Good Governance and Health: Assessing Progress in Rwanda

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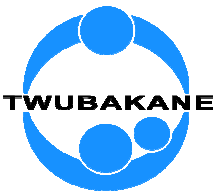

TWUBAKANE
Decentralization and Health Program
Rwanda

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Acronyms

CDF	Common Development Fund
DDP	District Development Plan
DFID	Department for International Development (United Kingdom)
DIF	District Incentive Fund
EDPRS	Economic Development and Poverty Reduction Strategy
FP	Family Planning
GBV	Gender-Based Violence
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit* (Germany)
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illness
JADF	Joint Action Development Forum
M&E	Monitoring and Evaluation
MIFOTRA	Ministry of Public Service and Labor
MINALOC	Ministry of Local Administration
MINECOFIN	Ministry of Economic Planning and Finance
MINISANTE	Ministry of Health
MIS	Management Information System
MTEF	Medium Term Expenditure Framework
NGO	Nongovernmental Organization
PAQ	*Partenariat pour l'Amélioration de la Qualité*/Community Partnership for Quality Improvement
PBF	Performance-Based Financing
RALGA	Rwandese Association of Local Government Authorities
SWAps	Sector-wide Approaches
SWOT	Strengths, Weaknesses, Opportunities, Threats
USAID	United States Agency for International Development
VNG	Association of Netherlands Municipalities

Introduction

Experience around the world has demonstrated that attention to governance is important to the ability of health systems to fulfill essential public health functions. Health governance concerns the institutions and linkages that affect the interactions among citizens/service users, government officials and health service providers. There is general agreement that good health governance is characterized by responsiveness and accountability; an open and transparent policy process; participatory engagement of citizens; and operational capacity of government to plan, manage, and regulate policy and service delivery. However, explorations of health system strengthening through the governance lens are few. Thus health decision-makers and international assistance agencies have few examples of how to incorporate health governance into system strengthening. This report contributes to filling that gap; it provides a case study of Rwanda's experience in addressing health governance in tandem with service delivery improvements.

The U.S. Agency for International Development's (USAID's) Decentralization and Health Program, known as Twubakane, provides financial and technical assistance to a selection of Rwanda's districts, health facilities and communities to provide improved services for maternal and child health, family planning, nutrition, and prevention and treatment of malaria. Rwanda's experience with decentralization is a significant case of health governance reform that has implications not simply for Rwanda but for other countries as well. This study examines that experience, explores the extent to which it supports the arguments related to health and good governance, and offers recommendations for integrating governance and health system strengthening.

Study objectives

The overall objective of the study is to investigate how Twubakane's efforts to support the decentralization of Rwanda's health system and to build the capacity of local governments to plan, budget for and deliver health services have enhanced health governance and contributed to improved health outcomes.[1] This analytic exercise examines the following research questions:

- How and in what ways have Rwanda's governance and decentralization reforms changed the relationships, accountability and incentives between government and citizens regarding health services?

- Have the governance reforms and innovations that decentralization has introduced, and Twubakane has supported, led to increased capacity and performance of government institutions in the areas associated with good health governance?

[1] This study complements recent USAID assessments of community health needs and corruption in the health sector. See Manning et al. (2008) and Gellar et al. (2008).

- Have the changes in capacity and performance of government institutions led to impacts on: health facilities management, health services delivery and health outcomes?

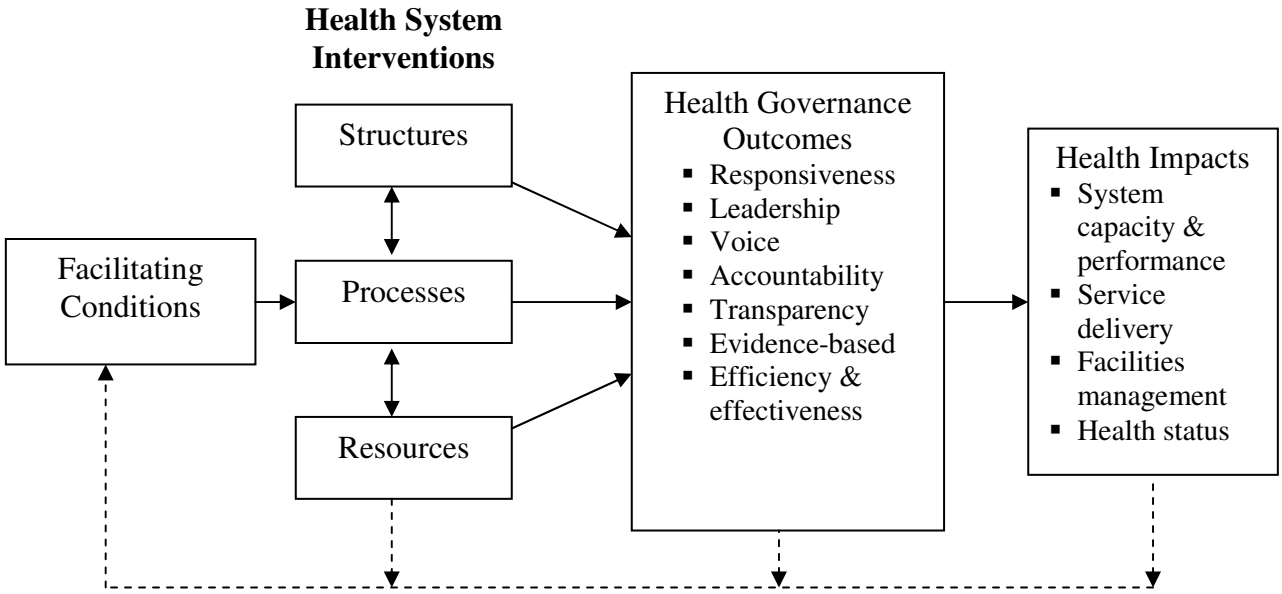
Methodology

To answer these questions, the study focused on four of Twubakane's six components: 1) decentralization policy, planning, and management (Component 3); 2) district-level planning, budgeting and management and district incentive fund (DIF) grants (Component 4), 3) community engagement and oversight (Component 6), and 4) health facilities management and community-based health insurance (Component 5). The methodological framework for the study builds on Brinkerhoff and Bossert (2007). Health governance concerns the interactions among three sets of actors: citizens/service users (individuals and communities); providers (public and private facilities, educational institutions, pharmaceutical firms, insurance agencies); and state actors (politicians, policymakers, ministry staff and other government officials). When these interactions function well, they lead to outcomes that characterize good health governance: responsiveness to public health needs and citizen preferences, leadership that addresses priorities and manages trade-offs, the legitimate expression of health needs and preferences (voice), clear and operational accountability, transparency in performance and resource allocation/utilization, evidence-based policy and decision-making, and efficient and effective service delivery and management.

Figure 1 illustrates the framework. The facilitating conditions contain contextual factors that affect health system reform. These include, for example, receptivity to change, the presence of a change team with reform champions, the degree of decentralization, availability of resources, state-society relations (e.g., citizen trust, government openness) and political will. The three types of health system interventions represent the activities of Twubakane that are the object of the assessment. The links from those activities to health governance outcomes constitute the core of the study: which of Twubakane's interventions have contributed to the elements of good health governance and how have they done so? The health impacts box contains the changes that result from better health governance.

The team spent the period January 9-29 in Rwanda and conducted field visits and interviews in three districts, plus the city of Kigali. Districts visited were selected to encompass sites where the full range of Twubakane activities has been undertaken; they included Gasabo, Ngoma and Nyamagabe. Annex 1 provides a list of persons contacted. To supplement the interview data, the study methodology included a questionnaire that collected perceptual data on health governance in Rwanda's health system at two points in time: prior to the second phase of decentralization (2004) and currently. The team obtained 50 completed questionnaires from a convenience sample. In addition, the team consulted government, donor agency and project documents as well as relevant published literature.

Figure 1. Health Governance Study Conceptual Model



Improving Rwanda's Health Governance: Reforms and Challenges

Observing Rwanda today, it is easy to forget that only fifteen years ago, the country had suffered an orgy of violence and devastation that left its infrastructure destroyed, institutions damaged and discredited, service delivery capacity close to nonexistent, and citizens dispersed and traumatized. The health system had collapsed, and over 80% of health professionals had been killed or had fled. Post-genocide Rwanda confronted the challenge of rebuilding the health system while simultaneously re-establishing a social and political order based on inclusiveness, reconciliation and unity. These social and political objectives have given a strong impetus to reforms in governance and to the restoration of the health system. Reform strategies include decentralization, results-based government, and citizen participation. Although Rwanda remains poor, with a GDP per capita of US$214, the country has made remarkable progress since 1994.[2]

Decentralization

Rwanda's adoption of decentralization emerged from the countrywide self-reflection on the causes of the genocide. A variety of government documents cite the role of bad governance, poverty and socio-political exclusion as the impetus for the ambitious decentralization program begun in 2000 and continuing through 2015 (MINALOC 2006, 2007). Several of the team's interviewees repeated these factors as motivators. Decentralization is being implemented in three phases:

[2] From United Nations statistics, available at: //data.un.org/CountryProfile.aspx?crName=Rwanda. See, for example, Rugumamu and Gbla (2003) on post-conflict reconstruction in Rwanda.

- Phase 1, 2000 through 2003, concentrated on devolution of functions and responsibilities, supporting legislation and policy reforms, and the design of intergovernmental financial transfers.[3]

- Phase 2, 2004 through 2010, concentrates on strengthening districts and local resource management and mobilization, participatory planning and the design of accountability mechanisms.

- Phase 3, 2011 through 2015, concentrates on decentralizing to the sector level and below, down to the cells, and on expanding and deepening local citizen participation and accountability.

Each of these phases of decentralization concentrates on a progressive step-down approach to building capacity, defining roles and responsibilities and transferring policy-making and administrative responsibility and authority to sub-national levels. Local governments are assuming greater roles in service delivery, facilities management, infrastructure investment and maintenance, revenue collection and budgeting. Further, they are seeking to respond to citizen preferences and to include citizens in planning and decision-making. The Rwandan government has advanced the timetable for the implementation process, starting Phase 2 a year ahead of the original schedule, which had a planned start of 2005; and Phase 3 is planned to start sooner than 2011 as well.[4]

As part of the decentralization process, various policies and strategic plans were developed, including the National Health Strategy (February 2005) and the Health Sector Strategic Plan for 2005-2009 (see Government of Rwanda n.d.). The strategic plan provides the framework and directives for development of the health sector, taking cues from the Economic Development and Poverty Reduction Strategy (EDPRS). During Phase 1 of the decentralization process, the administrative structure in Rwanda consisted of 12 provinces, 40 health districts and 106 administrative districts. Health districts were defined according to the location of district hospitals and operated relatively independently of administrative districts, reporting directly to the central-level health ministry. The existence of separate health and administrative districts in Rwanda contributed to a lack of integration and collaboration at both central and local levels.

The Rwandan government launched an administrative reform and redistricting process in early July 2005—a process that had a major impact on all levels of government. In addition to territorial reform and redistricting, the reform involved new roles and responsibilities at all levels. The Ministry of Health, along with other sectoral ministries, significantly reduced the number of central-level staff as personnel were shifted to lower levels. Under the new administrative structure, health districts were incorporated into the new districts as departments of health and social services. Reporting relationships were

[3] See Munyara (2002) for a comprehensive overview of the policy and legal framework for decentralization, and an analysis of implementation issues.
[4] The advancement of the timetable accounts for the discrepancies in the dates associated with the phases of decentralization across various documents.

modified. Health officials responsible for district-level service delivery and management now reported directly to locally elected officials. The results of these reforms created four provinces and 30 districts and eliminated health districts altogether, blending them into one administrative structure designed to encompass health and other sectors.

Service delivery and performance

Rebuilding service delivery capacity of the state was a key objective of the government following the genocide, and health services figure prominently among the services that citizens need and desire. The government's interest in decentralization is in part driven by the performance link between decentralization and improved service delivery. The commitment to performance is demonstrated in several other ways as well. Perhaps most distinctive is the system of performance-based contracts that reference a traditional Rwandan rite where groups or individuals would make public commitments to particular actions and then strive to live up to their pledges, with failure being associated with shame and dishonor. This customary practice is called *imihigo*.

The Kagame administration introduced *imihigo* agreements as a means of reinforcing motivation for district service delivery performance. Starting in April 2006, mayors and President Kagame have signed annual contracts that are tracked and publicly reported on quarterly, with an annual ranking of districts (MINALOC 2008a). The typical *imihigo* contract contains approximately 100 indicators, including about 15 health-related indicators. Examples are contraceptive prevalence rates, births in health facilities, membership in community-based health insurance schemes, use of insecticide-treated nets and construction of latrines to promote good hygiene. The *imihigo* have helped galvanize local support and encouraged mayors and other district authorities to become advocates for public health, increase their local health budgets and demand additional resources from national health programs that had been previously centralized.

Another performance-enhancing practice the government has adopted is the use of citizen report cards. A 2008 report card exercise canvassed citizens' views on services across a variety of sectors. In the health sector, the evaluation revealed relatively high levels of satisfaction with access to health care, community-based health insurance (*mutuelles de santé*), malaria treatment and reproductive health (see MINALOC 2008, 30-34). These findings suggest that the government's results-based approach to service delivery is paying off in the eyes of service users.

The government, with donor assistance, has also experimented with several models of performance-based financing (PBF). The experiments revealed positive impacts on availability and utilization of services and on health worker motivation (see Soeters et al. 2006, Logie et al. 2008). PBF is now moving to a national roll-out. PBF contracts with facilities have not replaced traditional input-based financing but are complementary.[5]

An integral element of the performance-driven approach to service delivery has been a proliferation of indicators. The government has committed to achieving the Millennium

[5] See also the USAID-funded Rwanda HIV Performance Based Financing Project, www.pbfrwanda.org.rw.

Development Goals, which set targets for 2015. The government's Vision 2020, the EDPRS (Economic Development and Poverty Reduction Strategy) results monitoring framework, the national and district-level three-year Medium Term Expenditure Frameworks (MTEFs) and the annual *imihigo* all have targets and indicators associated with them (see MINECOFIN 2000, Short 2003, Government of Rwanda 2007). Sectoral ministries have instituted performance-based programming, which has led to additional development indicators and reporting requirements.

Districts have on average 67 reports to do monthly, quarterly and annually; 12 of the 67 are health-related. Each ministry is charged with identifying 25 to 30 indicators to track performance outcomes. The health ministry came up 222 health indicators; of these, 27 are so-called core indicators. The Ministry of Local Administration (MINALOC) proposed 60 local governance indicators. Given that there are nine line ministries, the districts are concerned about serious reporting overload. A further challenge for districts is that the indicators are in a constant state of revision. Lacking sufficient capacity, most ministries are dependent on donor-funded projects to disseminate their indicators and to collect the data.

Citizen participation

The government's unity and reconciliation agenda accords a prominent place to citizen engagement and participation. Rwanda's Government of National Unity has operationalized citizen participation through decentralized consultations for needs assessment and planning at a variety of levels. Participatory planning is a hallmark of district development plans, which build from bottom-up consultations at the cell and sector levels. As with the *imihigo*, traditional community practices and structures have been incorporated into governance and service delivery. These include: 1) *umusanzu*, the notion of voluntary social contribution to the public good; 2) *ubudehe*, originally the practice of shared cultivation of an individual community member's fields, which has been adapted to frame cell-level, poverty-focused project development to feed into district plans and is the most used practice for soliciting citizen input into local and district plans; 3) *umuganda*, community public works teams that contribute labor and materials for repair, maintenance and/or construction of infrastructure; and 4) *gacaca*, a traditional justice and dispute resolution mechanism that has been adapted to help deal with the large numbers of genocide crimes through fostering community reconciliation and mediation (see Musoni 2004, 2005).

As in many developing countries, engaging citizens in Rwanda faces the challenges of differential capacities to participate as a result of varying degrees of skills, knowledge, access, political connections, resources and motivation. The government's commitment to inclusiveness, particularly for the poor, can be hard to fulfill since the poor are less able as a rule to participate than better-off citizens. Beyond the capacity question, however, is "space" for citizens to initiate engagement with government. Various observers have noted that participation is largely state-driven, with limited opportunities for civil society, as an independent actor, to engage (Smith et al. 2002, MIFOTRA 2008).

Helping the Health Sector Meet the Challenges: the Twubakane Program

The Twubakane Program is a five-year (2005-2010) effort intended to foster strong decentralized local government that is responsive to local needs and to promote the sustainable use of high-quality health services.[6] The program's overall goal is to increase access to and the quality and utilization of family health services in health facilities and communities by developing the capacity of local governments and communities to ensure improved health service delivery at decentralized levels. The program has aimed to achieve this goal through three broad types of activities that contribute to health system strengthening:

- Support to reform and capacity building in new administrative and health structures
- Introduction of, and assistance to, new processes and procedures, for example in planning, management and reporting
- Targeted provision of resources to districts and selected agencies.

Program start-up

As USAID was designing the decentralization and health bilateral program, Rwanda was in the midst of the first phase of decentralization. The original design slated the program to work in 11 health districts and 35 administrative districts, covering three provinces and the City of Kigali. However, first-year start-up confronted the nation-wide redistricting begun in July 2005, and by January 2006, Twubakane had adjusted its intervention zone to support 12 of the country's 30 districts. In addition to coordinating activities with key central ministries, especially the Ministry of Health (MINISANTE) and MINALOC, Twubakane began to work closely with district administrative personnel, district health teams, health facilities and communities.

To get the program underway, Twubakane organized participatory planning workshops at the provincial and district levels that assembled representatives of administrative and health offices and civil society organizations to discuss health and decentralization—generating enthusiasm (and creating 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 had low participation rates in district-level planning and budgeting exercises, provoked discussion during the forums on how to define civil society. The plans generated during these workshops were first validated at the local level, then at the central level during a joint stakeholders' workshop. Considerable effort went into ensuring that Twubakane's action plans were harmonized with those of the districts', and that the plans aligned with national policies and strategies. The participatory planning workshops helped prepare stakeholders for the second phase of decentralization by bringing together health and administrative authorities.

[6] IntraHealth leads the implementing partnership of RTI International, Tulane University, Rwandese Association of Local Government Authorities (RALGA), EngenderHealth, VNG (Netherlands International Cooperation Agency) and Pro-Femmes.

Twubakane components

Since its launch in March 2005, the Twubakane Program has focused on generating results in six areas: family planning and reproductive health; child survival, malaria and nutrition; central-level support of decentralization policy, planning and management; district-level capacity building; health facilities management and *mutuelles*; and community engagement and oversight. Twubakane has maintained a central office in Kigali, deploying technical staff to districts based on agreed-upon work plans and needs. In addition, the program supports five district offices, where a district coordinator and assistant are posted to be closer to district staff, thereby facilitating identification of and responses to service delivery and health governance needs.

A description of the objective and major interventions of each component is outlined below. An important crosscutting element woven into the six components is gender equity. Twubakane has addressed gender inequity by systematically supporting decentralization policy goals for women's participation in local government and health service use. In addition, selection of program personnel and trainees and partner agencies, community strategic planning, grants awards, media outreach and advocacy initiatives have incorporated attention to gender.

1. Increase access to and quality/utilization of family planning and reproductive health services in health facilities and communities. Twubakane has focused on repositioning family planning at the national level, training and supporting supervising district-based providers (hospitals and health centers) in all family planning methods, instituting alternative family planning service sites near Catholic-supported facilities, strengthening contraceptive security, strengthening and introducing emergency obstetric and neonatal care in districts, improving skills in fistula prevention, and improving data collection and reporting. Family planning and reproductive health are pillars of integrated family health, and the government's commitment to addressing population growth issues and fully engaging in family planning has dramatically improved since the Twubakane Program began.

2. Increase access to and quality/utilization of malaria, nutrition and child health services in health facilities and communities. While maintaining a holistic and integrated approach to all aspects of child survival, Twubakane delivers specialized attention to malaria, the major cause of illness and death in Rwanda, and to nutrition, an underlying factor in most childhood illness. To improve morbidity and mortality associated with malaria, Twubakane has supported integration of malaria prevention and treatment during antenatal care, introduced home-base management of fever in children in selected districts, advocated for and leveraged support for greater overall attention to child health issues, trained and supervised providers on the Integrated Management of Childhood Illness (IMCI), introduced IMCI to community health workers, initiated a community-based approach to preventing malnutrition and introduced a community-based health surveillance system.

3. Improve the capacity of the MINALOC and the MINISANTE and national systems to put policies and procedures in place for decentralization with an emphasis on health

services. Twubakane has supported improved policies, planning and management of decentralization, with an emphasis on health services, through close collaboration with the MINALOC, MINISANTE, RALGA and other partners. In collaboration with central ministries and other partners, Twubakane has supported the development of numerous policies and their dissemination, developed systems to assess districts' capacities to function and improved funds transfer to districts.

4. Strengthen capacity of districts to plan, budget, mobilize resources and manage services, with an emphasis on health services. A principal focus of Twubakane's assistance to districts has been to support their ability to function in the decentralized context using a grant mechanism, District Incentive Funds (DIFs), to provide financing to support their priorities in health and decentralization. Since the start of the program, there have been three funding cycles, starting in 2006. To further support the decentralization process and improved health status and coordination among the three districts comprising the City of Kigali, Kigali was added as a grantee for the 2008 cycle.

5. Strengthen capacity of health facilities, including health centers and hospitals, to better manage resources and promote and improve the functioning of mutuelles. The Twubakane program's support to health facilities management has focused on ensuring that *mutuelles* are functional and effectively leading to increased access to services, including supporting *mutuelles* management structures and collaborating with the MINISANTE and other partners to adapt the *mutuelles* program to a changing environment. Twubakane has also supported preparation of district hospital and health center strategic, operational and business (only for hospitals) plans and developed management tools to assist hospitals with the implementation of these plans.

6. Increase community access to, participation in and ownership of health services. Twubakane, in collaboration with other partners, has supported the MINISANTE in the development and dissemination of the national policy on community health, training materials for community health workers, and a community-based health information system. The program also supported the establishment of community-provider partnerships to improve quality, or PAQs (*Partenariats pour l'Amélioration de la Qualité*), in program-supported health centers.

Taking Stock of Progress to Date: Health Governance Results

The team assessed Twubakane's assistance activities in terms of the health governance outcomes (illustrated in Figure 1), which are those associated with good governance in the health sector. Table 1 provides the team's assessment of where Twubakane has had the greatest impact on improvements in health governance. The darker gray indicates the strongest impact, and the lighter gray secondary impact. The table reveals that, overall, the major impacts have been largely in three areas: responsiveness, accountability, and efficiency and effectiveness. The ratings in this assessment do not mean that there were no impacts on the other areas related to good health governance, simply that these three were the primary areas, in the team's collective judgment, where impacts were achieved.

Table 1. Twubakane Health Governance Assessment

Twubakane-supported Interventions	Health Governance Outcomes						
	Responsive-ness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Participatory planning at district, sector and community levels							
District SWOT (strengths, weaknesses, opportunities, threats) analysis							
Joint Action Development Forums (JADFs)							
District leadership/management training through RALGA forums							
DIFs							
Community-provider partnerships (PAQs)							
Health policy and protocol development							
Auditor training							
Open House and Accountability Days (Journées des portes ouvertes)							
Improving communications using mass media							
Fiscal and financial decentralization							
Facilities planning and management							

In this section, the key interventions supported by Twubakane that have had impacts on health governance outcomes are discussed. The findings reported here draw upon the team's interviews and a review of documents and reports. The section closes with a summary of the health governance questionnaire data, where respondents provide their views on improvements in governance that have occurred since the launch of the second phase of decentralization.

Participatory planning at district, sector and community levels

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Participatory planning							

With decentralization came the mandate to develop plans and budgets at the district level for the myriad of services that local government authorities must now provide to citizens. In the health sector, as noted above, this meant that the old health districts that fell under the auspices of the MINISANTE merged with the new administrative districts. New district health and administrative officials along with locally elected leaders assumed the role that the MINISANTE used to perform for planning and administrative oversight of district health activities, including district hospital and health centers. District officials now must work closely with health facility managers to develop their strategic plans and budgets and incorporate them into district plans and budgets. Although the MINISANTE, along with donors, continues to play a very important role at the district level in public health policy, programming and technical oversight, districts must ensure that key health investments and operations are covered in their local budgets and plans.

Under the new decentralization policy, districts must produce annual plans and performance contracts (*imihigo*), three-year MTEF plans and five-year District Development Plans (DDPs). All of these plans have impacts on the health sector because they determine resource flows to districts for investments in health services, facilities and personnel. Plans must accurately reflect local needs and priorities as districts are held accountable by the central government for performance with actual contracts. Thus, the planning process is predicated not only on the active collaboration and participation of district government and health authorities, but also on citizens being able to give voice to their needs and priorities through local planning mechanisms.

Twubakane has strengthened the participatory planning capacity of local governments through a variety of interventions. These include:

- Production of training manuals for the one- three- and five-year planning processes
- Monitoring tools for *imihigo*, comprising a set of criteria and checklists to monitor performance
- Training in monitoring and evaluation, management information systems (MIS) and target setting to track performance
- Technical assistance during planning processes
- Clarifying planning roles and responsibilities between district administrative and health authorities
- Capacity building for key participatory planning mechanisms, such as JADFs and PAQs (see below)
- Providing resources such as computers and other equipment through the implementation of the DIF grants (see below).

During study team interviews, all local government officials visited reported that training, technical assistance and equipment provided by Twubakane have led to increased planning capacity and significant improvements in the planning processes at all levels of local government. Since the plans now actively involve the participation of local nongovernmental organizations (NGOs), civil society organizations and even donors, planning processes are more participatory and are based on the local population's needs and problems. Districts are more results-oriented and have better mechanisms in place to monitor results. Plans produced are also more realistic and are better linked to actual resources available.

District SWOT analysis

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
District SWOT analysis							

Once authority for budgeting and planning was transferred to districts, the need for accurate data on the capacity of districts to manage and deliver key social services to citizens became paramount. Recognizing the need that districts have to assess their own capacity for managing and delivering services, Twubakane, along with RALGA and VNG International (a Dutch NGO) developed a self-assessment tool for districts called the district SWOT analysis. Integrated into the district government planning process, the self-assessment tool makes it easier for local governments to systematically scan the range of capacities required to effectively finance, manage and deliver health services; identify gaps; and help them build capacity in areas most critical for effective performance. In 2006, 2007 and early 2009, Twubakane and RALGA assisted local

governments in 12 districts to conduct SWOT exercises. The results from these self-assessments helped local governments diagnose key service delivery problems and effectively plan for their resolution. Anticipating capacity needs has greatly helped districts integrate health activities into their plans and budgets. Twubakane and district staff reported to the study team that the overall number of health activities financed by districts has increased.

The Twubakane-designed SWOT analysis has also impressed the central government as a useful tool for data collection and participatory planning. The result was a nationwide district capacity building needs assessment, conducted in early 2008 by Adam Smith International. The study noted issues and/or gaps related to institutional arrangements, management systems, human resources management, work relations and stakeholder communication, networks and partnerships, and facilities and equipment (see MINALOC and MIFOTRA 2008). The 30 district assessments provided decision-makers with a much finer-grained picture of capacity needs than before.

Both MINISANTE and MINALOC have endorsed the SWOT process and have advised all districts that they should be conducted annually, so as to provide regular data on capacity needs and progress in filling gaps. To date, it seems that outside of the Twubakane-supported districts, SWOT analyses are not regularly being conducted, which indicates that overloaded district officials may need outside help to put this into practice.

Joint Action Development Forums

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
JADFs							

JADFs are a mechanism for information sharing, coordination, resource mobilization and planning at district levels, helping districts to achieve their annual performance targets and *imihigo* contracts with the central government. Although they do not have decision-making authority and do not replace the national dialogue between district and central governments, JADFs are an important structure within which local government authorities can engage and interact with their development partners. Through the JADFs, plans and budgets are shared and discussed with key groups operating in the district, getting their feedback on issues and concerns. Usually chaired by the vice mayor of economic affairs, and meeting once a quarter, JADFs are designed to have broad participation, with members coming from local government—including service sector heads and service delivery providers—and the district's development partners. These latter include international and local NGOs, faith-based groups, private sector groups (cooperatives and industries) and civil society (youth councils, women's councils). If

JADFs grow too large, districts are advised to form smaller task forces, chaired by the executive secretary and made up of one representative from each service sector (health, education, etc.) and type of development partner. This task force would meet monthly and get more heavily involved at the technical level with reviewing and validating both district plans and district evaluation and performance reports before they go to the larger group for review and then on to the central government. Another option is to set up sectoral commissions chaired by technical unit directors who report on their activities to the JADFs.

Thus, JADFs are a good way to get inputs from all stakeholders for joint planning and the monitoring and evaluation of a district's *imihigo*. They also help development partners, particularly donors, coordinate with local government authorities and with each other, which reduces duplication and keeps everyone focused on the district's development plan and goals. During JADF meetings, districts may actually solicit development partners for financial and human resources to support their development and performance targets.

When Twubakane began operating in the 12 newly organized districts in mid-2006, few if any JADFs had been constituted and none were meeting, although Nyamagabe District officials reported to the team that the JADF was similar to a pre-existing forum in their district called the Community Coordination Committee. Initially using resources provided by DIF grants as needed to secure a venue and provide transportation, Twubakane and RALGA staff helped districts organize their JADFs and make them functional. Workshops were held to discuss the purpose and functions of JADFs and why investing in them was a good use of busy local leaders' time. RALGA and Twubakane also used JADFs to introduce and conduct the district SWOT self-assessments, which provided good baseline data to each district for capacity building planning and setting performance targets. JADFs were also a means to bring partners together for action planning and to obtain feedback from members on their usefulness and how to improve them. This feedback was provided to MINALOC at the central government level. One recommendation of JADF members in Twubakane-supported districts was to constitute them only at the district level for the time being and ensure their efficient and effective functioning before decentralizing them to the lower administrative levels of government (sector or cell).

The team's interviews revealed that districts are now investing in JADFs and securing resources through membership fees, development partners and district funds to keep them operating. In Gasabo District, for example, the local government has developed JADF membership categories A through D, which correspond to different levels of monetary contributions from different members, with international partners paying the highest fees. Although the Gasabo JADF was made up of volunteer members, the JADF secretary is planned to be a paid position, starting in May 2009. Gasabo District officials reported that they found the JADF a useful way to get to know and harmonize the action plans of development partners operating in their district. To ensure their effectiveness, international development partners were expected to establish their own performance contracts and make their budgets transparent. By doing this, Gasabo District hoped to achieve a more equal distribution of partner activity and funding throughout its district.

The district government in Ngoma is also moving forward with its JADF but has had some difficulty getting it organized and consistently financed. Since 2007, the Ngoma District JADF has met only five times, and dues have not yet been consistently collected. There are plans to appoint an executive secretary and have this be a paid position. At present, however, the JADF seems to be a somewhat ad hoc group. Ngoma officials also reported that NGOs and district officials participated in the JADF much more frequently than church officials and businessmen, but there was participation from the local business association.

District management and leadership training through RALGA forums

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Management/leadership training							

Formed in 2002, RALGA was identified by Twubakane as a key counterpart institution to develop the capacity of local governments to put into place the new health reforms and to orient them on their new roles and responsibilities. Mandated with the responsibility for improving local government leadership and management as well as for advocating on behalf of local government interests and concerns, RALGA plays an important role in helping the country implement its decentralization program. One of its responsibilities is to partner with MINALOC and the Ministry of Economic Planning and Finance (MINECOFIN) to train elected local government and sector officials to effectively fulfill their new responsibilities under decentralization. Although RALGA was not formed to focus specifically on health, Twubakane reached out to RALGA as a partner because it recognized that it could play an important role in improving good health governance and sustaining key components of Twubakane's health governance activities, including transparency, accountability and responsiveness.

Since the start-up of the project, Twubakane has worked closely with RALGA to develop its capacity to train local government and health authorities in participatory planning, including mobilizing the JADFs; district capacity needs self-assessments (SWOT analyses); anti-corruption and increased transparency; leadership and conflict-resolution; management; resource mobilization; clarifying new roles and responsibilities in district health management with local government and health managers; sensitization in gender-based violence (GBV) and GBV readiness assessments. Since 2007, RALGA has also organized competitions between levels of local government—districts, sectors and cells—giving media recognition to top performers and publicizing best practices for

national replication (see MINALOC 2008a, 81). The World Bank has picked up on this initiative, called the "Competition for Excellence in Local Governance," and supports this effort by contributing awards worth Rwf. 45 million to winners.

Working with RALGA in the 12 project districts, Twubakane provided direct technical assistance to the organization as it carried out its district capacity building activities. For example, RALGA held leadership forums for the vice mayors of Social Affairs, district health officers, district hospital directors, and health center directors and clarified their new roles and responsibilities. While resolving conflicts within district governments, the forums also helped promulgate and apply the government's new decentralization policy and clarified the roles of the two central ministries most involved in the process: MINISANTE and MINALOC.

Through interviews with local government authorities in the Ngoma District, the team learned about a three-day retreat organized by Twubakane and RALGA for council members, the council president and the district executive secretary. The purpose of the retreat was to build better communications between members and help resolve conflicts between the council president and the executive secretary. Although the executive secretary did not participate in the team's interview, the president expressed his appreciation for the retreat and said that it resulted in 51 constructive resolutions to improve accountability and transparency through better monitoring of district activities and reporting to citizens. Monitoring and reporting on district pharmacy services were specifically mentioned as areas that have seen improvement. In addition, council meeting agendas and actions are now always posted, and all citizens are invited to meetings, which are also announced on radio broadcasts. He told the team that initially not many people attended but participation has since increased, particularly when the topic has high local interest (for example, when land issues are discussed or to hear why a particular decision was made).

Another important activity was the training and technical assistance that Twubakane provided to RALGA to implement the annual capacity self-assessment tool in all 12 project districts (see above). Results provided crucial baseline information for Twubakane target districts for planning and target setting purposes. At the same time, Twubakane worked with RALGA and district authorities to review and strengthen district *imihigo* contracts, as well as evaluate the responsiveness of Twubakane's DIF grants to citizens' needs. Resources allocated under the DIF grants provided an important means to fund these capacity building efforts.

District Incentive Funds

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
DIFs							

Direct funding mechanisms in Rwanda such as the central government's Common Development Fund (CDF) have suffered from low absorptive and utilization rates that forced, in some cases, districts to return funds unused. Problems most frequently cited have been those related to the district's capacity to plan and administer these funds, particularly with regard to procurement and tendering. There are delays in releasing CDF monies that also prevent districts from moving forward with implementing planned activities. CDFs are not accompanied by training, which is handled by other government entities such as the Rwanda Institute of Administration and Management or the Human Resources and Institutional Capacity Development Agency.

In contrast, Twubakane's DIF program has provided direct funding and technical assistance to the project's 12 districts for high-priority activities that improved district capacity to plan, budget, manage and deliver health services. Ranging from $100,000 to $150,000 each year to each district, DIF grants have proven to be a valuable capacity building as well as resource-mobilization tool that helped districts to integrate governance activities into their health programs in a non-threatening way. Planning and implementing DIF grants forced district elected, administrative and health officials to work closely together, while engaging NGOs in the participatory planning process. District administrative capacity building for health represented one of the largest activities supported by DIF grants, climbing from 27% of the portfolio in 2006 to 39% in 2008. Before the DIF grants, there were few health activities in district plans other than plans for constructing new facilities. All three districts studied by the team reported that there was better integration of health program activities into the annual (*imihigo*), medium (MTEF) and long-term (DDP) investment plans, which have translated into more support for maternal and child health, family planning, nutrition, and malaria prevention activities, as well as health facility improvements and more funding for medical supplies and equipment.

The Twubakane team goes through the planning and budgeting process with district officials and participants from civil society step by step to build their capacity and ensure that participation is broadened. Since the Twubakane DIF team always starts with doing a plan with district officials, the process of preparing DIF grant proposals has allowed Twubakane to understand where capacity building is most needed. DIF grants assure that important participatory mechanisms like JADFs and PAQs are actually constituted and

functioning. DIF disbursement procedures must follow all Rwandan laws, as well as USAID regulations, regarding procurement and tendering. Twubakane worked closely with district officials and MINALOC to produce a grants manual that provides clear guidelines for planning, implementation and accounting procedures.

By working with officials to ensure that processes are followed correctly, Twubakane staff members have helped local officials build their procurement and financial management capacity. Districts are more capable now in the final years of the project than in 2006 of doing planning and budgeting; additionally, the process of expense reporting required to account for utilization of DIF grant funds has improved. Districts are also more capable of collecting and reporting health data since DIF grants supported the installation of computers and trained district and health officials in MIS and monitoring and evaluation. Using DIF grants to increase tax revenue available to districts, to fund income-generation activities for indigents, to make *mutuelle* payments and to sustain PAQs were other innovative features. There are now more resources available for districts to finance health services.

DIF grants reflect local health priorities and have been used to fund a wide range of activities. These can be broken down into five broad categories:

- Building district-level administrative capacity
- Activities to support the sustainability of *mutuelle* payments for the poor
- Improvements to health and public hygiene infrastructure, and health equipment and supplies
- Community mobilization and communication activities
- Health-related training of local authorities.

In 2006, upgrading districts' basic health infrastructure (including some facility renovation and the purchase of medical supplies and equipment) was emphasized, as well as planning and budgeting capacities. Activities to support the sustainability of *mutuelle* payments for the poor through income-generating projects also were in demand. Community-mobilization activities mostly focused on information campaigns on hygiene, family planning and encouraging women to give birth in health facilities. Mobilizing district resources for health by improving district taxpayer databases and revenue collection efforts was also common in many districts. Nyamagabe District, for example, used DIF grants to improve the living conditions of its poorest and most vulnerable citizens with income-generation projects. After six months, citizens receiving support were able to cover their *mutuelle* fees. Nyamagabe also used DIF grants to renovate and supply health centers, improve maternity wards in two hospitals and establish a fuel fund to transport patients.

By 2008, updating district plans, baseline data collection and purchasing computer equipment for districts continued to remain a district priority but with district officials doing most of the work themselves. Health training for district authorities was no longer as much in demand since most had been trained. Purchases of medical equipment and supplies continued to be a priority while community mobilization focused almost

exclusively on assuring the operation and sustainability of PAQs with income-generating activities. Resource mobilization included increasing tax collection through privatizing local market tax collection and providing income-generating opportunities for indigents. Although it is impossible to attribute improvements in health outcomes directly to the resources and technical assistance provided by (and with) DIF grants, district officials reported that there were dramatic improvements in facility utilization after DIF-supported renovations, training and public health campaigns. Nyamagabe District, for example, told the team that the percentage of couples using modern family planning increased from 11% in 2007 to 27% in 2008 alone and that the use of prenatal care and deliveries at health centers was way up because the quality of services improved.

Community Partnerships for Quality Improvement

	Health Governance Outcomes						
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
PAQs							

PAQs were developed as a structure to bring local leaders, health center medical providers, health center managers and community representatives together to improve services provided by health centers. Although the concept was not invented by Twubakane, the project invested heavily in first constituting and then making PAQs operational at all health centers in the 12 project districts. During 2005, there were only 27 PAQ teams established in Twubakane districts; this climbed to 99 in 2006, 130 in 2007 and finally reached 134, or 98.5% coverage of all health center facilities in Twubakane-supported districts in 2008.

PAQs serve a dual function: extending the reach and effectiveness of health services in local communities by increasing citizen participation (voice and responsiveness) while providing oversight and problem-solving at health centers (accountability). Extending the reach and effectiveness of health services in communities involved a myriad of possible activities: creating family planning task forces at sector, cell and *umudugudu* (village) levels to sensitize communities on reproductive health and use of family planning; radio programs for communities on decentralization, improving nutrition, using family planning and preventing malaria (using insecticide treated bed nets); and giving communities information on vaccinations, preventing GBV and using health facilities for prenatal care and delivery. Examples of the problem solving and oversight responsibilities of the PAQs include improving punctuality and attendance of health center staff, giving feedback on staff behavior, lobbying for more resources and staff in health center budgets, and improving the cleanliness of facility.

With DIF grants, Twubakane provided capacity building training to PAQ members; during 2006, no PAQ teams received DIF support, but by 2008, 11 out of 12 districts identified support to PAQ teams as a high priority for DIF funding. DIF grants supported a range of capacity building activities identified by PAQ members as priorities including community health worker training and capacity building; establishing vegetable gardens and livestock production to improve household nutrition; income-generation projects to provide resources to indigent and vulnerable populations, including revenue to cover the *mutuelle* fees of poor members of the community; and income-generation projects to support the operations of the PAQs themselves (e.g., small stipends to PAQ members for transport and meetings). Recently, Twubakane has been actively training and mentoring PAQ supervisors to ensure continued sustainability. Because Twubakane has effectively demonstrated that the approach can work, it has been officially identified by the MINISANTE as a best practice in quality assurance and an innovation that should be supported in all of the country's health centers.

The study team interviewed three PAQs and found the following characteristics:

- They were fairly large committees, averaging 20 to 25 members comprised of four categories of participants: (1) administrative officials from the sector level, including the executive secretary of the sector; the president of the local council, a member of the district health office and the head of the local *mutuelle*; (2) community leaders and other members of the community who usually were salaried workers (teachers, for example); (3) local members of women's and youth associations; and (4) the head of the health center, health center medical service providers and community health workers.

- PAQs are supposed to meet quarterly to discuss issues of concern and to make recommendations for health facility and service improvements. A 2007 assessment with a random sample of 60 health centers conducted by Twubakane found that nearly 70% of PAQs had met in the last three months. A 2008 assessment found that 84% of PAQs had met in the previous three months, and 7% had met four to six months prior.

- The types of issues that PAQs have chosen to address centered on the physical condition and/or cleanliness of the facility; the attitude, behavior and/or absence of health center staff; incidences where the confidentiality of the patient was not respected; and the length of time patients spent waiting for services. Recommendations to improve these areas were either passed to health center management or forwarded to local authorities for action. The 2008 assessment revealed that 74% of PAQs were able to influence change in their health facilities, affecting health services or infrastructure.

- PAQs also have played an active role in prioritizing health problems and contributing towards planning in the district. For example, the Mbuga Health Center PAQ in Nyamagabe District has developed a well thought out list of ten priorities for action by the district, including rehabilitating the maternity ward,

opening a health post specifically designed for family planning, buying a milk cow for the community to reduce malnutrition and beautifying the grounds around the health facility.

- PAQ members are also very active in informing the community about PAQ meetings and mobilizing community members to utilize health services and participate in important prevention activities, such as ensuring all families are informed about an upcoming vaccination campaign.

The most notable results from PAQs indicate an increase in health center utilization rates as the quality of services has improved and a significant increase in *mutuelle* enrollment. For example, Gasabo District reported enrollment increasing from 40% in 2006 to 91.3% in 2008. Twubakane estimates that the average subscription rate to *mutuelles* is 68% in all Twubakane-supported districts, and the utilization rate of health facilities by *mutuelles* members is close to 100%. The Gikomero Health Center in Gasabo District cited its PAQ's outreach activities as one reason for a dramatic increase in family planning acceptance, which grew from 5% in 2006 to 35% in 2008. Prenatal visits and deliveries at the health center were also reported to have improved.

Health policy and protocol development

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Health policy/protocol development							

Twubakane helped the Rwandan government to develop policy frameworks and protocols that contributed to better health governance and more efficient and effective service delivery, including providing significant help in rewriting Rwanda's Decentralization Strategic Framework. Twubakane also played an important role in disseminating policies, procedures and manuals and in offering orientation and training to local governments and health facilities staff. Areas where Twubakane provided support included:

- To improve the efficiency and effectiveness of health service delivery, Twubakane developed, in cooperation with MINISANTE consultants and hospital directors, improved health care service norms, standards and protocols for maternal and child health, family planning, communicable diseases (malaria, HIV/AIDS, tuberculosis) and GBV.
- Twubakane provided significant contributions to the government's policy on community health insurance and developed management guidelines and a

mutuelle training module and manual, along with *mutuelle* supervisory checklists and protocols.

- To improve health facilities management, health facility management guidelines and a management manual and training module were developed. To support health finance policy and planning at the central (MINISANTE) level, Twubakane developed a methodology for more accurate data collection and costing of both the minimum and comprehensive packages of services. This methodology included guidelines for data collection and Excel spreadsheets to analyze data. The results of the costing study are being used to establish yearly health service fees at hospitals and health centers. Private insurance companies and *mutuelles* are also using the results, along with national health accounts data, to set and negotiate service fees and rates.

- Twubakane, in partnership with the World Bank, GTZ and DFID, contributed to the MINISANTE's first draft of a health financing policy and set up a health financing web-based user group for exchange of health finance documents between the government and donor partners. An historical health financing database is in the planning stage.

- Along with GTZ, Twubakane played a significant role in providing input to develop MINALOC's MIS framework, including guidelines and tools, for local governments; the monitoring and evaluation manual for district governments; a JADF operations manual and tools; and a district accountant training manual, tools and guidelines. Twubakane worked with RALGA to prepare a training module on good governance and leadership. A district council manual is being finalized.

- With MINECOFIN, Twubakane developed a district auditor training manual, tools and guidelines for district-level budgeting and planning cycles and contributed to adding the accounts codes to the charter of accounts codes for development projects and DIF grant accounting at the district level (see below).

- Twubakane helped develop districts' capacity to collect and report health data since DIF grants supported the installation of computers and modems; program staff trained district and health officials in MIS and monitoring and evaluation in Kicukiro, Muhanga, Ruhango, Ngoma and Gasabo districts. Information generated now provides a database for policy decisions and for improved facility operations.

- Finally, Twubakane developed anti-corruption, transparency and accountability guidelines for local governments and RALGA members and trained RALGA in their dissemination.

Auditor training

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Auditor training							

Another cross-sectoral activity supported by Twubakane that has helped improve district accountability and transparency, as well as contributed to efficiency and effectiveness, was building capacity to audit financial records and produce consolidated financial statements. Budgeting, accounting, auditing and tax administration are linked; all need to be strong to plan, budget, implement and pay for health services. Robust accounting systems and audits are needed to track how funds are used and to keep officials transparent, accountable and honest. However, district accountants have been notoriously overloaded, sometimes managing more than 30 accounts; thus their ability to fulfill their function has been limited.

In partnership with MINECOFIN, Twubakane trained district accountants and auditors to produce quality reports, providing many districts with needed software. Not all districts have computers, and some accountants still need more skills training, but consolidated financial statements have now been produced two years in a row (2007 and 2008). DIF grant accounting has, since June 2008, been incorporated into the accounting system that districts are using. This year, with MINECOFIN support, Twubakane staff will continue to work with district accountants on this as a demonstration of the integration of donor funds into district accounting systems.

Recently government auditors helped uncover the misuse of *mutuelle* fees and co-payments by cell-level officers and health workers in charge of *mutuelle* funds in several districts, one of which was Ngoma, a Twubakane-supported district. These fees, which amount to many millions of Rwandan francs per year, are collected and used to offset the costs of health services provided to the insured in district health facilities. With strengthened accounting and audit systems now in place, districts are in a better position to protect *mutelle* and other district funds from leakages and malfeasance.

Open House and Accountability Days

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Open House and Accountability Days							

All district and sector officials visited by the team noted the importance of Open House and Accountability days (*Journées des Portes Ouvertes*) to them and their constituents. *Journées des Portes Ouvertes* connect local government officials to citizens in a way that promotes accountability, voice and transparency and allows citizens a regular opportunity to question public officials and become informed about DDPs, services, etc. Twubakane has provided advice to districts on how to organize *Journées des Portes Ouvertes* and what their function and content should be.

Responses received by the team from local government officials indicated that Accountability Days helped promote increased engagement of citizens and civil society organizations in holding government officials accountable. Although the turnout for these tended to be relatively small—for example, Ngoma District reported that no more than 20 people would show up—interviewees expressed the view that attendance numbers were increasing.

The structure of *Journées des Portes Ouvertes* involves local officials opening their doors to the general public to answer any and all questions posed. In Ngoma District, the mayor and his staff hold Accountability Days monthly where citizens may ask any question they like. The period for office visits is followed or preceded by press conferences with general announcements. Questions concerning the quality of health services have been raised at these forums. One question the mayor of Ngoma revealed to the team that had been recently asked was: "Why isn't our health center working well?" Another inquiry was a complaint about the slow pace of the district hospital's construction. Gasabo District officials mentioned that Accountability Days existed at the cell level as well. Consultative councils made up of cell-level elected officials open their meetings to the public, and every Tuesday the council reviews citizen requests, which are noted down along with solutions in a notebook.

Improving communications using mass media

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Improving communications							

Twubakane helped districts use mass media to communicate important health messages and to solicit citizens' feedback on local government performance in health. In Rwamagana District, Twubakane provided resources to publish a newspaper that featured articles on health, and Ngoma District encouraged communication of important health messages through religious sermons and announcements to church congregations. Radio, however, has been the principal form of mass communication favored by districts and supported by the project. By focusing on radio, Twubakane supported a means of mass communications for transparency and information dissemination that was accessible to much of the local population. Several Twubakane-supported districts used their DIF grants to help them develop radio programs for information sharing with call-in components that allowed citizens voices to be heard by public health officials.

One example where radio was extensively used was Ngoma District where official messages about family planning, children's rights, *mutuelles*, infectious diseases, International Women's Day and other topics were discussed. The program was broadcast each Friday for one hour, with 20 minutes of presentation and 40 minutes of call-ins from listeners who asked questions and raised issues. An example of one call-in was testimony on domestic violence and its relationship with poverty that brought awareness to a very personal level. This program won third prize in the innovation competition for local governments in Rwanda, sponsored by RALGA and the World Bank. Twubakane also provided capacity building in Muhanga and Ruhango districts in communicating messages to the public on decentralization and health programs using radio. With help from Twubakane, RALGA also has used radio programs that feature call-ins from listeners to broadcast information to local governments and citizens on transparency, holding officials accountable for quality and access to health services and citizens' role in decentralized governances.

Fiscal and financial decentralization

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Fiscal/financial decentralization							

In order for local government authorities to carry out their decentralized functions efficiently and effectively, financing must follow function. Thus, along with decentralization and responsibility for providing services, districts need to be given greater fiscal and financial management of resources. An analysis of central government transfers and local resource mobilization capacity conducted by Twubakane in late 2005 found a number of problems: weak institutional capacity at all levels; uneven local resource mobilization capacity; and inadequate and uneven funding and transfers from central to local governments to support services.

During the first half of 2006, Twubakane provided support to MINALOC's Local Government Finance Unit and MINECOFIN to establish a countrywide fiscal and financial equalization policy to ensure adequate resources for health and other services. This technical assistance developed an equalization formula for unconditional transfers of sectoral funds to districts. The aim was to achieve a balance in central transfers that took into account the ability of local governments to raise local tax revenue: transfers allocated to poorer, more rural districts should be higher than those of wealthier, more urban districts. The technical assistance in fiscal decentralization helped Twubakane and RALGA staff to develop a local resource mobilization and capacity building strategy for districts that would increase local revenue collection.

RALGA and Twubakane provided ongoing capacity building assistance to help districts raise and better manage local revenue for health and other services. In addition to financing income-generation projects to sustain health interventions and help the poorest pay their *mutuelle* premiums, DIF grants were used by districts in other ways to mobilize more resources to respond to citizen needs. For example, most Twubakane-supported districts financed the updating of taxpayer rolls and databases in their districts with DIFs in order to clamp down on tax evaders and collect more taxes.

Another area of DIF investment by four districts (Rwamagana, Kayonza, Ngoma and Kirehe) was privatizing the collection of taxes from their district markets in order to increase the efficiency, effectiveness and accountability of revenue collection. An important source of revenue for district authorities, the collection of market taxes was

delegated through an open tendering process to a private enterprise through a service contract. The private service provider must account for and transfer the total amount collected into the district account before being remunerated and is paid an agreed percentage of taxes collected and transferred. DIFs also supported the rehabilitation of two markets in Gasabo District in order to improve hygiene and to increase patronage and corresponding tax revenue. Twubakane and RALGA also worked with districts to assure civil society and taxpayer buy-in to whatever tax collection system is put into place (privatized or carried out by the districts themselves).

Facilities planning and management

Health Governance Outcomes							
	Responsiveness	Leadership	Voice	Accountability	Transparency	Evidence-based	Efficiency & Effectiveness
Facilities planning/management							

Along with strengthening the capacity of districts to plan and manage health services, Twubakane has invested in building the capacity of district hospital and health center managers to more effectively plan, budget and manage their facilities. As district SWOT analyses revealed capacity building areas at the district level needing support, Twubakane developed a tool to do a similar assessment at the facility level. A health facility management assessment was conducted in 2008 to determine priority areas needing capacity building assistance in facility management and planning to improve efficiency, effectiveness and responsiveness of health service delivery.

The assessment tool focused on management practices; strategic planning and budgeting processes; strengths and weaknesses of financial and administrative management, including human resources; health information systems; data collection and utilization; and the organization, patient flow and delivery of health care services. Results from the assessment were shared and discussed in a workshop setting with facility managers, district health directors, hospital directors and development partners. The experience of jointly analyzing issues and identifying and sharing best practices not only improved accountability but also helped increase participants' ownership of solutions. Data from the assessment were also used to focus capacity building on priority training needs and improve performance in strategic and operational planning, budgeting and accounting, administrative systems, data collection, and management of hospitals and health centers. As efficiency and effectiveness of health facility management improved, health service delivery has improved and become more responsive to patient needs.

Questionnaire survey results

The team distributed a questionnaire that requested respondents to assess the extent to which 18 statements reflecting good governance in the health sector described practices in Rwanda at two points in time: prior to decentralization (Phase 2, in 2006) and currently.[7] The team received 50 completed questionnaires; 10% of respondents came from central government, 80% came from district government and 10% from NGOs. The largest category of respondents rated themselves as service deliverers or in some kind of program management or supervisory role. Twenty percent rated themselves as policymakers. Analysis of results revealed a consensus among respondents' perceptions that there have been significant improvements in health governance in Rwanda from before decentralization to the current situation. In several cases the percentage changes in perceptions were dramatic. Of the 18 statements characterizing good governance practices in the health sector, scores of respondents' ratings on all of them showed positive changes between now and prior to decentralization. Respondents' ratings on ten of the statements revealed assessments of highly positive changes of over 50% (rating them as reflecting practices in Rwanda's health sector to either a very high or high extent). These statements and ratings are displayed in Table 2. Annex 2 provides a complete compilation of the survey results.

Table 2. Strongest Perceived Improvements in Health Governance: Pre-and Post-Decentralization, Phase 2

Statement reflecting good health governance practice	% change in ratings (high and very high), before decentralization compared with today
Development and application of protocols and standards for service delivery	57.6
Existence of oversight structures when standards are not complied with	54.0
Existence of structures and procedures to allow citizens and communities to participate in health planning and priority setting, resource allocation decisions and service quality	58.9
Availability of information and tracking on the allocation and utilization of resources	53.0
Existence of systems for reporting and investigating the misallocation or misuse of resources	57.8
Organization of forums to solicit input and ideas from the public and stakeholders on health services and priorities	57.1
Opportunities exist for the public to meet with hospitals, health centers and clinics to raise issues about service efficiency or quality	54.7
Stakeholders have the capacity and resources to advocate for policies and changes in health services	54.7
Availability of information on quality and cost of health services to inform patient choice	50.8
Procedures to eliminate or control bias and inequity in the availability of health services	53.9

[7] The questionnaire used a set of pretested questions from an on-line study of health governance conducted by the Health Systems 20/20 project. See Brinkerhoff and Helfenbein (2008).

The questionnaire survey results confirm what the team found through the interviews conducted during fieldwork. The reforms put in place by decentralization in the health sector have led to significant perceived improvements in health governance, based on the assessments of questionnaire respondents. Several of the governance areas in which strong improvements were noted by respondents relate to those where Twubakane has had a role in providing assistance. These include, for example, participatory district planning, the development of protocols and standards, management manuals and procedures for facilities, assistance to JADFs and PAQs, and District Accountability and Open House days. It should be noted that the government's commitment to performance and results, embodied in the *imihigo* program, also contributes to the positive assessments found through this questionnaire.

Interestingly, the only responses that indicated a perceived decline in the quality of health governance came from three of the central-level respondents. The areas noted as declining had to do with the formulation of policy on the basis of evidence, and the ability of government officials to make decisions about resource allocation based on effectiveness of services; these assessments could reflect the fact that central-level officials are closer to the political process of policymaking in resource allocation than staff in the districts and thus observe the influence of political factors on health sector decision-making. In any case, these assessments were definitely a minority among the questionnaire sample; only three out of 50 of the respondents noted any declines on any of the 18 statements related to health governance.

Clearly the sample was not random or scientific in any statistical sense. However, the responses obtained provide supporting evidence for the positive impacts of decentralization on planning, resource allocation, citizen participation, responsiveness and accountability in the health sector. With 80% of respondents coming from the district, the results of the survey provide one window into the perceptions of those working at the district level of the kinds of changes that have been brought about by the Government of Rwanda with support from Twubakane.

Summary of Health Governance Outcomes

In sum, the majority of Twubakane’s impacts on health governance outcomes resides in three areas: efficiency and effectiveness; accountability; and responsiveness. These three are followed next in importance by voice and transparency. Table 3 provides a summary compilation of the team’s assessment.

Table 3. Summary of Health Governance Impacts of Twubakane

Health Governance Outcomes	Primary impact	Secondary impact	Total
Responsiveness	0	7	7
Leadership	1	0	1
Voice	2	3	5
Accountability	3	5	8
Transparency	1	3	4
Evidence-based decisions	1	1	2
Efficiency and effectiveness	4	5	9

Efficiency and effectiveness

The largest impacts on health governance from the Twubakane program fall in the category of increased efficiency and effectiveness. Health policy and protocol development, fiscal and decentralization policy development, JADFs, and improvements in health facility management and planning produced the strongest results in this category. Better planning that involved increased stakeholder participation, DIFs, management training, auditor training and district SWOT assessments also contributed to greater efficiency and effectiveness. For example, one interviewee, a vice-mayor, commented on Twubakane's assistance and the links between better efficiency and effectiveness and district leadership. She noted that "the demands of Twubakane for reporting and implementation follow-up helped to build the capacity of district mayors and increased their ability to be leaders."

As the previous discussion points out, numerous interviewees cited increases in service utilization rates, immunization rates and health insurance coverage that they attributed, either directly or indirectly to Twubakane interventions. While the team was not able to obtain systematic quantitative data on these increases, the interview data support this link to increased efficiency and effectiveness.

Accountability

The Accountability Days, auditor training and DIFs had primary impacts on increasing accountability, and PAQs too have had an effect. The team's interviews revealed several statements that reflected, for example, how the participatory planning that provides input to DIF grants, and the specificity DIFs require on the use of those funds to achieve stated purposes, inject increased accountability into planning and budgeting. The auditor training was highlighted as clearly linked to providing a solid foundation of financial data on which to base accountability for the use of funds (see the quote below related to transparency). A couple of direct quotes further illustrate accountability results, for example:

- Noting the increased citizen interest in questioning local officials, one interviewee remarked, "At the most recent Accountability Day, we had 2,000 people at this meeting" (Nyamagabe District).

- "PAQs are another accountability mechanism; they focus on service quality and verification. There have been changes in services as a result of the PAQs" (Gasabo District).

The team's findings are reinforced by those of other assessments. For example, a recent IMF and World Bank (2008, 8) review noted "substantial improvements in accountability related to service delivery" in both health and education. A contributing factor is the government's performance and results orientation that has enhanced both the adoption and the impact of Twubakane's interventions. However, there remains room for improvement, particularly in terms of engaging non-state actors. A Ministry of Public Service and Labor report notes that "media and NGOs are not yet sufficiently involved in monitoring accountability, transparency and efficiency in the use of public resources. This is a government-wide weakness…." (MIFOTRA 2008, 13).

Responsiveness

In the team's assessment, seven of Twubakane's interventions have contributed to increased responsiveness. These include: health policy development, fiscal and decentralization policy, management training, district SWOT analyses, DIFs, PAQs and improvements in facility management and planning. Health and decentralization policy changes have contributed to the enabling conditions for responsiveness of the health system. Management training and better facilities planning have provided increases in capacity that support responsive service delivery, and the SWOT analyses helped to pinpoint areas needing improvement. DIFs, in the words of an interviewee in Gasabo District, are a mechanism that "starts with asking about needs and then responds to those needs by providing resources. These grants allow the health center to respond to citizens' needs, and they have led to an increase in service quality."

PAQs have increased responsiveness at the facility level. Several interviewees gave examples of how PAQ-initiated discussions—and in some cases complaints—led facility managers to make changes. As discussed above, examples of changes include health provider behaviors (punctuality, attendance and patient interaction), increased resources for facilities, and infrastructure improvements. A recent study of health worker motivation in Rwanda confirms the scope of the problem with staff behaviors as well as the positive impacts that community oversight has had in addressing them (Serneels and Lievens 2008).

Voice and transparency

The strongest voice outcomes resulted from PAQs and participatory planning. Both of these mechanisms have provided structures and procedures that allow citizens more of a say in the functioning of health facilities, in the case of PAQs, and in the identification of needs and the plans for responding to them, in the case of participatory planning. An interviewee in Nyamagabe District observed that PAQs are the "*porte parole* of the

population regarding the health sector." The Open Houses held by district officials also created opportunities for voice, as did the call-in radio programs. Communication via the media supported increased transparency as well by providing citizens with information on health issues and services.

The auditor training, by enabling better financial audits, increased transparency along with accountability while playing a role in better efficiency and effectiveness in financial management, reporting and oversight. An interviewee in MINECOFIN remarked:

> In 2007, this was the first time the government did 100% audits at the district level. The government was able to do this because there were records to audit and because capacity was there. This was a result of Twubakane. There's a consciousness of the audit process now; this is an incentive for accountability created by the fact that the audit is taking place.

Lessons from Rwanda and Twubakane

The team noted a number of facilitating conditions for good health governance in Rwanda. These are important in terms of identifying the features that contribute to the success Twubakane has realized. We note the following: strong political will from the president and senior officials, a strong commitment to decentralization, a commitment to fighting corruption, the synergy between Twubakane's efforts in the government-wide emphasis on performance, embodied in the *imihigo* process, the government's desire to identify and replicate best practices throughout the country and the availability of donor resources. Each of these facilitating conditions comes with some downside risks, however.

Political will and institutional capacity

The strong political will emanating from the senior levels of government has provided major impetus for reform, but the reforms also indicate a strong level of top-down control. Political will exists both for good governance, one of the pillars of the government's Vision 2020, and for decentralization. One of the benefits of decentralization, as demonstrated in the literature and experience in other countries, is the increase in local-level autonomy and adaptation to conditions that results from transferring authorities and resources from the central to lower levels of government. In Rwanda, it is more accurate to speak of deconcentration rather than decentralization due to the way that the decentralization program has been implemented.

Another feature noted by a variety of observers regarding decentralization is the pace at which it is progressing. Phase 2 of decentralization has been speeded up, and Phase 3 is set to begin. This third phase will push decentralization below the level of the district down to the sector and the cell level, but there are serious capacity issues involved. For example, several interviewees questioned how the ambitious hiring targets for new sector and cell staff could be met with sufficiently qualified people. One can raise the question about decentralization: is it too much, too fast?

The government's commitment to decentralization is a strong driver for reform. However, as noted, the pace of decentralization is extremely fast, and the capacity demands of decentralization exceed supply. This gap will be exacerbated in Phase 3 of decentralization that pushes below the district level, down to the sector and the cell. The top-level direction of decentralization plus local jurisdictions' dependence on central government transfers limit local government autonomy and discretion. This is why we speak of deconcentration rather than decentralization.

With decentralization, it is not just the capacity issue at sub-national levels that is important to consider but also the political will of public officials beyond the center. For example, several interviewees noted the important leadership role of district mayors. Thus, in addition to political will at the top, commitment to, and support for, reform at local levels will have a strong influence on progress and results on the ground.

Accountability and citizen participation

Decentralization reaches down through the district and sector to the cell level largely to engage citizens in support of centrally determined objectives (for example, Vision 20/20). While the intent is to foster inclusiveness, make services more widely available, and instill a performance ethic, the decentralized administrative structures of the government tend to manage the participation process, guided from the center. As a result, citizens are not so much initiating engagement with administrative structures to push for responsiveness; citizens are instead being mobilized to participate in state-set agendas (see also Smith et al. 2002).

This mobilization of citizens by government officials creates accountability relationships that orient the focus of responsibility onto citizens vis à vis the state rather than the other way round. This accountability pattern is reinforced by the government's management-for-results policies. The upward accountability imposed by performance contracts in the *imihigo* system and their associated indicator reporting requirements competes with downward accountability to local citizens. This is another area of concern when thinking about health governance because upward connections orient public sector actors to the priorities and demands of hierarchical superiors rather than reinforcing accountability to service users (see Brinkerhoff 2004, Brinkerhoff and Bossert 2008).

The commitment to fighting corruption is commendable and clearly something that is associated with good governance and accountability. However, the zero tolerance policy of the Rwandan government increases the risk of driving corruption underground. If all types of corruption, whether large or small, are subjected to the same penalties, it can be difficult to address any of this because no one is willing to admit that there is any corruption. This problem is one of the points raised in the USAID study of corruption in the health sector (see Gellar et al. 2008).

Managing for results and best practices

The government's commitment to managing for results and emphasis on performance is also admirable. But one of the lessons from management by results is the danger of displaced incentives. People tend to respond to outputs on which they are measured. This

places a lot of pressure on establishing the appropriate measures and performance indicators. The team noted that the health sector in Rwanda is swimming in indicators. Interviewees indicated that in some cases, particularly at the local level, facilities managers felt burdened by reporting requirements and the need to channel reports on performance upward. Ironically, one senior official interviewed at the MINISANTE remarked that the ministry uses only about 10% of the reporting information it receives.

Clearly the *imihigo* process puts performance front and center in the Rwandan public sector. However, the team heard a few stories of districts adjusting their population figures downwards in order to demonstrate achievement of their *imihigo* targets. The problem is multifaceted, beginning with the realism of the targets that are selected, the accuracy of the data collection and reporting, and the use to which the data are put. The team's concern regarding downside risk is echoed by Holvoet's and Rombouts' analysis of the problem in Rwanda: "If they [performance contracts] become instruments to judge district performance, they risk leading to biased M&E [monitoring and evaluation] at district level, where undoubtedly they will be 'cleaned up'" (2008, 587). This article also raises the issue of the potential political misuse of contract results, which could undermine the objectivity and accountability features of *imihigo*. Thus, there are important incentive issues embedded in Rwanda's performance contracting.

The emphasis on replicating best practices goes along with the government's performance and results-based approach. But again one of the implications is the drive to develop a one-size-fits-all approach. Best practices are identified and then turned into national policy. This skips over the possibility of adaptation and gradual modification to fit local circumstances, not to mention the process of learning that is necessary for any innovation.

Donor dependence

Rwanda is a classic case of donor-dependent country. While there are large amounts of resources available for the health sector, as respondents noted and various documents report, some of these resources are directed toward donor priorities, not those of Rwanda. A good example is the resources devoted to HIV/AIDS. Particularly for the long-term, the question of sustainability is critical.

President Kagame has publicly stated his aim to reduce Rwanda's dependency on donors. However in the short-term, reliance on the international community will remain strong. Some of the lessons of international experience regarding health system strengthening have been applied in Rwanda and are reflected, for example, in the use of SWAps (sector-wide approaches) as a means to align funding with country priorities and procedures. Similarly, the attention paid to institutional capacity building recognizes the lesson that channeling expanded levels of funding through weak health systems does not lead to sustainable results, and it opens the door to waste and corruption (see Walt et al. 1999).

Implications for Rwanda

Rwanda has a conducive environment for governance improvement, and decentralization has had a positive impact on health governance. Both questionnaire data and the team's interview data confirm this conclusion. The innovations supported by Twubakane have led to demonstrable health governance outcomes, most clearly related to accountability, responsiveness, and efficiency and effectiveness. These health governance outcomes have contributed to improved health results. These include, for example: increases in service utilization, increases in insurance coverage at the community level, and mobilization of communities around health issues and for the utilization of services. Respondents noted, for instance, increases in immunization rates, contraceptive prevalence rates, and increases in the number of births taking place in health facilities as opposed to homes.

Looking ahead, the team sees issues and concerns in the following areas:

- Capacity gaps are likely to affect the pace and quality of implementation. Capacity lags behind commitment and plans for decentralization (both Phases 2 and 3), and gaps exist both at the center and sub-nationally. The district capacity needs assessments point to serious shortcomings in management systems, human resources, working relationships with government structures and civil society, and facilities and equipment (MINALOC and MIFOTRA 2008, Kagina and Rubanzabigwi 2008). At the center, the National Decentralization Implementation Secretariat is critically weak, and MINALOC faces some capacity problems as well (see MIFOTRA 2008). Addressing these capacity gaps will be important to realizing the benefits intended from the continued pursuit of decentralization policies.

- Top-down policy direction and performance contracting dominate accountability relationships. This is something that we see as an imbalance. There needs to be increased accountability downward, toward citizens. Local responsiveness is one of the intended benefits of decentralization, but that will not happen without a shift in this accountability orientation.

- Information and reporting overload related to the expanded number of indicators: is this is a case of too much of a good thing? The reporting burden reinforces the upward orientation of accountability and constitutes a management burden on facilities at the district level and below. In addition, the political aspects of performance reporting, noted above, needs to be taken into consideration. These pose risks for the objectivity and validity of the data being reported.

- What are the sources of technical expertise and support for local government in the health sector following the completion of Twubakane? The project is consciously focusing on RALGA as a source for this assistance, but RALGA has its own institutional problems and issues. Experience in other countries with support to municipal support organizations reveals the problem of resources for such organizations, the dangers of lack of focus and the pursuit of activities

simply to garner the resources to continue functioning. This is a problem that has already been flagged as something that RALGA is confronting.

Implications for Donors

The team offers the following suggestions for USAID:

- Maintain the district incentive funds. These have had positive impacts on accountability, responsiveness, and efficiency and effectiveness. They represent an important mechanism for the transfer of resources to decentralized units in ways that reinforce incentives for good governance and for performance.

- Continue capacity building. This is required for central agencies, as well as for districts and sectors. Capacity building is required in the areas of skills, resources and processes. RALGA also needs capacity building; the focus here should be on "value for money," identifying what clients want and how to provide that.

- Capacity building for health service delivery is also a priority. This includes professional education. An assessment by Dussault et al. (2008) found that Rwanda's ability to produce health workers is limited by the capacity of existing training institutions. A reorganization of training is underway (consolidation of medical, nursing and public health schools under the proposed Rwanda Biomedical Center).

- Continue capacity building for PAQs and JADFs: but the emphasis here is on civil society, not just local officials and health facility managers or donor project staff. The focus should be on better downward accountability as noted previously.

- Support further integration of PAQs into the health system, including adding these kinds of structures at hospitals and health posts. This is something already under discussion and is worthy of support.

- Consider evidence testing for best practices. There should be some sort of piloting adaptation before moving to national-level scale-up.

- Rationalize data collection and reporting burden on districts and below. This can be accomplished by the following measures: reduce the number of indicators, link indicators more closely to priority setting and decision making, harmonize and reduce duplication among indicators, and streamline reporting requirements. It was very telling that in one of our interviews, a senior-level official at the central level commented that only about 10% of the indicators data collected for decision-making was used.

- Maintain support for decentralization. Pairing this support with assistance for increased service access and quality has positive impacts on health governance and health outcomes.

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Twubakane documents

The team consulted the program's Annual Reports (Nos. 1-4), Quarterly Progress Reports (Nos. 1-16) and various manuals and training materials, as well as the references listed.

Annex 1: Persons Contacted

Twubakane Project

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Emile Sempabwa	Community Participation Activities Team Leader
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Ferdinand Musabyimana,	Nyamagabe Assistant Field Coordinator

Kigali Ville Local Government

Jeanne d'Arc Gakuba	Vice Mayor of Social Affairs of Kigali Ville

MINECOFIN (Ministry of Finance and Economic Planning)

André Habimana	Director of Development Planning
Fred Mujuni	Accountant General
John Munga	Director of Public Accounts Unit

Ministry of Health

Claude Sekabaraga	Director, Planning, Policy and Capacity Building Unit

RALGA (Rwandese Association of Local Government Authorities)

Théogene Karake	Secretary General
Chantal Rwakazina	Capacity Building Program Officer
Faustin Serubanza	Senior Programs Officer

Oscar Nzirera	HIV/Family Planning Officer
Josephine Uwimana	Gender Officer

Gasabo District Local Government

Narcisse Ndagijimana	Vice Mayor, Social Affairs
Willy Mutabazi	Acting Executive Secretary (Good Governance Officer)
Johnson Mwebaze	Director of Planning
John Kalamagye	Director of Infrastructure
Richard Rutagwenda	MCH specialist, Health Unit
Georgette Umubyeyi	Health Unit
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MINALOC/NDIS (Ministry of Local Government/ National Decentralisation Implementation Secretariat)

Nepo Rugumintwaza	Acting NDIS Coordinator

Gikomero Health Center, Gasabo District

Didace Niyoyita	Titulaire-adjoint du centre
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Vincent Gatambara	PAQ president
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Nyange Health Center, Ngoma District

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Themistockles Uwizeyimana	Secretary of PAQ
Vincent Ngendahimana	Vice President of PAQ

Ngoma District Government

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Joséphine Mutesayire	Vice-Mayor Social Affairs
Francois Bushayija	Chairperson, District Council
Charles Twayigize	Director, Land Office
Silvère Ngarambe	Director, Good Governance
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Jonas Ndayisaba	Director, Health Unit
H. Fidele Rusatira	Planning Officer
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U. Emile Mbanzamihigo	Director of Finance
Victor Jemadari	Director, Education
J.M.V. Hakizimana	District Hospital Director

PAQ, Health Center of Mbuga, Nyamagabe District

Firmin Harelimana	President of the PAQ
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Frédéric Munyensanga	PAQ member (Health Center staff member)
Frédéric Nshizirungu	Chargé de la Sante
Caritas Uwizeyimana	Health Center nurse
Gaspard Nkurikiyumukiza	Health Center nurse
Emmanuel Bangayandosha	Health Center lab technician
Espérance Mukamuligo	Health Center nurse
Claire Hakizimana	Health Center nurse
Marthe Mushimiyimana	Health Center nurse

Ngoma District, Mugesera Sector

Arcade Muragijimana	Executive Secretary of the Sector

Nyamagabe District Government

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Immaculée Mukarwego	Vice mayor for social affairs
Colette Kayitesi	Director, District Health Unit

Republic of Rwanda Parliament, Chamber of Deputies

Jean D. Ntawukuriryayo	Deputy Speaker (former Minister of Health)

GTZ

Elena Zanardi	Governance Advisor

Southern Province Government

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USAID/Kigali

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Paul J. Kaiser	Democracy and Governance Advisor
Soukeynatou Traore	Population, Health and Nutrition Officer

Annex 2. Health Governance Questionnaire Results

Sample Composition

1. Where do you work?

Sector	Number	Percent
Government, central	5	10
Government, district	**40**	**80**
Private sector	1	2
Civil society	4	8
Total	50	100

2. What kind of work do you do?

Kind of work	Number	Percent
Policymaker/ministry official	10	20
Program/project management/supervision	13	26
Service delivery	**21**	**42**
Research/teaching	1	2
Consulting/advising	1	2
Other (planning)	3	6
Unspecified	1	2

Health governance in Rwanda: Responses

The following represents the extent to which each statement describes practices in Rwanda.

1. Government officials formulate policies, plans, regulations, procedures and standards on the basis of evidence about the effectiveness of health interventions, allocation of resources, spending patterns and so on.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	16	8	28.6	14	12.6
High	12	6	47	23	35
Moderate	28	14	20.4	10	-7.6
Low	42	21	2	1	-40
Very low	2	1	2	1	0

2. Government officials make decisions about resource allocation for health services on the basis of evidence regarding needs and effectiveness of services and in conformity with policies.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	14	7	32	16	18
High	28	14	50	25	22
Moderate	30	15	14	14	-16
Low	16	8	4	4	-12
Very low	12	6	0	0	-12

3. Law makers regularly seek input from technical experts in government organizations and civil society and users of health services as inputs into legislation concerning health, including roles of the public, civil society and private for profit sectors.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	4	2	24	12	20
High	20	10	42	21	22
Moderate	30	15	24	12	-6
Low	28	14	10	5	-18
Very low	18	9	0	0	-18

4. Service providers regularly review and update the mix of services they deliver on the basis of evidence about the effectiveness of health services, client needs and health problems.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	26.5	13	26.5
High	14.6	7	51	25	36.4
Moderate	43.7	21	8.2	4	-35.6
Low	27.1	13	10.2	5	-16.9
Very low	14.6	7	4	2	-10.6

5. Protocols, standards, and codes of conduct, including certification procedures for training institutions, health service facilities, and health providers, have been developed for all actors involved in health services delivery and have been widely disseminated.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	18	9	16
High	10.4	5	52	26	41.6
Moderate	35.4	17	20	10	-15.4
Low	43.7	21	6	3	-37.7
Very low	8.3	4	4	2	-4.3

6. Public sector, voluntary and private organizations exist to monitor adherence to protocols, standards, and codes of conduct in public, NGO and private health provider organizations.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	22	11	22
High	23.4	11	38	19	14.6
Moderate	27.6	13	24	12	-3.6
Low	42.5	20	10	5	-32.5
Very low	6.4	3	6	3	-0.4

7. Structures (for example, regulatory agencies with appropriate human resources) and procedures for oversight allow providers, clients and other concerned stakeholders to seek redress when regulations, protocols, standards, and/or codes of conduct are not complied with.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	14.6	7	14.6
High	8.5	4	47.9	23	39.4
Moderate	42.5	20	18.7	9	-23.8
Low	36.2	17	14.6	7	-21.6
Very low	12.7	6	4	2	-8.7

8. Financing, service provision and oversight arrangements offer incentives to public, NGO and private providers to improve performance in the delivery of health services.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	37.5	18	37.5
High	27.2	12	35.4	17	8.2
Moderate	27.2	12	20.8	10	-6.4
Low	31.8	14	4.2	2	-27.6
Very low	13.6	6	2	1	-11.6

9. Structures and procedures exist to allow/encourage the public, technical experts and local communities to review and comment upon health priorities, resource allocation decisions and service quality during government strategic planning processes.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	30.6	15	28.6
High	14.6	7	44.9	22	30.3
Moderate	41.6	20	16.3	8	-25.3
Low	35.4	17	4	2	-31.4
Very low	6.2	3	4	2	-2.2

10. The allocation and utilization of resources is regularly tracked, and information on results is available for review by the public and concerned stakeholders.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	18.4	9	16.4
High	8.3	4	44.9	22	36.6
Moderate	43.7	21	22.4	11	-21.3
Low	31.2	15	12.2	6	-19
Very low	14.6	7	2	1	-12.6

11. Systems exist for reporting, investigating and adjudicating misallocation and misuse of resources.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	4	2	40	20	36
High	10.2	5	32	16	21.8
Moderate	34.7	17	16	8	-18.7
Low	32.6	16	12	6	-20.6
Very low	18.3	9	0	0	-18.3

12. Government and health provider organizations regularly organize forums to solicit input/views/ideas from the public and concerned stakeholders (vulnerable groups, groups with particular health issues, etc) about priorities, services and resources.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	38.8	19	38.8
High	18.4	9	36.7	18	18.3
Moderate	42.8	21	12.2	6	-30.6
Low	24.5	12	10.2	5	-14.3
Very low	14.2	7	2	1	-12.2

13. Civil society organizations (including professional organizations—e.g., RALGA, specialized health-related NGOs, the media) provide oversight of public, NGO and private provider organizations in the way they deliver and finance health services.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	22.9	11	20.9
High	14.6	7	37.5	18	22.9
Moderate	29.1	14	20.8	10	-8.3
Low	18.7	9	12.5	6	-6.2
Very low	35.4	17	6.2	3	-29.2

14. The public or concerned stakeholders have regular opportunities to meet with management of health service organizations (hospitals, health centers, clinics) to raise issues about service efficiency or quality.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	34.7	17	32.7
High	20.8	10	42.8	21	22
Moderate	33.3	16	14.3	7	-19
Low	31.2	15	6.1	3	-25.1
Very low	12.5	6	2	1	-10.5

15. The public and concerned stakeholders have the financial means/tools/capacity to advocate and participate effectively with public officials in the establishment of policies, plans and budgets for health services.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	30.6	15	28.6
High	12.7	6	38.8	19	26.1
Moderate	38.3	18	20.4	10	-17.9
Low	29.8	14	8	4	-21.8
Very low	17	8	2	1	-15

16. Information is publicly available about the quality and cost of health services to help clients make choices as to where they want to go for health services.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	2	1	28.6	14	26.6
High	16.6	8	40.8	20	24.2
Moderate	31.2	15	12.2	6	-19
Low	27.1	13	14.3	7	-12.8
Very low	22.9	11	4	2	-18.9

17. Procedures/systems exist to reduce/eliminate/control bias and inequity in accessing health services.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	24	12	24
High	8.1	4	38	19	29.9
Moderate	30.6	15	24	12	-6.6
Low	42.8	21	14	7	-28.8
Very low	18.3	9	0	0	-18.3

18. Structures exist for civil society and the private sector to participate as equals in the planning and budgeting process for health programs at national and local levels.

Extent	Before decent		Now		% Change
	%	N	%	N	
Very high	0	0	34	17	34
High	22.4	11	36	18	13.6
Moderate	28.6	14	14	7	-14.6
Low	24.5	12	10	5	-14.5
Very low	24.5	12	6	3	-18.5