data on a bi-annual basis and use this data for planning and decision making	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	9%	30%	80%	90%	100%
		32	Percent of health centers with a mechanism for communities to provide input on quality of services (in target districts)	Rapid Facility Assessment	Rapid Facility Assessment Y1 and Y5 with bi-annual monitoring	52%	60%	75%	90%	90%