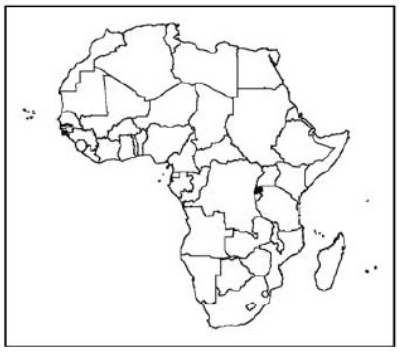
Rwanda Strategic Plan 2010-2013

and year one operational plan

July 2010

Map of Rwanda



Rwanda DHS 2007/08

Abbreviations and Acronyms

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
CARMMA	Campaign for the Reduction of Maternal Mortality in Africa
CHW	Community Health Worker
CPAF	Common Performance Assessment Framework
CPR	Contraceptive Prevalence Rate
CTAMS	Cellule Technique d'Appui aux Mutuelles de Santé
DFID	Department for International Development (UK)
DP	Development Partners
EDPRS	Economic Development and Poverty Reduction Strategy
FBO	Faith Based Organisation
FP	Family planning
FFRP	Rwanda Women Parliamentarians' Forum
GoR	Government of Rwanda
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IDHS	Interim Demographic and Health Survey
IEC	Information, Education and Communication
JHPIEGO	An affiliate of John Hopkins University
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MINECOFIN	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MNH	Maternal and newborn health
NGO	Non-Governmental Organization
PBF	Performance-Based Financing
PER	Public Expenditure Review
PMNCH	Partnership for Maternal, Newborn and Child Health
RDHS	Rwanda Demographic and Health Survey
SWOT	Strength, Weakness, Opportunity and Threats
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WRA	White Ribbon Alliance
WHO	World Health Organisation

Contents

Executive Summary

1. Every year more than half a million women die in childbirth or as a result of becoming pregnant. Ninety nine per cent of these maternal deaths are in developing countries. In sub-Saharan Africa, one in 22 women has the risk of dying during pregnancy or childbirth over a lifetime, compared with about one in 8,000 women in the developed world.[1]

2. Rwanda is among the countries with a very high maternal mortality ratio. For every 100,000 live births, 750 women die. The Government of Rwanda has committed itself to achieving the MDG's and, while having made good progress on almost all, Millennium Development Goal 5 (MDG 5) is well behind meeting both international and national targets.

3. The three year Strategic Plan 2010-2013 of the White Ribbon Alliance Rwanda (WRA R) is the organisation's first strategic plan since its inception in October 2008 and therefore represents an important milestone in the development of the organisation as well as a reinvigorated safe motherhood movement in Rwanda to support the achievement of MDG 5.

4. WRA Rwanda has successfully mobilised support from the Ministry of Health (MOH), UN agencies, development partners, faith based organisations (FBOs), and national and international NGOs, and this is reflected in its membership composition and the 18 member National Board of Directors. The First Lady, Mrs Jeanette Kagame, is the Patron of the organisation and she will play an influential role in championing WRA and safe motherhood in Rwanda, and beyond.

5. WRA Rwanda is fully committed to working in support of the Government of Rwanda (GOR) priorities, policies and plans, in particular, Vision 2020, the Economic Development and Poverty Reduction Strategy 2009-2013 (EDPRS) and the Health Sector Strategic Plan July 2009–2012 (HSSP), all of which identify maternal and newborn health as a key priority.

6. WRA Rwanda is formally recognised as an affiliate of the White Ribbon Alliance for Safe Motherhood, a global movement founded in 1999 to galvanise increased attention, investment and action on maternal and newborn health. As a national movement, taking forward the safe motherhood agenda within the specifics of the Rwandan context – the Alliance both benefits from as well as contributes to a wider body of knowledge, experience and action around safe motherhood through its association with the WRA global programme. This strategic plan has been developed in line with the guiding principles and high level strategic framework of the WRA global plan, itself the outcome of a fully consultative process involving all global Alliance affiliates and key stakeholders.

7. As a membership organisation, WRA's capacity to mobilise support and action from both organisational and individual members, from grassroots to national level, is a key component of both its organising principles and its practise. To this end, members and other key stakeholders actively participated in formulating this plan and will be instrumental in its successful implementation as well as its monitoring and evaluation processes.

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[1] WHO. 2010.

8. This Strategic Plan provides an operational framework to guide WRA Rwanda's direction over the next three years and includes performance indicators to measure progress. As WRA is a new programme, this first 3 year plan gives prominence to building the organisational capacity of WRA to enable it to efficiently and effectively deliver on the defined results areas.

9. The overall programme **goal** is to contribute to national efforts aimed at reducing maternal and newborn mortality and morbidity in Rwanda. The more specific project **purpose** is to increase access, use and quality of family planning and MNH services for women of reproductive age, and in particular those in underserved rural areas.

10. The following *6outputs*, or results, provide the programme's focus over the next 3 years:
    - **Output 1**: Increased incentives for all health workers, with a focus on those in rural areas
    - **Output 2:** Increased availability of midwives
    - **Output 3:** Increased public awareness on family planning and maternal health services and rights
    - **Output 4**: Improved community level collection, analysis and use of maternal and newborn mortality data
    - **Output 5:** Strengthened national and district level presence, action and capacity of WRA
    - **Output 6:** Strengthened M&E capacity of WRA

11. The programme will use a range of strategies to achieve these results, including: evidence based advocacy activities to influence government and donor priorities, policy, practise and resource allocation; use of mass media to mobilise increased public awareness and support for safe motherhood rights and services, in particular in rural areas; training of community health workers to improve the accuracy and use of maternal and neonatal death data; and building human resource and systems capacity to improve programme performance.

1 Background and context

1.1 The global picture

Maternal mortality and morbidity remain a major challenge world wide. Women in developing countries are disproportionately affected because health systems are weak and poor women are more vulnerable to pregnancy and childbirth-related complications and death.

Measuring maternal mortality and morbidity is notoriously difficult and it is generally accepted that available data under-estimate the real situation. An assessment of global maternal mortality jointly sponsored by WHO, UNICEF, UNFPA, and the World Bank, estimated 535,900 maternal deaths in 2005, down from 576, 300 in 1990. However, a more recent study, by Hogan et al[2], reported in the Lancet in April 2010 - albeit using a different methodological approach - estimated 342,900 maternal deaths worldwide in 2008 (down from 526,300 in 1980). This same study also estimated that, in the absence of HIV, the number of maternal deaths in 2008 would have been 281,500, thus confirming the impact the HIV pandemic is having on maternal death rates.

While the data suggest progress in some countries, the number of maternal deaths remain unacceptably high, and most are preventable. Additionally, and often forgotten, an estimated 20 million women endure life long disabilities such as pelvic pain, incontinence, obstetric fistula, anaemia and infertility.[3] If urgent action is not taken, an estimated 2.5 million maternal deaths and 49 million maternal disabilities are likely to occur in Africa over the next 10 years (African Union, 2009).

The main medical causes of maternal death are haemorrhage, sepsis, hypertensive disorders of pregnancy (eclampsia or convulsions), prolonged or obstructed labour, and complications of unsafe abortion. Key health service delivery strategies to prevent maternal and newborn deaths include: antenatal care; skilled attendance at delivery; emergency obstetric care; post partum care; safe abortion; and family planning services. Of these, family planning (FP) is one of the most cost-effective interventions. It is estimated that $100 million spent on Family Planning can avert 2.1 million unintended pregnancies, prevent 825,000 unsafe abortions, prevent 70,000 infant deaths and save 4,000 maternal lives. In Zambia (and other countries), it was found that one dollar invested in FP saved four dollars in other development areas.[4]

The global response

The global campaign to reduce maternal mortality was launched in February 1987, when three UN agencies, UNFPA, the World Bank, and WHO, sponsored the international Safe Motherhood Conference in Nairobi, Kenya. The event aimed to raise awareness about the numbers of women dying each year from complications of pregnancy and childbirth, and to challenge the world to do something. The origins of the conference dated from 1985, when women's advocates from around the world heard WHO announce that half a million women were dying each year from obstetric complications. This led to a series of regional and national conferences that made safe motherhood an accepted and understood term in public health. By 1994, the

[2] Maternal Mortality for 181 Countries, 1980-2008: a systematic analysis of progress toward Millenium Development Goal 5, Hogan et al, the Lancet, April 2010
[3] World Bank
[4] Making the Case for International Family Planning U.S. International Family Planning Assistance. Speidel et al. January 2009.

year of the International Conference on Population and Development (ICPD), every region of the world had held a safe motherhood conference. The importance of maternal survival was reinforced in 2000 with the **Global commitment to Millennium Development Goals**. The fifth MDG called for the reduction of maternal mortality by three quarters between 1990 and 2015. As 2015 approaches, only one developing region (Middle East and North Africa) is on track to achieve this target.

A plethora of un-coordinated approaches and programmes led to the **Paris Declaration** in March 2005[5] and the **Partnership for Maternal, Newborn and Child Health** (PMNCH) launched in 2005 with 5 UN agencies and the World Bank. These aimed to promote harmonised programming but were still northern owned and driven initiatives to improve aid effectiveness in health in southern countries.

The **Maputo Plan of Action in** September 2006 received unanimous support by African Union Health Ministers for better family planning, improved contraceptive commodity security and action to reduce unsafe abortion. From this came the launch of the **Campaign for the Reduction of Maternal Mortality in Africa (CARMMA)** a commitment made during the 12th AU Summit held in Addis Ababa in January 2009 for increased action towards the reduction of maternal neonatal and child mortality in Africa. Lacking personnel and funding, achievements have been limited to scattered country CARMMAs but this is an African owned and led initiative which is significant.

In 2008, the UN Call to Action was issued to accelerate the response to the MDGs. The same year, the United Nations Populations Fund (UNFPA) signalled intent to create a "Thematic Fund for Maternal Health" to increase resources.

While MDG 5 has generated renewed international attention and commitment progress on reducing maternal and newborn deaths has been slow, in particular in Sub-Sahara Africa and South Asia, the two poorest regions. Funding shortfalls remain a major constraint despite mounting evidence that investments in FP and maternal and newborn health lead to healthier and more productive women, children and families as was as having economic and environmental[6]. Singh et al also note that despite governments having committed to making services available to all, funding from governments and donor agencies has fallen far short of the amounts pledged for reproductive health and donor assistance dedicated specifically to family planning has dropped dramatically in absolute dollar amounts since the mid-1990s.

1.2 Maternal and newborn health in Rwanda

> *"The rate of women dying during childbirth in Rwanda is amongst the world's highest. Around 2770 mothers die each year whilst giving birth – that is close to one death every three hours every day of the year"*
> DFID/WRA press release October 2008

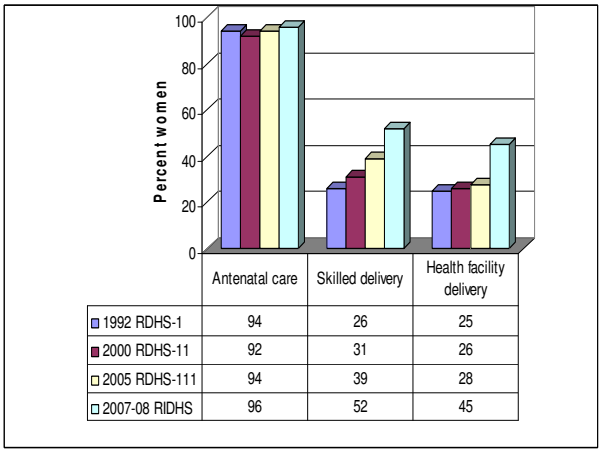
Rwanda, with a population of approximately 9 million people, is the most densely populated country in Africa and is ranked 167 out of 182 countries on the United Nations Human Development Index.[7] The Government of Rwanda has recognised health and population growth as important factors in its economic development.

[5] Paris Declaration on Aid Effectiveness, Ownership, Harmonisation, Alignment, Resulrs and Mutual Accountability. March 2005.
[6] Adding it Up: The Costs And Benefits Of Investing In Family Planning And Maternal And Newborn Health, Singh S et al, Guttmacher Institute and UNFPA, 2009
[7] Human Development Report 2009

Slowing population growth while improving health is one of four priority areas in the 2008–2012 Economic Development and Poverty Reduction Strategy (EDPRS).

As in most developing countries, women in Rwanda die from a range of complications in pregnancy, childbirth or the postpartum period. Though it is thought that unsafe abortion accounts for about 50% of maternal deaths[8] major killers are: haemorrhage, infections, eclampsia and obstructed labour. Malaria and HIV contribute significantly.

Figure 1: Trend in ANC and skilled delivery



	Antenatal care	Skilled delivery	Health facility delivery
1992 RDHS-1	94	26	25
2000 RDHS-11	92	31	26
2005 RDHS-111	94	39	28
2007-08 RIDHS	96	52	45

Source: Rwanda DHS 2007-08

Geographical access to services has improved with the construction and rehabilitation of 3 new District Hospitals and 14 health centres, but approximately 23% of patients still have to walk for more than one hour or more than 5Km to reach the nearest health facility.[9] Though Figure 1 shows an increase in health facility delivery, 48% of Rwandan women still deliver at home in unfavourable conditions. Less than 4% of women make 4 antenatal care visits while only 10% of them come for post natal care (IDHS, 2008). Still little more than half of Rwandan women have a skilled attendant for their delivery.

The percentage of total GoR budget for health has increased from 8.2% in 2005 to 9.1% in 2007 (PER 2006-2007). This compares favourably with many other countries but is still far from the 15% Abuja target. Reliance on external financing for health was 56% in 2007. The community health insurance scheme (Mutuelles) while impressive at 85% coverage (CTAMS, August 2008), does not cover those unable to afford the RWF 1000 annual contribution.

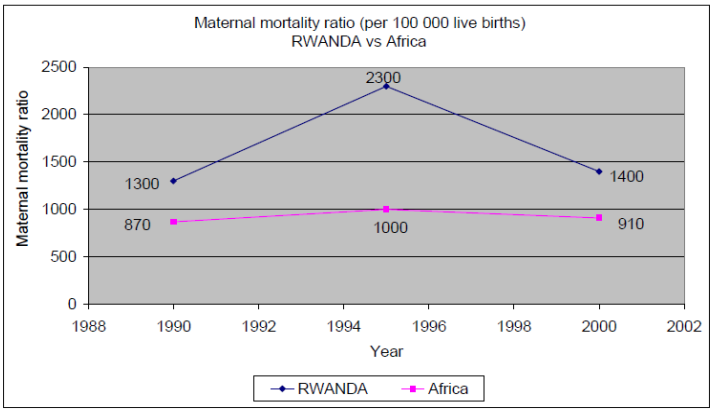
Progress made towards meeting the MDGs in Rwanda

Rwanda has made substantial progress towards meeting some MDG health targets: immunisation rates at 98 percent are among the highest in Sub-Saharan Africa; use of insecticide-treated bed nets increased from 4 to 65 percent of the population from 2004 to 2008; HIV prevalence, at 3 percent, has been decreasing. Unique in Africa, Rwanda has scaled-up access to health insurance (through local schemes called *mutuelles de santé*), from 7 to 70 percent of the population between 2003–2007 leading to increased use of health services, as reflected for example in the number of assisted deliveries. Over the past four years, the percentage of the population with access to water almost doubled from 44 percent in 2003 to 71 percent in 2007.[10]

[8] Ministry of Health report. No details.
[9] World Bank Rwanda Country Status Report, 2009
[10] Ibid

The infant mortality rate is down from 86 in 2004 to 62 per 1000 live births, while the under five mortality rate declined from 152 to 103 per 1000 over the same period. If the rate of this downward trend continues, Rwanda will meet the child mortality MDG by 2015.

Progress made towards achieving the maternal mortality MDG has been less impressive. The 2000 DHS showed that the average MMR during the 5 years before 2000 was 1,071 per 100,000 live births. Although this had declined to 750 per 100,0009 live births in 2005, this is still high and far from the Vision 2020 target of 200 per 100,000 live births. Nonetheless, some progress has been made in this area: the rate of deliveries assisted by skilled staff has increased from 39% to 52%, deliveries in health facilities have risen from 24% to 45.2% (IDHS, 2008), average referrals for obstetric emergencies has increased from 2 to 5 per month and the number of women who came for at least one ANC visit increased from 84% in 2005 to 95% in 2007.



WHO Fact Sheet 2006

As already noted, family planning is the most cost effective means of reducing maternal mortality. The percentage of women between 15 and 49 years using modern contraceptive methods increased from 10% to 27% (IDHS, 2008). Though the mean number of children per woman decreased from 6.2 in 1992 to 5.8 in 2000, and finally to 5.5 in 2007-08, the fertility rate for Rwandan women remains high at 5.5 children per woman (4.7 for urban areas and 5.7 rural areas).

Abortion is thought to account for 50% of women who die from reproductive health complications, according to the Ministry of Health. Rwanda is still listed among the countries where abortion is illegal and punishable under the Penal Code.

The number of health care professionals has recently increased considerably but there remain severe shortages of quality human resources, which are unevenly distributed and concentrated in the urban areas, particularly in Kigali. The problem of insufficient midwives practicing in rural areas is of particular concern. It is estimated that Rwanda has only around 100 midwives practicing in both private and public health facilities with 1 doctor per 18,000 people and 1 nurse per 1,700 people. The number of community health workers (CHWs) has been scaled up from 12,000 to 45,000 and their responsibilities have been expanded.

1.3 Rwanda health sector priorities & plans

The Government of Rwanda's various health and development policies, strategies and plans provide the context for the WRA Rwanda Strategic Plan. WRA's mandate is to assist GoR with the implementation of these plans in the area of reproductive and sexual health and its own framework, indicators and targets are therefore consistent with those of the GoR. The following documents provide this context:

Vision 2020

Vision 2020 elaborates a national long-term vision in terms of goals and objectives to be achieved by the year 2020. By that year Rwanda should: be a middle-income country; have halved the percentage of people living in poverty; raised life expectancy to 55 years; and have reduced its aid dependency. It expects to reach these goals by means of seven strategies/pillars, which include decreasing population growth, increasing access to education and improving the health of the people. This document serves as the basis for the elaboration of national and sector plans in the medium term.

Vision 2020 acknowledges the importance of education and health in ensuring an efficient and productive workforce. It also identifies demographic pressure as a major cause of the depletion of natural resources and subsequently, poverty and hunger. To reverse this trend and improve the health status of the population, health policies should target the poorest and seek to improve access, quality, and cost of health care.

Economic Development and Poverty Reduction Strategy 2008-2012

The EDPRS provides a medium-term framework for achieving the goals set out in Vision 2020 and sets the national priorities within which the sector strategic plans should be developed. It describes the status quo, targets for 2012, and what Rwanda is going to do to meet these targets.

Good Governance and Decentralisation Policy

The decentralisation process was launched in 2000. The policy states that the minimum requirements are: at least one hospital for each district; at least one health centre (HC) per sector; and at least one health post (HP) for each cell. Additionally, a network of male and female community health workers is proposed below sector level. The Rwanda Decentralisation Strategic Framework (RDSF) was developed to guide the implementation of the policy and serves as the overall framework of reference for current and future interventions towards decentralisation in Rwanda.

Health Sector Policy 2005

The Health Sector Policy, was revised in 2004 drawing on Vision 2020, the PRSP (2002) and the Good Governance and Decentralisation policies. It provides the basis of national health planning and is the first point of reference for all health sector actors. It sets the health policy objectives, identifies priority health interventions for, outlines the role of each level in the health system, and provides guidelines for improved planning and evaluation of health sector activities. A companion **health sector strategic plan** elaborates the strategic directions to support the implementation of the policy. The Policy's seven objectives include: improving the availability of human resources; quality drugs, vaccines and consumables; improving access to health services including financial accessibility; improving the quality and demand for disease control services; strengthening national referral hospitals, research and treatment; and strengthening institutional capacity.

Health Sector Strategic Plan July 2009 – June 2012

The HSSP-II operationalises the EDPRS and Health Sector Policy and guides the entire sector in the medium term. It provides a framework for health sector reforms and interventions. The HSSP-II is implemented through the Medium Term Expenditure Framework (MTEF), which is linked to the national budget and the goal and objectives of the HSSP-II have been aligned to the MTEF to ensure consistency in sector planning, budgeting and monitoring for 2009-2012.

The three strategic objectives (supported by 7 cross cutting programmes are:

i) Services for maternal and child health, family planning, reproductive health, nutrition;
ii) Disease prevention and control and
iii) Health promotion.

The plan indicates that it is in these areas where there is the largest gap in funding.

Human Resources for Health Strategic Plan 2006-2010

The shortfalls in human resources in the health sector have to be addressed as a priority. The HRHSP provides an analysis of the gaps and needs, based on demographic and epiodemiological data. The HRHSP provides a framework for decision-making; identifies where resources and skills are needed and their cost; guides professional development and identifyies needs for external assistance.

The National Reproductive Health Policy 2003

The NRHP provides a framework for establishing and sustaining quality family planning and reproductive health (FP/RH) services in Rwanda and includes six priority components: 1) Maternal and child health; 2) Family planning; 3) Prevention and treatment of HIV/AIDS and other sexually transmitted infections; 4) Adolescent reproductive health; 5) Prevention and treatment of sexual violence and 6) Increasing women's decision-making/authority in FP/RH.

A performance needs assessment carried out revealed gaps in all six of the national policy priority components. MOH is revising FP/RH standards, holding workshops for supervisors, integrating gender sensitivity into FP/RH activities, and strengthening in-service training for providers of FP/RH.

2 White Ribbon Alliance for Safe Motherhood

2.1 WRA Global

The White Ribbon Alliance (WRA) is an international coalition of individuals and organisations formed to promote increased public awareness of the need to make pregnancy and childbirth safe for all women and newborns. Since its launch in Washington in 1999, the White Ribbon Alliance has been leading global advocacy efforts on maternal mortality and now has members in 148 countries and National Alliances established in 15. With members in 142 countries and National Alliances in 14 developing countries, WRA is working to build coalitions, strengthen capacity, influence policies, secure resources and catalyse action to reduce maternal and new born mortality and morbidity. WRA's original funders were USAID, Gates Foundation and DFID, supporting core programming as well as country specific programmes. WRA's high profile has helped to broaden its donor base and generate significantly increased funding.

2.2 WRA Rwanda

The White Ribbon Alliance Rwanda was initiated by a core group of agencies that included the Ministry of Health, the Office of the First Lady, UNFPA, DFID, USAID, ACCES/JHPIEGO, and the World Bank. This core group served as a national steering committee as well as an Interim Board until the official launch of the WRA Rwanda chapter and election of the national Board at the 1st General Assembly in October 2008. The First Lady of Rwanda, Mrs Jeannette Kagame, was the Guest of Honour at the ceremony when she officially became patron of WRA Rwanda chapter.

This inaugural meeting brought together 100 participants including government officials, Minister of Health, parliamentarians, civil society organisations and development partners. The Minister of Health signed as the first member of the Alliance Rwanda Chapter. On 14th January 2009, the Alliance was affiliated to the Global WRA. DFID agreed to hire a technical advisor for the national secretariat located in the UNFPA offices.

Value added of the WRA Rwanda

WRA Rwanda's focus is on saving mothers' lives and has a key role in uniting the multiple programmes in support of safe motherhood around one framework of action:

Advocacy and Influencing:

- With the First Lady as patron, WRA's board of high level decision makers and representatives from diverse areas can influence policies and laws in support of safe motherhood as a human right;

Accountability

- WRA will hold Government to account – ensuring that national commitments are kept, funding is ring fenced and that programmes are focused on the poorest;

Coordination and harmonisation:

- WRA brings together diverse actors/stakeholders/ partners from communities to increase awareness on safe motherhood, involve men and all members of the community to play an active part in safe motherhood;

Resource mobilisation

- Since the WRA-Rwanda is part of a global campaign, it will advocate for resource mobilisation to solicit global support for safe motherhood in Rwanda.

Box 1: WRA Rwanda development milestones

July 2008	Consultation meetings between DFID, UNFPA, USAID, World Bank and JPHIEGO – interim board proposed reps from above organisations plus MOH and the Office of the First Lady
October 2008	103 people from a range of organisations participated in an Advocacy Meeting to mobilise support for an intensified focus on maternal health and for the establishment of Rwanda chapter of WRA. First 77 members subscribed.
	221 people attended the official launch of WRA Rwanda by Her Excellency the First Lady of Rwanda who formally became the Alliance's Patron. Membership rose to 125.
January 2009	Affiliation as a member of the White Ribbon Global Alliance
June 2009	Technical Advisor recruited to coordinate WRA activities. Position supported by DFID and hosted in UNFPA offices
October 2009	First WRA General Assembly – National Board of Trustees approved with representation of 18 institutions of which 6 were elected as an Executive Board. Chair from the Rwanda Women Parliamentarians Forum (FFRP). Partners make statements of support for the Alliance. Membership total: 282.
November 2009	First WRA Board Meeting. 3 sub-committees formed to lead on priority activities: i) development of the strategic plan; ii) legal registration; and iii) resource mobilisation
	Participation in WRA global meeting in Tanzania.
March/April 2010	Workshop and consultations on development of WRA Rwanda Strategic Plan 2010-2013

WRA Rwanda will be guided by the three year Strategic Plan 2010-2013 developed by its members and which is consistent with national health policy and plans. The Strategic Plan provides a monitoring and evaluation framework while the costed annual Operational Plan provides detail on implementation schedules, roles and responsibilities.

During the planning process 6 priority issues were identified that the WRA programme will focus on over the next 3 years. These are detailed in the plan and the logical framework at Annex 1.

1. *Shortage of qualified government health staff, in particular in rural areas, to provide quality family planning and safe motherhood services*
2. *Inadequate number and of trained nurses and midwives and insufficient resources to support the 5 nursing and midwifery training schools*
3. *Low family planning use and home deliveries without skilled attendance*
4. *Inaccurate and inadequate data on maternal and newborn deaths at community level.*
5. *Limited capacity of WRA to effectively mobilise and support a decentralised programme of action in support of safe motherhood*
6. *Limited capacity of WRA to effectively monitor and evaluate programme performance.*

3 Strategic plan

3.1 The planning process

The overall strategic direction for the three years 2010-2013 and year one operational plan and budget was developed through a participatory and consultative process with WRA members and key stakeholders under the leadership of a sub-committee of the WRA National Executive Board. The process culminated in a two day strategic planning workshop in March 2010 which included key national members and stakeholders as well as representation from the WRA Global Secretariat. (see annex 7)

At this workshop, a shared vision, mission and strategic direction for the organisation was agreed and more precise project goal, purpose and outputs identified based on Government of Rwanda priorities, policies and plans; gaps and needs in the national MNH programme; and the strengths and aspirations of WRA Rwanda (see SWOT analysis Annex 4), as well as the added value of it being linked to a global safe motherhood movement through its affiliation to WRA Global. A year one operational plan and budget were also prepared and are attached as Annexes 2 and 3.

Vision

The vision of WRA Rwanda is that every woman in Rwanda achieves her right to optimal health throughout pregnancy, childbirth, and the post-partum period for herself and her newborn baby. WRA in Rwanda plans to do this through community mobilisation, capacity building for service delivery and advocacy.

Mission

The Mission of WRA Rwanda is to work as a grassroots movement that nurtures the culture of safe motherhood, influences policies and their implementation, gathers resources and inspires actions to save lives of women and newborns in Rwanda.

The following principles are WRA Rwanda's shared beliefs, which provide guidance about structure, processes and overall conduct to all who join the Alliance. These are shared with and adapted to the Rwanda context from the WRA global principles:

Guiding principles	
1	Members have a voice and responsibility to participate in decision making, and to develop and maintain an accountable, transparent, responsive and sustainable alliance
2	Members may organise activities consistent with the mission, vision and principles of the White Ribbon Alliance for Safe Motherhood
3	Members are committed to enhancing local understanding of safe motherhood and building local capacity to advance the goals of safe motherhood at all levels.
4	Members are committed to sharing best and promising practices to advance the goal of safe motherhood;
5	WRA Rwanda promotes collaboration and open exchange of information, ideas and learning in ways that are appropriate in the local, national and international context;

Guiding principles	
6	WRA-Rwanda actively seeks the participation and/or partnership with women, men, their families and communities, professionals and practitioners from diverse fields, members of civil society, the private sector, UN agencies, bilaterals, donors, and all sectors of government;
7	WRA Rwanda values, aspires and works to recognize each member's voluntary contribution to the goals of safe motherhood and connects local action with the larger vision;
8	WRA Rwanda respects, protects and encourages individual, gender, cultural and social diversity;
9	WRA Rwanda is open for membership irrespective of caste, colour and creed by any individual or group agreeing to its mission, vision and principles and the unifying symbol of the white ribbon; and
10	WRA-Rwanda advocates for safe motherhood as a basic human right.

3.2 Goal & purpose

The overall **goal** of WRA Rwanda is **to contribute to reducing maternal and newborn mortality and morbidity in Rwanda**. This is in line with millennium development goal (MDG) 5, priority given to FP and MNH in Government of Rwanda national plans[11], and the WRA global strategic goal.

The purpose (intended outcome) of the WRA programme is **to increase access to and use of quality family planning and MNH services by Rwandan communities, in particular in rural areas**

To achieve the programme purpose, WRA has identified a number of key output areas based on the priority issues outlined above. They Alliance will use a variety of **strategies** to achieve the outputs and purpose, including:

- *mobilising* a national movement from grassroots to national level to *raise awareness* and *galvanise action* in support of safe motherhood;
- undertaking studies to provide the *evidence base for advocacy* to increase investments in MNH, with key policy makers, planners and budgetary decision-makers;
- using a variety of *mass media* to create awareness of FP and MNH services and rights and to create demand for services; and
- *building capacity* of community health workers in community level data collection and analysis as well as strengthening the organisational capacity of WRA

The programme will use a decentralised approach that seeks to connect the concerns and voices of local communities with national policy and planning processes; and that focuses on the needs of rural communities, and in particular on the needs of young and poor women with increased risk of pregnancy, delivery and post partum complications and with less access to and awareness of FP and MNH services and their rights.

[11] As outlined in the Economic Development Poverty Reduction Strategy (2008-2012) and Health Sector Strategic Plan II (2009-2012)

3.3 Outputs

The 6 identified priority issues outlined above provided the basis for the development of the 6 strategic focus areas, and are expressed as programme outputs – or 'results the programme will deliver'.

Output 1	**Increased incentives for all health workers, with focus in rural areas**
Output 2	**Increased availability and quality of midwives**
Output 3	**Increased public awareness on family planning and maternal health services and rights**
Output 4	**Improved community level collection, analysis and use of maternal and newborn mortality data**
Output 5	**Strengthened national and district level capacity of WRA**
Output 6	**Strengthened M&E capacity of WRA**

3.3.1 Health worker incentives

Output 1	**Increased incentives for all health workers, with focus in rural areas**

Addressing the shortage of qualified staff, in particular in rural areas, is key to improving MNH health outcomes. The problem is two-fold: firstly there is an overall net shortage of health staff in Rwanda and secondly, it is difficult to attract and retain staff in rural postings that are perceived less attractive. In terms of addressing the latter component, one strategy is to provide incentives, in particular for staff working in underserved rural areas.

in order to attract, motivate and retain staff in rural areas, health providers working in rural areas do not receive any additional incentives beyond their salary and performance based financing (PBF), which all staff are eligible for regardless of their work location, The purchase of tax-free cars is an incentive provided only to doctors, and an initiative of the Ministry of Health and the Rwanda Medical Association dating from 2002 to facilitate housing loans, again for doctors only, has not been implemented.

Strategic approach

- WRA will support the MOH by conducting a study on existing incentives provided to health workers, including through the PBF scheme, that takes into consideration all categories of staff (not just doctors), as well as incentives in rural as well as peri-urban and urban areas. This will provide the evidence base for the development of recommendations on a new package of incentives that would be focussed, albeit not exclusively, towards meeting the qualified staffing needs of health facilities in rural areas.

- The report and recommendations will be used as the basis for WRA and other key stakeholders to negotiate with the Ministry of Health and Ministry of Economic Planning and Finance and to get agreement on a new health worker incentive package that covers all health workers, has a focus on incentives for those working in rural areas and has an attached resource allocation to cover the costs involved. It would also be used as an advocacy tool with DPs to increase their contribution to the health budget.

3.3.2 Availability of midwives

Output 2	Increased availability and quality of midwives

Rwanda has an acute shortage of midwives with only about 100 qualified midwives in the entire country. This is a serious barrier to provision of safe motherhood services, including antenatal, delivery and post natal care to both mother and newborn, in particular when delivery or postpartum complications arise – and especially in rural areas.

The Ministry of Health has initiated an ambitious E-Learning program to upgrade the skills of A2 nurses to become registered A1 nurses and is also trying to strengthen the capacity of the 5 nursing and midwifery training schools to train more midwives. Challenges identified during the implementation of these programmes include; insufficient numbers and quality of educators and instructors, inadequate educational materials, poor internet connections, insufficiently resourced training laboratories, transport for practical sessions, and different training kits especially for midwifery training. Overall, each of the schools 5 years strategic plans are not adequately funded to enable them to expand their student quota and provide quality training.

Strategic approach

- Through this programme WRA is focussing attention on the 5 nursing and midwifery training schools to strengthen their capacity to train more students and to improve the quality of the training provided, including: ensuring adequate number of trained instructors; up to date training materials and tools based on current best practise; equipped training laboratories; resources to support students practical sessions and placements; and improved internet access to support e-learning and communications.

- The first step is aimed at gathering evidence on the existing nursing and midwifery training programmes and identifying gaps and needs as well as learning from the experience of other countries which have been successful in addressing HR challenges and deficits, similar to those Rwanda is experiencing. The information, analysis and recommendations from this process will then be used to refine each of the 5 schools strategic priorities and plans and to advocate to the MoH and development partners for full funding of the proposed plans. It would also form the basis for a media campaign to raise awareness and support among the public.

3.3.3 FP and MH services and rights

Output 3	Increased public awareness on family planning and maternal health services and rights

All the government policies and plans recognise the importance of family planning, not only to address macro economic needs but also the indirect causes of maternal and newborn mortality and morbidity. The MOH aims to achieve the national target of increasing the percentage of women using family planning services to 70% and women who deliver at the health facilities by skilled health practitioners to 95% by 2015. However, considerably more effort is required if Rwanda is to meet MDG 5 and national targets. Significant efforts to increase the number and the skills of the health workforce are needed, combined with on-going professional development, incentives and supportive supervision.

Strategic approach

- The Alliance will use its network of organisations using mass media, sensitisation, development of IEC materials and promoting the charter of women's rights among others. WRA will raise awareness of client rights to quality family planning and safe motherhood services with a particular focus on reaching men and women in rural areas.

3.3.4 Measuring Maternal and newborn mortality

Output 4	Improved community level collection, analysis and use of maternal and newborn mortality data

Targeting programmes can only be successful when the reasons why women die are understood. Since the government introduced the maternal death audit system, the method has already identified the major causes of maternal mortality in Rwamagana District. The audit system will strengthen community health worker's capacity to carry out evidence based and knowledge analysis of the direct and indirect causes of maternal and newborns deaths in the community and barriers to care in Rwanda and be able to report on a quarterly basis to the health centres in their catchment areas by 2013.

Strategic approach

- WRA Rwanda member organisations will assist MOH with capacity building of Community Health Workers to carry out the community death audit. This will require initial assessments of CHWs skills and subsequently training for CHWs on data collection, analysis and reporting on community maternal death and their causes.

3.3.5 National and district level capacity of WRA

Output 5	Strengthened national and district level capacity of WRA

The success of WRA Rwanda in spearheading a national safe motherhood movement is dependent on effective leadership and strong relations with and support from Government of Rwanda and development partners (DPs), a clear decentralised structure that connects the national level with community level concerns, priorities and action, an expanded and actively engaged and supported membership, an effective and efficient monitoring and reporting system, effective resource mobilisation, and sufficient human resources with expertise is the areas of WRA work.

The Alliance is currently operating at the national level with a Secretariat hosted by UNFPA and one full time Technical Advisor. There are no decentralised (district and sub-district) structures in place and this has limited its ability to fully engage the active participation of current members scattered in different parts of the country, or to mobilise new members. During the establishment phase, the Alliance has operated with no strategic or operational plans and no resource mobilisation strategy and has yet to achieve legal recognition. In order to effectively lead and fully realise the collective strengths of a Rwanda safe motherhood movement, strengthening the capacity of the Alliance is a priority.

Strategic approach

- The WRA Rwanda will need to conduct an institutional assessment and develop a detailed alliance organisational structure, with specified roles and responsibilities, ensure that vacant positions are filled with appropriately skilled personnel and that monitoring systems are installed. It is expected that the global WRA will provide technical assistance, drawing on experience in other countries. By 2013, it is planned that WRA Rwanda will have a focal person in all districts reporting to the national secretariat on a quarterly basis.

3.3.6 M&E capacity of WRA

Output 6	Strengthened M&E capacity of WRA

In order for WRA to effectively monitor programme performance, the organisation will need to have a robust monitoring and evaluation system in place. It will be a priority in the year one workplan to develop an effective M&E framework and systems based on the agreed project logframe and to ensure that baselines are in place for all indicators. WRA goal and purpose indicators should be aligned with national indicators and selected output indicators must be able to be verified.

In addition to monitoring output indicators it is anticipated that the systems would also monitor process or activity level indicators to support donor reporting as well as accountability to the WRA membership and importantly beneficiary communities. In relation to the latter, participatory processes will be used as much as possible to maintain engagement of key beneficiaries and stakeholders in monitoring the programmes progress. Reporting tools that effectively capture key data and lessons at district level will need to be developed (also see section 4.2)

Strategic approach

- WRA Rwanda will need guidance from WRA global as well as from expertise within the Board to support the development of M&E systems and tools. If needed additional technical support may be sought. It is anticipated that a tested and fully functioning system will be in place by the end of year one.

3.4 Year one priority activities & budget

The following is a summary of key activities and budget under each output for the first year of the programme. A detailed operational plan and budget estimate are attached at Annexes 2 and 3.

Output	Key Activities	Budget US $
1. Increased incentives for all health workers with focus in rural areas	– Conduct study on current HRH incentives scheme – Disseminate results and recommendations to MOH & key other stakeholders & donors – Advocate for new incentive package and resources to support it	5,000
2. Increased availability and quality of midwives	– Conduct study on nursing and midwifery coverage and training needs – Gather further information on successful strategies and best practise from other countries – Use evidence to brief MOH, MOFEP & DP's and to advocate for increased resources to meet midwifery HR training needs – Conduct media campaign to highlight HR shortage issues	9,000
3. Increased public awareness of family planning and maternal health services and rights	– Organise mass media campaign on family planning and safe motherhood services (TV, radio, drama) – Contribute to development of IEC materials on FP and SM – Revise Patients Rights Bill and develop Women's Rights charter	12,000
4. Improved community level collection, analysis and use of maternal and newborn mortality data	– Conduct CHW training needs assessment – Train CHW's on data collection, analysis and use – Develop CHW data collection and reporting tools	?
5. Strengthened national and district level presence and capacity of WRA	– Recruit Advocacy and Community Mobilisation Officer and Driver for Secretariat – Identify focal point persons for each of the 30 districts – Expand WRA membership and active engagement , in particular at district level – Develop M&E systems and other internal systems and processes required to support an expanded programme	175, 950
6. Strengthened M&E capacity of WRA	– Develop detailed performance monitoring plan – Develop M&E and reporting tools	?
	Total budget :	**US$ 201,750**

4 Management

4.1 Structure and governance

WRA Rwanda will be responsible for implementing the programme. The Secretariat is currently hosted within the UNFPA offices in Kigali and will move to its own premises once funds have been secured. A Technical Advisor is in post and 2 additional staff will be recruited as per the plans for strengthening the capacity and performance of WRA.

A more decentralised structure is proposed with an emphasis on strengthening district and sub-district presence as well as 2-way communication and dialogue between the districts and the national secretariat. A focal point person for each district will be selected to facilitate district level mobilisation of members and partners and to support implementation (see Annex 6 for WRA organisational structure).

The WRA Rwanda Alliance is made up of the General Assembly composed of Alliance members. At the time of preparing this plan membership stood at 282 individual and organisational members. The patron of the Alliance is the First Lady of Rwanda. WRA Rwanda is managed by the board of directors (BOD) composed of 18 institutions that are elected from the general assembly and an executive board composed of six institutions elected from the BOD (see Annex 6). The BOD meets on a quarterly basis while the executive board meets on a monthly basis. Extraordinary BOD meetings can be called as needed. Currently the Board chair is the Rwanda Women Parliamentarians' Forum (FFRP). Key roles, responsibilities and accountabilities for each of the key elements are defined below:

The patron:

- To support the WRA and promote the mission, values, aims and objectives of this initiative in Rwanda at every opportunity.
- To act and serve in accordance with the aims and objectives of the WRA for the promotion of safe motherhood.
- To lend credibility and high level support to the WRA initiative in Rwanda to include help with fundraising, campaigning and public relations.

General assembly:

- To elect the board members and the leaders;
- To carry out community mobilisation;
- To represent the alliance in different meeting and event at various levels;
- To recruit new members of the alliance;
- To support the alliance through contributing time and resources e.g. volunteering; and
- Develop and implement strategic and activity plans for the alliance.

Board of Directors:

- To give direction to the alliance;
- To keep members informed and engaged in the activities of the alliance;
- To play an advisory role to members and decision making bodies;
- To advocate for implementation of the strategic plan;
- To oversee recruitment, training and evaluation of the secretariat full time staff and consultants; and
- To carry out a partnership role with other forums.

Executive committee:

- To organise and conduct the general assembly, the BOD and the executive board meetings;
- To carry out action plan, budgets approval and monitor its execution; and
- Together with the national secretariat, coordinate all the activities carried out by the WRA/RWANDA.

National secretariat:

- To ensure day to day running of the White Ribbon Alliance under the supervision of the executive committee;
- To develop WRA-Rwanda action plans and submit them to the executive committee for approval;
- To implement the decisions taken by the general assembly and those of the BOD;
- To coordinate the activities linked with mobilizing alliance members; and
- Together with the executive committee, organise the White Ribbon Alliance meetings and take secretariat role.

4.2 Performance monitoring & evaluation

Performance Monitoring & Evaluation are vital to measuring progress and the relevance of programme design. M and E will be integral to WRA's organisational policy and programme cycle and will be used for budgeting and resource allocation, employee motivation, performance measurement, monitoring services and for communication.

It is important that WRA Rwanda staff have capacity to develop appropriate M & E and reporting tools, to monitor and measure progress and to document and communicate results.

Table 1: Key indicators and targets in Vision 2020, MDGs, EDPRS, CPAF and SBS

Indicator	Baseline 2005/6/7	Target Vision 2020	Target MDGs 2015	Target EDPRS 2012	Target CPAF 2012	Target SBS	Target HSSP
Maternal mortality rate per 100,000 live births	750 [3]	200	268	600	600		600
% of pregnant women with 4 antenatal visits	23.9%[2]			50%			50%
% of deliveries in HF	45.2[2]			75%	60%	52%	75%
Infant mortality rate per 1000 live births	62 [2]	50	28	70	70		50
IMR in bottom wealth quintile per 1000 live births	114 [4]			99			99
U5 child mortality rate per 1000 live births	103[2]		47				70

1 HMIS, 2 IDHS 2008, 3 DHS 2005, 4 EICV

The following indicators, baselines and targets, consistent with the national health strategy, will provide the basis against which progress will be measured. These are further elaborated in the project logical framework attached as Annex 1.

Table 2: WRA Rwanda monitoring and evaluation framework

	Indicators	Baseline	Target
Goal: **To contribute to reducing maternal mortality and morbidity in Rwanda**	– Maternal mortality ratio – Infant mortality ratio – Total fertility rate		
Purpose: **To increase access, use and quality of family planning and maternal health services**	– CPR – Proportion of births attended by skilled health personnel – % budget allocated to FP – % budget allocated to MNH		
Output 1: **Increased incentives for all health workers, with focus on those in rural areas**	– Number and category of staff covered by new incentive package – Resources allocated to staff incentives Health workforce coverage in rural areas		
Output 2: **Increased availability and quality of midwives**	– Resources allocated to 5 nursing and midwifery schools – Number of midwifery graduates/year – Proportion of B-EOC facilities with trained midwives – % of facilities with trained midwives		
Output 3: **Increased public awareness on family planning and maternal health services and rights**	– Number of facilities with patients rights charter posted – % FP service uptake in 3 campaign focussed districts – %pregnant women with 4 ANC visits		
Output 4: **Improved collection, analysis and use of maternal and newborn mortality data at community level**	– Number of CHW's trained to collect community level mortality data – Number of districts producing annual MN death audits		
Output 5: **Strengthened national & district level presence and capacity of WRA**	– Number of Alliance members/district – Number of districts with active focal point persons		
Output 6: **Strengthened M&E capacity of WRA**	– M&E tools & systems developed – Fully functioning M&E system in place		

4.3 Knowledge management and communication

Priority will be given *to analysis and learning* as the project develops. Documentation of lessons learned will be done using different methods and media depending upon the target audience and purpose of communication.

It is expected that *operations research* will be undertaken at different levels to inform health sector performance and human resource planning. For advocacy at national level, policy briefs will help guide policy and decision makers including politicians. Stories in local languages from the community can be shared at the local level and adapted as needed for resource mobilisation.

Effective use of the media will help communicate with different audiences and films can be used at global conferences to share Rwanda's experience with a wider audience.

Reporting to government and donors will be given priority and quality assurance of reports will help ensure that relevant information is packaged using data that are accurately analysed and interpreted.

4.4 Risks & risk management

WRA Rwanda is a young organisation in the early stages of its development. Awareness of potential risks and vulnerabilities that may affect the programme's success, and developing strategies to minimise risk, is an important element of programme management. This is true at any stage of an organisation's development, but in particular for young organisations where considerable investments of time and energy need to go into building relationships and credibility, engaging members and getting consensus on a shared vision and joint plan of action, recruiting staff and volunteers, setting up internal governance and management systems, and securing funding - alongside delivering on the programme.

The following matrix outlines key risks to programme success and strategies the programme will employ to mitigate risk. Monitoring and managing risk will be integrated into project planning, monitoring and reporting cycles.

POTENTIAL RISKS	Risk management strategies
1. Donor dependence	– Diversify the donor funding base – Develop strategies to raise unrestricted funds – Seek opportunities for contracting via government – Ensure judicious and appropriate use of resources available
2. Lack of institutional capacity of WRA	– Recruit appropriately skilled and experienced staff committed to achievement of MDG 5 – Develop clear criteria and consultative process for selection of district focal point persons – Seek opportunities to further develop technical skills of WRA staff and volunteers – Invest in developing strong internal systems, policies and procedures with particular attention to financial management

POTENTIAL RISKS	Risk management strategies
	systems and controls – Keep workplans balanced with capacity to deliver
3. Poor or ineffective leadership and governance	– Develop a strong legal framework and governance structures with clarity of roles and responsibility between the Secretariat and the Board as well as responsibilities of the membership – Invest in leadership development of staff and board members – Link with WRA Global and other WRA country programmes for support and learning exchange – Ensure effective communication and consultation within the Alliance membership
4. Credibility and legitimacy with members and other stakeholders	– Ensure WRA priorities and plans are aligned with GoR policies and plans – Deliver on agreed commitments and ensure timely and accurate reporting – Engage Alliance members is joint planning and decision-making – Nurture respectful and open relationships and partnerships within WRA and with other key stakeholders and donors – Develop and maintain strong relationships with the media – Ensure transparency and accountability in all WRA dealings
5. Losing touch with the grassroots	– Develop and maintain membership strength and action at district and sub-district levels – Use participatory approaches and bottom up planning to ensure beneficiary communities are actively engaged and their priorities are heard and responded to, in particular those of poor and most vulnerable women – Ensure young people are involved and support the inclusion of men and boys in programmes to support service access and rights

Annexes

Annex 1: Project logframe

Goal	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
To contribute to reducing maternal and newborn mortality and morbidity in Rwanda	Maternal mortality ratio	750 per 100,000 LB (DHS 2005)		600/100,000 (HSSP II)		
		Source: DHS, MDG report				
	Indicator	86 per 1,000 LB (2005 DHS)		50/1,000 (HSSP II)		
	Infant mortality ratio	**Source:** DHS, MDG report				
	Indicator	152 per 1,000 LB (1DHS 2008)		66/1,000		
	Neonatal mortality rate	**Source**: DHS				
	Indicator	5.5 (DHS 2008)		4.5 HSSP II)		
	Total Fertility Rate	**Source:** DHS				
Purpose	**Indicator**	**Baseline+ year**	**Milestone 2011**	**Milestone 2012**	**Target 2013**	**Assumptions**
To increase access, use and quality of family planning and MNH services	CPR married women using modern methods	27% (DHS 2008)		70% (EDPRS rev 2009)		– DPs and GoR allocate sufficient resources for delivery of HSSP II – Political and economic stability – Political commitment to MDG 4 & 5 – Stability of health personnel – SRH commodity security – Commitment to joint vision and action among/by WRA members/partners – WRA global provides adequate support to the
		Source: DHS				
	Indicator	52% (DHS 2008)		69% (EDPRS rev 2009		
	Proportion of births attended by skilled health personnel	**Source:** DHS				
	Indicator	US$ 2.17m (EDPRS 2009 report)				
	% health budget allocated to family planning	**Source:** MoH, MOF, EDPRS Reports				
	Indicator	?				
	% of health budget allocated to MNH	**Source:** MoF, MoH				

						Rwanda chapter

Output 1	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Increased incentives for all health workers with focus in rural areas	**Indicator 1.1**					– Adequate funds are available to finance the expanded incentive package – MOF and MEP approve the budget for incentive package – Incentive package will attract and retain heath providers in rural settings
	Number and category of staff covered by new incentive package	**Source:** HRH Strategic plan report and/or HRHMIS?				
	Indicator 1.2	? current			Set from incentive study	
	Resources allocated to staff incentives	**Source:** MoF, MoH				
	Indicator 1.3					
	Health workforce coverage in rural areas	**Source:** HRH Strategic plan report and/or HRHMIS?				

Output 2	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Increased availability and quality of midwives	**Indicator 2.1**	0 (HSSP II no data)				– Capacity and resources of training institutions are sufficient to meet training targets – Nurses want to undergo further training to be midwives – Midwifery instructors have updated skills in evidence based practise – Opportunities for CPD are available
	Resources allocated to the 5 nursing and midwifery schools	**Source:** Ministry of Health Budget and/or School accounts				
	Indicator 2.2	?? (2009)				
	Number of midwifery graduates/year	**Source:** MoH records and/or schools records				
	Indicator 2.3	30% (DHS 2008)			37% (HSSP II)	
	Proportion of B-EOC facilities with trained midwives	**Source:** Health facility surveys, HRH reports				
	Indicator 2.4	1/100,000 (HRH database 2008)		1/20,000 (HSSP II)		
	% facilities with midwife	**Source:** HRH reports				

Output 3	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Increased public awareness on family planning and maternal health services and rights	**Indicator 3.1**	X of X			X of X	– Media and religious organisations support promotion of family planning – Men and women respond to media campaigns by accessing services – Media channels used are appropriate, targeted, context specific, gender sensitive
	Number of health facilities with Patients Rights Charter posted	**Source:**				
	Indicator 3.2	X% FP users per clinic				
	% FP service uptake in 3 campaign focused districts	**Source:** Clinic records				
	Indicator 3.3	23.9% (DHS 2008)		50% (HSSP II)		
	% pregnant women with 4 ANC visits	**Source:** DHS				

Output 4	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Improved community level collection, analysis and use of maternal and newborn mortality data	**Indicator 4.1**	0				– CHWs have the capacity to acquire the level of knowledge and skills required – CHWs are willing and have the time to take on additional tasks – Communities and CHWs willing to report on maternal and newborn deaths – Adequate number of CHWs in each community – Good data collection and reporting tools are developed
	Number of CHW'S trained to collect community level mortality data	**Source:**				
	Indicator 4.2	0			30	
	Number of districts producing annual maternal and newborn death audits	**Source:** MOH				

Output 5	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Strengthened national and district level presence and capacity of WRA	**Indicator 5.1**	282 (March 2010)				– Rwanda gets adequate support from WRA global – Identified district focal point persons are effective – Robust governance, management and financial management systems are developed – Adequate funding is sourced – Strong partnerships are developed – Leadership capacity and commitment of current and new staff is strong
	Number of Alliance members	**Source:** WRA reports				
	Indicator 5.2	0			30	
	Number of districts with focal point persons	**Source:** WRA reports				

Output 6	Indicator	Baseline+ year	Milestone 2011	Milestone 2012	Target 2013	Assumptions
Strengthened M&E capacity of WRA	**Indicator 5.1**	No system in place (March 2010)				– Rwanda gets adequate support from WRA global – Baseline data is available for selected indicators – WRA staff have M&E capacity
	Functioning M&E systems and tools	**Source:** WRA M&E framework, reporting tools, programme reports				
	Indicator 5.2					
		Source:				

Annex 2: Year one operational plan

SN	Key Activities	Lead & partner responsibilities	Time frame - months											
			1	2	3	4	5	6	7	8	9	10	11	12
1.	**Incentives for health workers**													
1.1	Conduct study on current HRH incentives scheme													
1.2	Disseminate results and recommendations to MOH & key other stakeholders													
2.	**Availability and quality of midwives**													
2.1	Conduct study on nursing and midwifery coverage and training needs													
2.2	Use evidence to brief MOH, MOF and MEP & DP's and to advocate for increased resources to meet midwifery HR needs													
2.3	Conduct media campaign to highlight HR issues in the health sector													
3.	**Public awareness on FP and MNH services and rights**													
3.1	Organise mass media campaign on family planning and safe motherhood services													
3.2	Contribute to development of IEC materials on FP and SM													
3.3	Revise Patients Rights Bill and develop Womens Rights charter													
4.	**Maternal and newborn mortality data**													
4.1	Conduct CHW training needs assessment													
4.2	Train CHW's on data collection, analysis and use													
4.3	Develop CHW data collection and reporting tools													
5.	**National and district level capacity of WRA**													
5.1	Refine organisational structure and roles and responsibilities of staff and member organisations													
5.2	Recruit 2 additional staff for WRA Secretariat													
5.3	Identify focal point persons for each of the 30 districts													
5.4	Expand WRA membership, in particular at district level													
6	**WRA M&E Capacity**													
6.1	Develop details performance monitoring framework													
6.2	Develop M&E and reporting tools and systems													

Annex 3: Year one budget

See attached excel spreadsheet

Annex 4: SWOT analysis

Strengths, weaknesses, opportunities and threats identified during the Strategic Planning Workshop, 17-18 March, 2010:

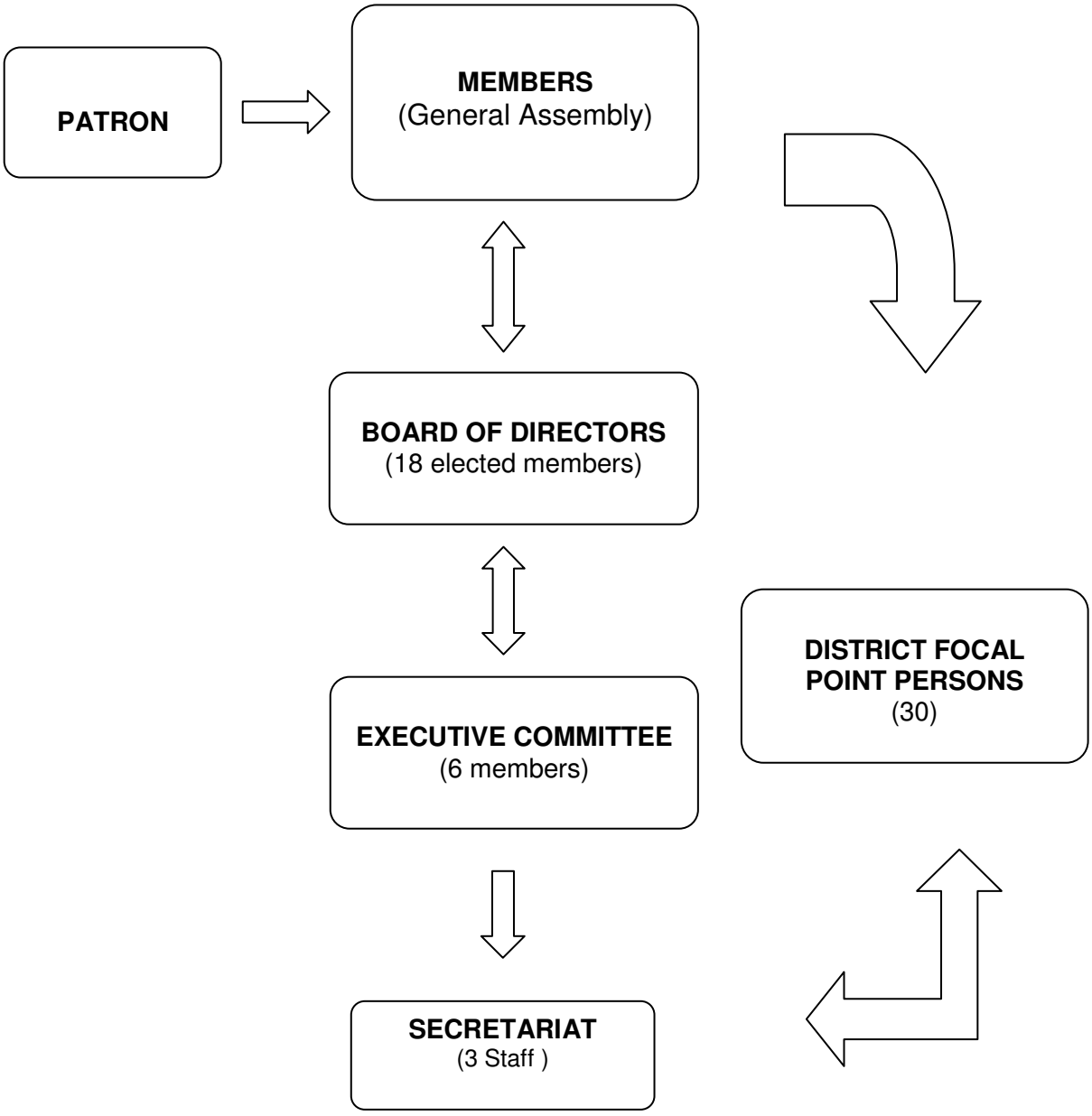
Strengths	Opportunities
• Members of the Alliance are multidisciplinary and contribute different backgrounds, experience and expertise to the Alliance; • The First Lady of the Republic of Rwanda is the Patron of the Alliance which gives it influence in terms of policies and laws, as well as advocacy and resource mobilization; • There is a functional organizational structure with a committed and dedicated National Board to govern the Alliance; • There is a National Secretariat with a full time Technical Advisor to run day to day activities of the Alliance; • There is strong support from the WRA-Global secretariat for the Rwanda national Alliance; • The Alliance has 282 members organizations that contribute to the achievements of the Alliance; • Existence of communication mechanisms including regular Board meetings and annual General Assembly meetings; and • Networking with various stakeholders addressing safe motherhood in and outside Rwanda.	• Strong political will to support the Alliance as high level leadership is involved; • Decentralized structures and systems will make the decentralization of the Alliance very easy; • National policies and strategies related to maternal and newborn health are in place; • WRA-Rwanda is developed in line with and will support government policies and plans; • Strong commitment from donor agencies to support the Alliance both technically and financially; • The WRA-Rwanda focus on safe motherhood is very relevant as this is acknowledged as a problem in particular at grassroots level; • Broad membership that includes individuals, professional associations, development partners and NGOs/FBOs which provide opportunities for networking and resources mobilisation; • Existence of a WRA Global Strategic Plan 2009–2013 to guide WRA-Rwanda's strategic direction; • Participation in high profile events that enables WRA-Rwanda to learn best practices on provision of safe motherhood services and share its experience globally.
Weaknesses	**Threats/Challenges**
• There is currently no legal statute for the Alliance in place making it difficult to be legally accepted to function and to have its own bank account; • The Members are not fully engaged and active in the process of running the alliance; • There has been no strategic plan and operational plan for the alliance making resources mobilization a big challenge; • The Rwandan public is not fully aware of the existence of the Alliance; • The coordination and communication is not systematic and smooth; • There is no monitoring and evaluation mechanism including and M&E plan and tracking tools; • Inadequate full time human resources (only one technical assistant) to run the Alliance; • Inadequate financial resource mobilization strategies	• Limited resources like financial, human and materials; • Increased fertility rates due to cultural issues resulting in increased maternal and newborn mortality and morbidity; • Cultural and social issues that handicap the process to safe motherhood; • Lack of enough skilled service providers at facility level especially lack of midwives and gynaecologists at different levels of service provision; • Poorly paid health providers leading to a higher turnover; and • Less commitment of some WRA-Rwanda members to the alliance goal.

Annex 5: Members of the 1st Board of Trustees

The following national board members were elected at the first General Assembly March 2010:

	Organisation	**Representative**
1	Rwanda Women Parliamentarians Forum **(President)**	Mrs, Denise Mutarambirwa
2	Media Association **(Vice President)**	Ms Faith Mbabazi
3	MOH **(Secretary)**	Dr. Fidele Ngabo
4	UNFPA **Treasurer)**	Mrs Daphrose Nyirasafali
5	DFID **(Advisor)**	Mr. Jean Gakwaya
6	Rwandan Women's Medical Association **(Advisor)**	Dr. Karema Corine
7	Office of the First Lady	Mrs. Radegonde Ndejuru
8	USAID	Dr. Sourkey Traore
9	JHIEPGO	Mrs. Therese Bishagara
10	World Bank	Mr Aly Sy
11	Ministry of Gender and Family Promotion	Ms Muteteli Yvette
12	Confession Religiouse (CRLS)	Mr. Ignace Singirankabo
13	Proffemme Twese Hamwe	Mrs. Izabiriza Beninya
14	Private Sector Federation (PSF)	Ms. Prisca Mujawayezu
15	Rwanda Nurses and Midwives Association	Mr. Andre Gitembagara
16	Rwandese Association of Local Government Authorities	Mr. Theogene Karake
17	Haguruka	Ms. Zaina Nyiramatama
18	Rwanda Network of Parliamentarians for Population and Development	Dr. Damscene Ntawukulilyayo

Annex 6: WRA organisational structure



Annex 7: Persons consulted

Representatives from the following organisations participated in the WRA Strategic Planning Workshop held on 17-18 March, 2010

Organisation	Name	Position
Office of the First Lady	Radegonde Ndejuri	Director General
Office of the First Lady	Keuria Sangwa	Communication
FFRP/Senate	Hon,.Speciose Ayinkamiye	Senator
FFRP/Senate	Hon. Marie Mukantabana	Chairperson
FFRP	Denise Mutarambirwa	Coodinator
RPRPD – Parliament	Jean-Marie Mbonyintwali	Program Officer
UNFPA	Daphrose Nyirasafari	NPO/RHR
Senate	Hon. Bizimana Jean Baptiste	Senator
DFID Rwanda	Sifa Uwera	Program Officer
RALGA	Josephine Uwimana	Gender Officer
JHPIEGO	Jeremie Zoungrana	Country Director
JHPIEGO	Therese Bishagara	National Program Coordinator
Rwanda Nurses and Midwives Association	Andre Gitembagara	President
Media House	Faith Mbabazi	President
PROFEMME Twese Hamwe	Izabiriza Beninya	Executive Secretary
Faith Based Organisation (RCLS)	Ignace Singirankabo	Executive Secretary
WRA Rwanda	Jackson Bamwesigye	Technical Advisor
WRA Rwanda	Dr William Twahirwa	Member & Local Consultant
WRA Global Secretariat	Frances Ganges	Xx
WRA Global Secretariat	Betsy	Deputy Executive Director

Other persons consulted:

Organisation	Name	Position
DFID Rwanda	Jean Gakwaya	Deputy Program Manager
DFID Rwanda	Aden Richard	Health Advisor
Ministry of Health	Dr Fidele Ngabo	Coordinator MCH
UNFPA	Mr. Cheikh Fall	Deputy Representative

Are these lists now complete?

Annex 8: Documents reviewed

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