

District Incentive Fund (DIF) Grant Initiative

Final Assessment



January 2010



TWUBAKANE
Decentralization and Health Program
Rwanda

ACKNOWLEDGEMENTS

All field studies are made possible by the efforts of numerous people. Without their support and commitment we could not have conducted this assessment. We would like to express our appreciation to the Government of Rwanda, especially the Ministry of Health and the Ministry of Local Governance for their ongoing support and collaboration on the DIF grant initiative. We would also like to thank USAID/Rwanda for their interest in documenting the DIF grant initiative's contributions to the Twubakane Program's efforts to strengthen decentralized health systems and improve health outcomes in Rwanda. We owe Twubakane's DIF Team (Anatole Sentabire Kaboyi, Jean Paul Kagarama), Field Coordination Team (Alphonse Nzirumbanje, Charles Kayobotse, Evariste Nkunda, Marie Chantal Umuhoza Théophila Nyirahonora), F&A Team (Elyse Kalisa, Julienne Dieudonne), the Decentralization Policy, Resources Mobilization and Health Facilities Team (Antoinette Uwimana, Françoise Twahirwa, Philbert Ndaruhuste), Senior Team (Dean Swerdlin, Emile Sempabwa, Laura Hoemeke, Laura Hurley), as well as IntraHealth (Jana Scislowicz, Laure Almairac, Michael Hainsworth, Sara Stratton) and RTI (Dan Gerber, Catherine Fort, Derick Brinkerhoff) home office staff a large debt of gratitude for their enthusiasm and their essential support to making the study a success and for contributing their knowledge and experience. We would also like to thank Claire Viadro for her efforts to assemble the written report. We also thank all our Rwandan interviewees in Kigali and in the districts we visited for their efforts to respond to our inquiries, their willingness to share their views, and their commitment to improving the health status and quality of life of Rwanda's citizens. Rwanda's story is one that deserves widespread dissemination, and we feel privileged to contribute in a small way to that endeavor. Finally, we would like to state that the views expressed in this report are ours alone and do not reflect those of USAID; any errors of fact or interpretation lie with us.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
TABLE OF CONTENTS	ii
ACRONYMS.....	iv
EXECUTIVE SUMMARY.....	v
1. Introduction.....	1
1.1. Background	1
1.2. Rwanda’s Health Care System.....	2
1.3. Health in Rwanda	2
1.4. Decentralization	3
2. District Incentive Fund (DIF) Initiative.....	4
2.1. Overview	4
2.2 DIF and the Twubakane Program	4
2.3. DIF Start-up.....	4
2.4. DIF Award Amounts.....	5
2.5. DIF Grants Process.....	5
2.6. DIF Grants Management.....	8
2.7. DIF Monitoring.....	9
2.8. Peer Review of DIF Process	10
3. Methodology	11
3.1. Research Questions	11
3.2. Study Design	11
4. Results.....	12
4.1. Study Participants	12
4.2. DIF Overview	14
4.3. DIF Impact on Family Health Services	15
Perceived Impact of DIF on Strengthening Health Services	15
Performance Indicators: Service Use	17
DIF Support for Health Services.....	18
4.4. DIF Impact on District Capacity	19
Perceived Impact of DIF on Strengthening District Capacity	19
Performance Indicators: Capacity-building.....	23
DIF Support for Capacity-building.....	25

4.5. DIF Impact on Collaboration and Participation.....	25
Perceived Impact of DIF on Fostering Collaboration and Participation	26
Performance Indicators: Collaboration and Participation.....	26
DIF Support for Collaboration and Participation	27
4.6. Challenges	28
Policy and Sociopolitical Environment	29
DIF Characteristics	29
DIF Implementation	29
Administrative Capacity	30
Sustainability	31
5. Discussion.....	31
5.1. DIF Approach.....	32
5.2. Scope of Activities	33
5.3. Financial Management	34
5.4. Decentralization	35
5.5. Sustainability.....	35
5.6. Conclusions	36
Annex A. Study Design	37
Annex B. Interview Guides and Self-administered Questionnaires	42
Annex C. Members of DIF Assessment Team	55
Annex D. Categories of Activities Funded with DIF Grants, 2006-2009	56

ACRONYMS

ANC	Antenatal Care
CYP	Contraceptive Years of Protection
DDP	District Development Plan
DHS	Demographic Health Survey
DIF	District Incentive Funds
EDPRS	Economic Development and Poverty Reduction Strategy
FRW	Rwandan Francs
HSSP	Health Sector Strategic Plan
GOR	Government of Rwanda
JADF	Joint Action Development Forum
MCH	Maternal and Child Health
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Economic Planning and Finance
MINISANTE	Ministry of Health
MTEF	Medium Term Expenditure Framework
PAQ	<i>Partenariat pour l'Amélioration de la Qualité</i> (Partnership for Quality Improvement)
PBF	Performance-Based Financing (<i>L'Approche Contractuelle</i>)
PMP	Performance Monitoring Plan
RALGA	Rwanda Association of Local Government Authorities
RDSF	Rwanda Decentralization Strategic Framework
TA	Technical Assistance
USAID	United States Agency for International Development
USD	United States Dollar

EXECUTIVE SUMMARY

The District Incentive Fund grants were a key component of the five-year USAID-funded Twubakane Decentralization and Health Program in Rwanda, which began in January 2005 and ended in January 2010. Through the grants program, a total 5,311,508 USD (out of the total project budget of 28,379,327 USD) was awarded to Twubakane-supported districts, who contributed another 1,378,785 USD in cost-share.

The DIF assessment took place in late 2009, just prior to the end of the five-year project. The overall purpose of the DIF assessment was to examine the DIF grant initiative's contributions to the Twubakane Program's efforts to strengthen decentralized health systems and improve health outcomes. The specific objective was to document the DIF grants as a promising practice and key component of the Twubakane Program's broader platform of health and decentralization interventions and to document challenges encountered and lessons learned.

Results from interviews, focus groups, and survey responses, showed that that the District Incentive Funds (DIF) were broadly appreciated and praised as an effective approach. The assessment results indicate that, in synergy with multiple other local health initiatives, the DIF grants mechanism contributed to progress in health services, district capacity, and participation and collaboration. Within the dynamic context of decentralization, study participants especially appreciated the DIF grants' flexibility, and valued the opportunities for innovation offered by DIF. Even though many challenges to the success of the DIF grants were triggered by the rapidly changing decentralization, redistricting, and shifting geopolitical setting in Rwanda, the DIF initiative was largely viewed as timely. The DIF initiative gave district staff much-appreciated technical assistance and administrative capacity-building support, along with funding.

Districts expressed appreciation for the opportunity to use flexible funds to address health needs and priorities identified at a local level rather than imposed by development partners or central level authorities. Districts also appreciated the hands-on technical and programmatic assistance provided by the Twubakane Program field coordinators, who were based within the district teams and played an important role in building districts' capacity to prepare proposals, write reports, conduct site visits, and carry out other aspects of project management. The DIF approach also built incentives for the immediate application of capacity to achieve results, and had positive impact on accountability, responsiveness, and efficiency and effectiveness.

Challenges associated with ensuring appropriate and timely financial management represented a key theme of the DIF assessment results. Throughout the DIF implementation period, timely financial reporting presented major challenges. However, many districts demonstrated improved capacity to administer and justify DIF grant monies over time.

During the four years of DIF implementation (which began in 2006, during the second year of the Twubakane Program), both the Twubakane Program and participating districts learned how to tailor the DIF grants to the realities of rapid decentralization and the need to respond to local needs. Over time, districts evolved in their ability to work within the decentralized system. As a result, respondents generally were in favor of continuing or replicating the DIF approach.

Because the DIF model worked with—and enhanced—existing district systems rather than creating parallel systems, it leaves an infrastructure in place that can continue beyond the DIF funding cycle and can be adapted for other purposes. It is hoped that the Government of Rwanda (GOR) and its partners will continue to explore various options, including cost sharing, to ensure that resources are available at decentralized levels to support health and other social services.

In conclusion, the District Incentive Fund grants mechanism was greatly appreciated by district grant recipients and other stakeholders. The grants, implemented at a time when the districts were newly created and needed significant technical and financial support, provided much-needed resources to districts, promoted good governance, accountability, and responsiveness to local populations; strengthened district capacity in planning and budgeting; enhanced district resource mobilization; and, apparently, had a positive impact on the quality of and access to health services.

The DIF grants mechanism is a promising practice, one that should be considered by USAID for future projects, and by the Government of Rwanda and its partners as a means of providing financial and technical resources to decentralized levels. The government's commitment to managing for results and emphasis on performance is admirable. As the current emphasis on replicating best practices goes along with the government's performance and results-based approach, it is in this spirit that we recommend that the DIF mechanism be identified as one such practice that could be turned into national policy, after necessary adaptation and gradual modification to fit local and level circumstances.

1. Introduction

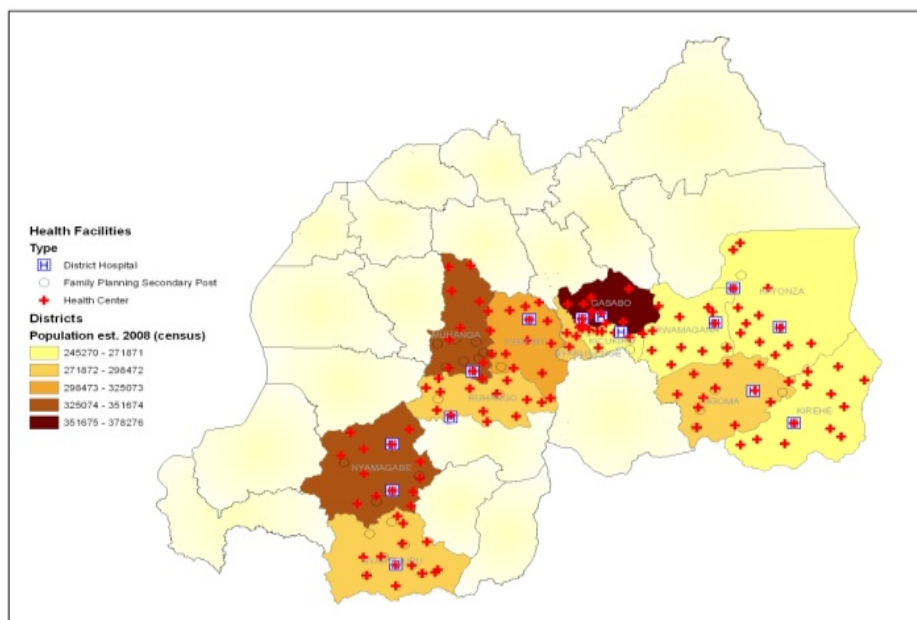
1.1. Background

The Rwanda Decentralization and Health Program was a five-year USAID-funded project developed to foster strong decentralized local government and to promote the sustainable use of high-quality health services. The project, designed in 2004, was awarded to IntraHealth International in January 2005. IntraHealth's partners included RTI International, Tulane University, the Rwanda Association of Local Government Authorities (RALGA), Pro-Femmes, VNG International and Engenderhealth. The program, named Twubakane (Kinyarwanda for "let's build together") during the design phase, had the goal of increasing access to and the quality and use of family health services in health facilities and communities by developing the capacity of local governments and communities to ensure improved health service delivery.

The District Incentive Fund (DIF) grant initiative was a unique feature of the Twubakane Program. The DIF grants were planned to provide a total of 6 USD million in funding directly to Rwanda's districts to strengthen capacity and improve health service delivery at decentralized levels.

The purpose of the DIF assessment, conducted during the last quarter of the Twubakane Program, was to ascertain how the DIF grants helped strengthen decentralized health systems and improve health outcomes from 2005 to 2009 in the 12 Twubakane-supported districts, and to make recommendations regarding similar or future granting mechanisms for Rwanda.

Map 1. Twubakane's 12 Districts of Intervention



1.2. Rwanda's Health Care System

The Rwandan government has made universal health care for all a national priority. The Government of Rwanda's (GORs) Health Sector Strategic Plan (HSSP II, 2009–2012) supports strengthening of interventions along three strategic objectives: (1) maternal and child health, family planning, reproductive health and nutrition; (2) prevention of diseases and promotion of health; and (3) treatment and control of diseases. Rwanda's national community-based health insurance (known as *mutuelles*), its performance-based financing (PBF) system for health care providers,¹ and the national policy for health care quality have all contributed to increased use of services and quality of care.

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

1.3. Health in Rwanda

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

Table 1. Key Maternal and Child Health (MCH) Indicators (DHS Surveys)²

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

The contraceptive prevalence rate in Rwanda increased dramatically from 4 percent in 2000 to 10 percent in 2005. By early 2008, modern contraceptive use was 27.4 percent, an additional dramatic gain in less than three years. Although Rwanda has made unprecedented advances in the use of modern contraception, the country's total fertility rate is still high at 5.5. The issues of population growth and FP are prominent in Rwanda's 2008-2012 Economic Development and Poverty Reduction Strategy (EDPRS). Results from Rwanda's interim Demographic Health Survey (DHS) of 2007-08 identified decreases in the under-five mortality rate (from 152 per live births in 2005 to 103), infant mortality rate (from 86 to 62), and neonatal mortality rate (from 37 to 28). The maternal

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

² Barrere T, et al. Enquête Démographique et de Santé, Rwanda 1992. Calverton, Maryland; MacroInternational Inc, 1994. Office National de la Population (ONAPO) [Rwanda], ORC Macro. Enquête Démographique et de Santé, Rwanda 2000. Calverton, Maryland; ORC Macro, 2001. Institut National de la Statistique du Rwanda (INSR), ORC Macro. Rwanda Demographic and Health Survey 2005. Calverton, Maryland; INSR and ORC Macro, 2006. National Institute of Statistics (NIS) [Rwanda], Ministry of Health (MOH) [Rwanda], and Macro International Inc. Rwanda Service Provision Assessment Survey 2007. Calverton, Maryland; NISR, MOH, and Macro International Inc., 2008.

mortality rate is high at 750 per 100,000 live births, but was last measured nationally during the last full DHS of 2005 DHS. Interim DHS results indicated promising results related to maternal health; births delivered by a health professional increased from 39 percent in 2005 to 52 percent in 2007-08. Although 96% of women use antenatal care (ANC) services, most seek their first visit late in their pregnancy, and do not attend the recommended four ANC visits.

1.4. Decentralization

When the Twubakane Program was designed in 2004, Rwanda was composed of 12 provinces (including Kigali City), 106 administrative districts and 40 health districts. In July 2005, the Ministry of Local Government, Good Governance, Community Development and Social Affairs (MINALOC) announced an ambitious and wide-reaching plan to condense the country's second phase of decentralization (originally scheduled for 2005-2009) into a much shorter period of time (about six months). With country-wide redistricting as the cornerstone of this effort, MINALOC streamlined the governance structure into four regions (plus Kigali city), and 30 districts. This phase was intended to lead to better district- and sector-level coordination and integration in the areas of health, education, housing, environment, and data collection.

The decentralization process has had and continues to have a major impact on all levels of government. In addition to the territorial reform and redistricting, the 2005/2006 phase of decentralization established new roles and responsibilities at all levels. Under the new administrative system, the GOR eliminated the distinction between health districts and administrative districts, incorporating the health districts into the districts as departments of health and social services. In addition, local government entities (including district-level education, health, and administrative officials) became accountable to the same constituents, and were managed by the same district authorities. In the health sector, each district established a district health office under the direction of a newly hired health officer who had overall responsibility for budgeting, planning and overseeing health services in district facilities, including district hospitals, health centers and health posts. Formerly, overall responsibility had been vested in the district hospital director who reported directly to the Ministry of Health (MINISANTE).

As part of the second phase of decentralization, the GOR introduced *imibigo*, performance contracts between each district mayor and the President of Rwanda describing commitments for improvements in health, education, agriculture, as well as other facets of district administration. The *imibigo* contracts have served as a mechanism to reinforce motivation for improving health service delivery, enhancing district mayors' and other authorities' understanding of the connection between development and health, and strengthening their role as public health advocates.

In August 2007, MINALOC published the Rwanda Decentralization Strategic Framework (RDSF) as implementation guidelines for the National Decentralization Policy to promote good governance; reduce poverty; and improve the efficiency, effectiveness and accountability of public sector service delivery. As outlined in the framework, each level of government from central to village has responsibilities to ensure that quality health care services are delivered, including provision of basic health care and HIV/AIDS-related care; promotion of basic hygiene and good nutrition; and promotion of national medical insurance.

The accelerated push for decentralization was not anticipated when the Twubakane Program was first developed by USAID and the GOR. Originally, the program was designed to work in four provinces (Gikongoro, Gitarama, Kibungo and the city of Kigali), which comprised 11 health districts and 35 administrative districts. In early 2006, pursuant to the redistricting, Twubakane shifted to supporting 12 of the country's 30 new districts (which closely aligned with the four former provinces). In the 12 selected districts, the Twubakane Program has had six integrated components: 1) family planning and reproductive health; 2) child survival, malaria and nutrition; 3) decentralization policy, planning, and management; 4) district-level capacity building; 5) health facilities management and *mutuelles*; and 6) community engagement and oversight.

2. District Incentive Fund (DIF) Initiative

2.1. Overview

As originally designed, the District Incentive Fund (DIF) grants were expected “to support discrete elements of the district's integrated district plan and budget as they relate to integrated health” and “to be programmed, where appropriate, in combination with TA (technical assistance), training, and/or other recipient inputs toward achievement of specific objectives that respond to expressed local needs and contribute to achievement of program objectives.” As put forth by the Twubakane Program, the DIF grants therefore had three broad objectives:

- 1) To encourage districts to commit resources to improve access to and use of high-quality health care services;
- 2) To build the capacity of district-level health officials to undertake their work more effectively;
- 3) To encourage district-level collaboration on planning, monitoring, and evaluation of integrated health services.

2.2. DIF and the Twubakane Program

The Twubakane Program had the goal of increasing access to, quality of, and utilization of family health services in health facilities and communities by strengthening the capacity of local governments and communities to ensure improved health service delivery at decentralized levels. Among the six program components, the fourth component aimed to strengthen the capacity of districts and sectors to plan, budget, mobilize resources and manage services, with an emphasis on health services. The DIF grants were a key element of this component. Through the DIF funding process (described below), the DIF grants afforded districts the opportunity to implement high-priority activities focused on improved planning, budgeting and delivery of health services. The grants also facilitated district-level integration of all six components of the Twubakane Program.

2.3. DIF Start-up

The DIF grants were originally scheduled to begin in 2005, during the first year of Twubakane Program implementation. However, in light of the changes brought on by redistricting and accelerated decentralization (announced in mid-2005), the Twubakane Program delayed the launch

of the grants until 2006, when the new districts were officially established and locally elected district mayors were in place.

In early 2006, the Twubakane team worked closely with key representatives from the MINALOC, MINISANTE and USAID to develop a DIF Grants Procedures Manual that provided complete instructions, application forms, and tools and details on the application and awards processes, financial procedures, grants management, and evaluation. The manual, made available in French and English, sought to make the DIF process as transparent and user-friendly as possible.

Prior to the launch of DIF grants, district and sector officials received an orientation from Twubakane Program staff on the grants program, the manual and the rollout plan. District-level accountants also received training and orientation to learn how to prepare budgets according to DIF procedures.

The DIF grants were officially launched in July 2006, at a ceremony (held in Ruhango District) attended by the Minister of MINALOC, the Permanent Secretary of the MINISANTE, the USAID Director, district mayors and other local authorities. Eleven districts received their first disbursement of funds in July; the remaining district, Nyaruguru, received funds in the fourth quarter of the year due to delays in planning for a major health center renovation (their principal project for that year).

2.4. DIF Award Amounts

As a result of the initiation of the second phase of decentralization and the redistricting that took place in late 2005 and early 2006, the initial proposal for the Twubakane Program allocation for the DIF grants was revised to total 6 USD million of grant funding, or an average of 500,000 USD over a four-year period to each of the 12 Twubakane-supported districts (see Table 2). These allocations were intended to correspond to the Program’s new geographical zone, and were approved by USAID, MINISANTE and MINALOC in early 2006.

Table 2. Anticipated timetable for DIF allocations to 12 Twubakane districts

	Anticipated Annual Allocation	Districts	Total
Year One	Delayed	---	---
Year Two	\$100,000	12	\$1,200,000
Year Three	\$150,000	12	\$1,800,000
Year Four	\$150,000	12	\$1,800,000
Year Five	\$100,000	12	\$1,200,000
TOTAL			\$6,000,000

2.5. DIF Grants Process

The Twubakane Program established a number of criteria and procedures for awarding DIF grants. The criteria, outlined in Table 3, considered administrative, programming, and analytical/technical aspects of the proposed activities. Activities funded by the DIF grants were required to be health-oriented and clearly described in the five-year District Development Plan (DDP), in the Medium-Term Expenditure Framework (MTEF), in the annual district action plan and budget, or in the district’s *imihigo*, or performance contract.

DIF-supported activities also were expected to promote overall Twubakane Program goals and strategies (including participatory planning approaches, and communication and partnership initiatives), build local capacity to implement decentralization policy initiatives, and increase district revenues for health, through strengthening participatory planning and budgeting to increase resources for health, and, in some cases, through supporting updated tax rolls and models for increasing tax revenue for health.

Table 3. DIF award criteria

Category	Criteria
Administrative	<p>Districts must:</p> <ul style="list-style-type: none"> ▪ comply with USAID regulations ▪ have financial and accounting procedures that conform to Rwanda’s Local Administration’s Financial and Accounting Management Procedures Manual ▪ have appropriate internal audit and control systems ▪ have effective and adequate filing systems ▪ contribute cost share valued at 15% of funds received
Programming	<p>Activities must:</p> <ul style="list-style-type: none"> ▪ be part of district development plan or other comparable plan ▪ consider access to and quality of health services ▪ consider environmental impact ▪ ensure sustainability strategy for continuity of health service delivery and for district capacity in planning, budgeting and managing local resources ▪ generate additional resources <p>Requests must:</p> <ul style="list-style-type: none"> ▪ identify direct beneficiaries ▪ be non-discriminatory ▪ demonstrate/encourage women’s participation in the planning of activities
Analytical/ Technical	<ul style="list-style-type: none"> ▪ Expenses must be for activities clearly presented in district development plans and annual action plans ▪ Activities must be selected to solve specific problems and must be technically feasible and appropriate ▪ Implementation costs and activity budgets must be within reasonable limits and follow established norms and standards

In respecting the above-listed awards criteria, districts submitting initial DIF applications were required to include the following:

- Completed application form with information about the district and the proposed activities, signed by the District Executive Committee members.
- Funding request letter for and narrative of the activities that briefly described:
 - the activities to be funded and their goals
 - the location/s, beneficiaries, and the health center
 - the amount requested
 - the duration of implementation of activities
 - the banking references for the account established to receive transfers from Twubakane.
- Detailed budget for the proposed activities, including the recipient’s cost-share contribution, 15% of the budget.
- Copy of the district’s DDP and annual action plan and budget.

For each annual grant funding cycle, a review committee composed of Twubakane Program technical and administrative staff evaluated the districts' DIF grant requests. Using the defined criteria, the Twubakane committee evaluated the quality of the proposal's budget and narrative to determine whether the proposed budget was realistic and whether the proposed activities were in line with the district's development plans and performance contract. The team used an evaluation tool and checklist, designed as part of the manual development, to ensure a consistent review process. As part of the evaluation, the Twubakane team considered the average time needed for each district to spend and justify each transfer of funds (number of months versus dollar value), and the average time needed for each district to complete a full DIF activity cycle (number of months from issue of award to receipt of completed final reports). After review, the committee provided feedback to the districts and, in most cases, requested additional information and recommended adjustments. The district team subsequently revised its application to ensure conformity with DIF requirements.

After final review and approval by the Twubakane review committee, IntraHealth's Senior Grants and Contracts Manager (headquarters-based) and the district mayor signed a contract. Districts next submitted their initial request for a funding advance, limited to the minimum amount necessary for start-up costs (no more than 25% of the DIF grant total). To initiate the process of funds transfer, districts were required to open a sub-account (reserved for DIF grants under the district's name) in a local commercial bank or the *Banque Populaire du Rwanda*. Management of this sub-account, which was a requirement of the donor, USAID, helped districts build capacity to manage grant funding. Districts received the approved funds through a direct transfer payment into the sub-account. All payments were made in the local currency, Rwandan Francs (RWF).

Payments were made in allotments, initially following USAID instructions and directives for "Fixed Obligation Grants." However, after it became apparent that districts were not ready to manage some of the requirements of "Fixed Obligation Grants," the allotment mechanism was changed to that of "Simplified Subgrant Agreements," which enabled Twubakane to practice stronger monitoring of the subgrants. Twubakane staff also offered guidance to the districts on following and meeting the USAID regulations. In 2009, four districts that were particularly successful with the management of their 2009 grants received additional funds (25,000USD) granted through the "Fixed Obligation Grants" mechanism, reflecting the increased capacity of those districts to manage grants under the more advanced funding mechanism.³

All subsequent transfers of funds were made with reference to the following disbursement criteria, which were all included in the grant agreements:

- an agreed-upon disbursement schedule;
- successful implementation of project activities;
- defined milestones or benchmarks;
- justification of use of prior DIF funds (supported by banking statements, bank reconciliation, and banking journal, all showing and confirming the DIF fund balance); and
- availability of USAID funds.

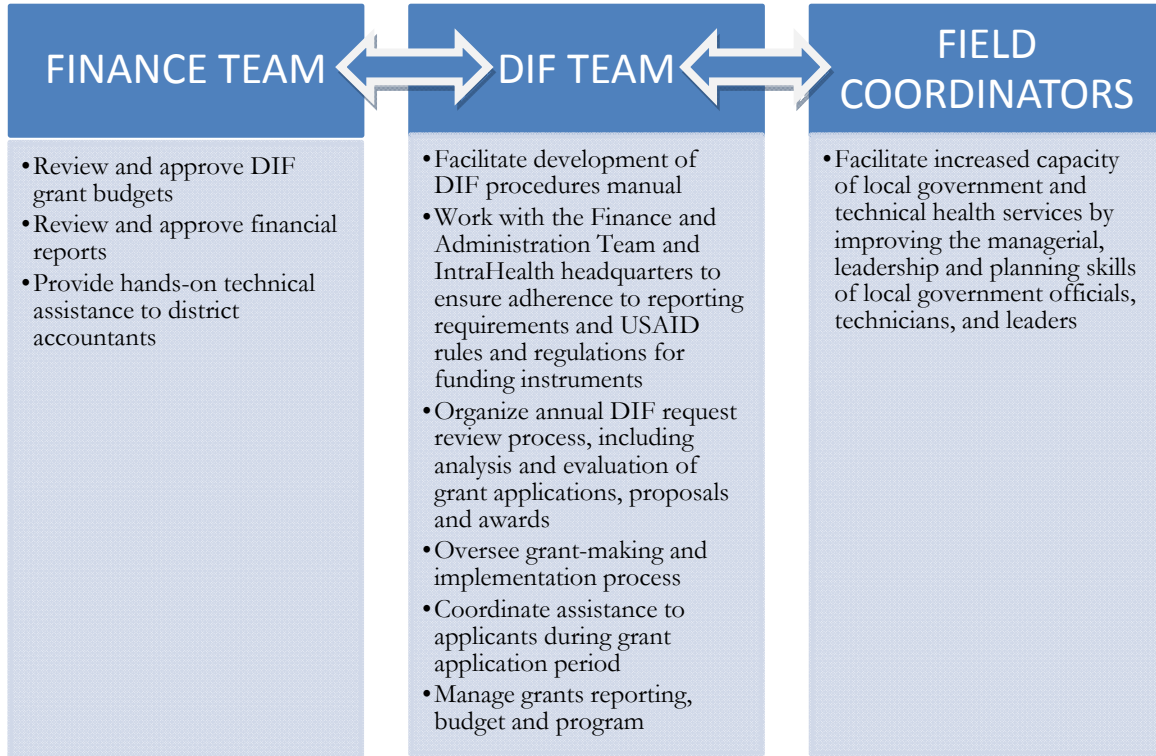
³ Both mechanisms are described in detail in USAID's Automated Delivery System, or ADS, at <http://www.usaid.gov/policy/ads/300/303.pdf>

2.6. DIF Grants Management

Figure 1, below, illustrates the roles and responsibilities of the Twubakane team staff members involved in the DIF process. The DIF Grants Manager was responsible for overall implementation and management of the grants. The Grants Manager’s specific responsibilities included liaising with the Twubakane Technical Team Leaders, overseeing the process of issuing solicitations or tenders using appropriate instruments in contracting, and conducting capacity-building with local counterparts in implementation of the instruments. The DIF Grants Associate Manager supported the DIF Grants Manager. Within the Twubakane finance and administration team, a designated DIF Accountant supported the payments and reconciliation process, with oversight from the Finance and Administration Team Leader.

To facilitate the various program activities at the district level, Twubakane engaged five Field Coordinators. The Field Coordinators, supported by Field Assistants, were assigned to cover two to three districts and were responsible for working closely with local authorities, opinion leaders, and community representatives to encourage them to fully participate in the health and decentralization program. The coordinators and their assistants also ensured the follow up, supervision, and monitoring of Twubakane activities, and provided technical assistance to decentralized entities on planning, budgeting and managing local resources.

Figure 1. Twubakane team members’ DIF roles and responsibilities



2.7. DIF Monitoring

As part of the DIF requirements, each district submitted detailed quarterly and annual reports of activities, milestones, and finances. The quarterly monitoring requirements were intended to provide information throughout the performance period that would allow Twubakane to anticipate and support troubleshooting of problems related to implementation or financial issues. Each district was responsible for submitting two types of quarterly reports and two annual reports:

Quarterly:

- A technical/program report on each completed milestone, including a status update on all activities, problems encountered, successes obtained, and relevant performance indicators.
- A financial report to justify each transfer received by the district from Twubakane, including all original accounting documents involved in the implementation and financing of activities from start-up to project close-out.

Annual:

- A cost-share report to confirm the district's cost-share match (including financial information documenting this contribution).
- A final report (required at the end of each annual grant cycle).

District accountants received and reviewed receipts prior to submitting the quarterly financial report to the Twubakane finance team. The Twubakane finance and DIF teams reviewed the quarterly reports, sending the reports back to the districts if documents were not conforming or missing needed information. This review and approval process for financial reports was a precondition for each subsequent disbursement of funds. The Twubakane team also cross-checked for consistency between technical and financial reports.

The Twubakane team continuously evaluated districts' performance in making strategic management decisions, using a series of database indicators to take stock of each district's capacity to plan, budget, and report on its grants (see Table 4). Once the annual grants were awarded, Twubakane team members carried out periodic site visits (usually quarterly) that indicated, in both a quantitative and ad hoc manner, how each district was responding to and learning from implementation challenges. These visits included assistance from Twubakane accountants to build capacity of district and health facility accountants, verify accurate accounting practices and, when needed, help districts prepare their financial report submissions. Twubakane technical staff also visited district grant activity sites and events to provide support and advice (e.g., specifications regarding equipment purchases for health facilities, curriculum content for training activities, message clarification for health sensitization events, policy on decentralization elements). The field coordinators also performed a monitoring role, ensuring timely submission of required technical and financial progress reports by the districts for each and every disbursement of funds; and providing weekly monitoring and technical advice to grantees and beneficiaries. The Twubakane team used all these sources of information to track each district's overall progress from year to year, and to manage risk by comparing the performance of one district against another.

Table 4. Monitoring roles of Twubakane technical and field office staff

Twubakane Staffing Level	Monitoring Activities
Technical Staff	<ul style="list-style-type: none"> ▪ Develop DIF grants management manual and tools ▪ Provide annual orientation on grants management procedures ▪ Conduct project site visits (grants managers and team leaders) ▪ Conduct accounting site visits (accountants) ▪ Provide technical advice on implementation ▪ Write progress reports ▪ Ensure full documentation of all steps of DIF grants process (proposals, contracts, site reports, financial/technical reports)
Field Office Staff	<ul style="list-style-type: none"> ▪ Coordinate regional peer review workshops at the end of each DIF grants cycle ▪ Ensure timely submission of technical and financial progress reports for each disbursement of funds ▪ Provide weekly monitoring and technical advice

2.8. Peer Review of DIF Process

In addition to the ongoing monitoring of the DIF grant provided by the Twubakane team and district authorities, Twubakane initiated a review process to identify areas and processes in need of improvement, and to provide a means for districts to exchange and learn from their experiences.

In early 2006, mayors, vice mayors and districts technicians were trained on DIF procedures. Then, each following year, the districts' accountants participated in a one-day refresher training course focused on financial management and accounting best practices. The course also reviewed grants tracking mechanisms, including presentation of financial reports, use of Excel accounting spreadsheets, internal accounting audits and controls, and bank reconciliation.

At the end of each annual DIF grants cycle, regional workshops were held to facilitate peer review and generate recommendations regarding DIF grants implementation, district performance, and Twubakane and other stakeholder involvement.

In addition, district mayors, vice mayors, executive secretaries, planning directors and other designated point persons carried out regular progress reviews and assisted in mitigating conflicts and delays (particularly delays of contractors not meeting deadlines or expectations regarding quality of work). District officials also were expected to sign off on and be present during the completion of activities, and to verify the quality of materials and services.

In late 2006, the Twubakane Program planned and facilitated peer exchange visits among districts within each region to allow DIF stakeholders to trade experiences and best practices on the management of DIF grant activities. In addition to two group meetings involving Eastern Province districts (in October) and Southern Province districts (in November), individual peer-to-peer exchange meetings also took place in each of the three districts of Kigali during the month of November. The peer exchanges brought together district executive secretaries, planning directors, accountants and vice mayors, as well as representatives from the provinces, MINALOC and

MINECOFIN (Ministry of Economic Planning and Finance). During these exchanges, participants reviewed progress on implementing DIF grants activities, discussed problems, shared solutions, and prepared for the planning of 2007 DIF grants contracts and activities.

In September 2008, a three-day evaluation workshop was organized to allow the districts to present results from DIF activities implemented in 2006 and 2007, to suggest best practices in DIF grants management, to share success stories realized through the DIF grants, and to discuss challenges and lessons learned.

3. Methodology

The DIF assessment took place in October—November 2009. The overall purpose of the assessment was to examine the DIF grant initiative's contributions to the Twubakane Program's efforts to strengthen decentralized health systems and improve health outcomes. More specifically, our objective was to document the DIF grants as a promising practice and key component of the Twubakane Program's broader platform of health and decentralization interventions.

In addition to considering the overall impact and successful aspects of the DIF approach, we also sought to examine challenges encountered and lessons learned.

3.1. Research Questions

The assessment sought to answer three research questions, corresponding to the DIF initiative's three objectives:

Research Question 1:

Did the DIF grants improve the **provision, quality and use of family health services** in Twubakane-supported districts?

Research Question 2:

Did the DIF grants build and strengthen **districts' capacity** to carry out planning, budgeting, and reporting functions within the structure of decentralization?

Research Question 3:

Did the DIF grants support and facilitate **collaboration and participation** between hospitals, health centers, the public and private sectors, and representatives of the community and civil society to plan and prioritize health activities?

3.2. Study Design

Methods

The assessment used a mixture of qualitative and quantitative methods to gather key stakeholders' opinions and experiences, and to examine the impact of the DIF grants. The four data collection methods (described in greater detail below and in Annex A) included:

- 1) Review of **project documents** to consider the background and evolution of the DIF grants.
- 2) **Interviews and focus group discussions** with key stakeholders at the central level and in five districts, as well as, separately, with Twubakane staff.

- 3) **Self-administered questionnaires** in 7 districts.
- 4) Cross-checking of results with district and project **performance indicators** tracked since the project's inception.

We developed three similar (and complementary) interview guides in both French and English (see Annex B). In general, the interview guides asked respondents to describe:

- The DIF mechanism
- The DIF grants' contributions to overall results in decentralization, health and capacity-building
- Activities implemented by the DIF grants
- Potential for DIF mechanism to be recommended as a promising or best practice to the GOR and other development partners.

Participants

Five broad categories of informants participated in the interviews, focus group discussions, and survey: central-level representatives, district administrators, sector administrators, health center managers (*titulaires*), and PAQ representatives. Twubakane staff from the DIF team, the technical team, and the finance and administration team were also interviewed separately in two focus groups.

Data Collection

The assessment was conducted by an internal Twubakane Program field team, with assistance from technical and monitoring and evaluation (M&E) staff from the IntraHealth and RTI home offices (see Annex C for a complete list of DIF assessment team members).

Sampling

Sampling was done purposefully to capture the Twubakane Program's 12 districts as well as central-level stakeholders most involved with or significant to the DIF process. Five districts were selected for interviews and focus group discussions on the basis of geographic representation and district performance. Specifically, five districts were chosen that represented all three Twubakane zones, and had either experienced notable *successes or had faced particular challenges with* DIF implementation. In the seven remaining districts respondents completed a self-administered questionnaire.

Performance Indicators

The DIF grants were a component of the larger Twubakane Program—which, in itself, was a part of the GOR's strategy for health and decentralization in Rwanda. To situate district performance within the context of these broader efforts, we reviewed the data collected with selected indicators from the Twubakane Program performance monitoring plan (PMP) indicators that have been tracked since the inception of Twubakane and DIF.

4. Results

4.1. Study Participants

Overall, approximately 110 individuals were interviewed or responded to the questionnaire. Below in Table 5, the number of individuals who participated in each data collection method is displayed.

Table 5. Data collection methods, by number of districts and respondents

Data Collection Method	Number of Districts	Number of Respondents
Central-level interviews	N/A	6
Individual interviews	5	5
Focus group discussions	5	8-12 per group
Self-administered survey	7	46

The selection of respondents for the individual, focus group, and self-administered interviews aimed to allow for as diverse experiences with and remarks on the DIF process as possible. Despite the diversity of experiences and remarks of participants, strong trends emerged across the groups of respondents, allowing conclusions on the DIF mechanism to come forward from well-documented data. Instances of variance were usually to outlier districts' experience. For example, those districts which found it particularly challenging to secure cost share shared a less positive opinion on the DIF mechanism's cost share requirement that those districts which secured their 15% cost share with little difficulty and which, in fact, praised the requirement.

Central-level Interviews

The six central-level respondents included two former MINISANTE and MINALOC representatives; a USAID representative; a RALGA program officer; a municipal vice mayor; and provincial governor.

District Interviews

Data collectors interviewed one individual in each of the five districts selected by the project for in-person interviews. Selection was based on identifying individuals with some insight of the DIF. As determined by availability, respondents included a mayor, two vice mayors, a district council member, and a field coordinator for a non-USG partner organization (GTZ).

Focus Group Discussions

From 8 to 12 individuals participated in each of the five district focus group discussions, for a total of 55 respondents. Most focus group participants represented the district level, including vice mayors, directors of various departments (i.e., finance; human resources; infrastructure; good governance; health and family promotion; economic development; and the District Executive Secretary, Planning Director), accountants, and procurement officers. Other participants included health center managers, sector executive secretaries, and PAQ team representatives.

Self-administered Survey

A total of 56 surveys were distributed in-person by Twubakane field coordinators to potential respondents in the seven remaining Twubakane-supported districts. Of these, 46 were completed between October 21-30, 2009 for a total response rate of 82%. The field coordinators delivered the blank surveys to the districts, assisted respondents in filling out the surveys, if needed, and returned the completed surveys to Twubakane. Survey respondents' professional affiliations were similar to those of the interview and focus group participants, but also included some directors of education, youth, sports and culture.

4.2. DIF Overview

District-level representatives participating in focus group discussions conveyed a broad level of support for the DIF initiative. Focus group participants described the DIF grants as:

- **Enabling:** “With the DIF, a district can prepare [and execute] a financially viable project.”
- **Incentivizing:** “The DIF grants are funds to motivate districts.”
- **Practical:** “The DIF grants are funds that allow us to rapidly execute projects.”
- **Focused on district needs:** “The DIFs are shared funds that are designed to ensure and promote district development in specified domains.”
- **An element of the Twubakane Program:** “The DIFs are funds that fall within a district’s budget priorities for health and decentralization in the context of district-Twubakane financial agreements.”

With the requirement to address district development plans and local health priorities as a springboard, from 2006 to 2009 the DIF grants were used to fund 212 activities focused on health services, district capacity, and community participation and collaboration. The activities funded can be broken down into three broader categories and five specific subcategories, as follows:

- Health Services:
 - Health equipment and improvements to health and public hygiene infrastructure
 - Activities to support sustainability of *mutuelle* payments for indigents
- District Capacity:
 - District administrative capacity-building activities
- Community Participation and Collaboration:
 - Health-related training of local authorities
 - Community mobilization and communication activities

As Figure 2 shows, health services captured the largest proportion of DIF support over the four-year period (101 activities). This is not surprising given that the program focused on health and decentralization. Also, one of the criteria of the DIF activities was that the activity “considers access and quality of health services”. Throughout the program period, districts also recognized the DIF grants as a mechanism which allowed them to focus on health indicators included in the *imibigos*. Renovations of health centers, for example, permitted the population greater access to health services, thereby improving indicators for those districts selecting this DIF activity.

Figure 2. Number of DIF activities funded from 2006-2009, by category of support

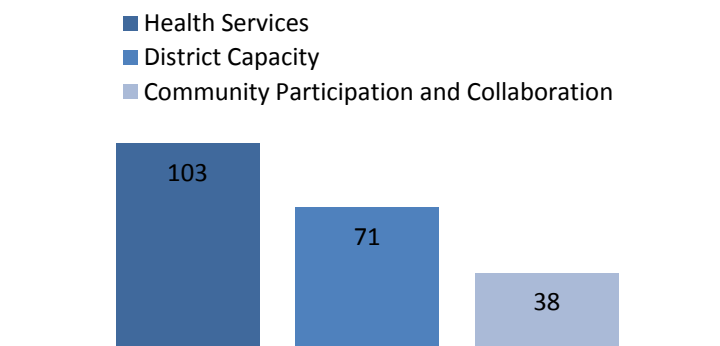
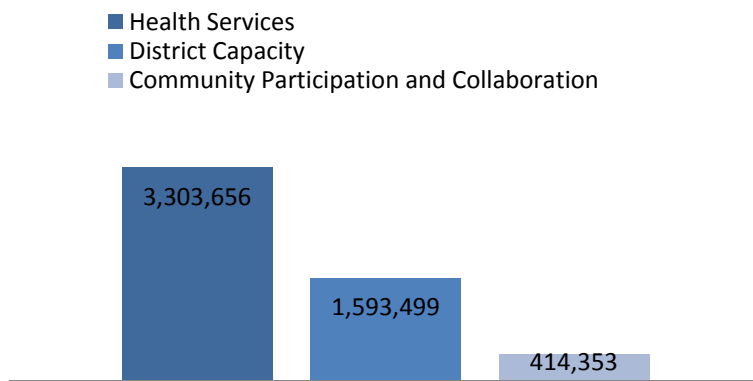


Figure 3. Cost of DIF activities in USD from 2006-2009, by category of support



4.3. DIF Impact on Family Health Services

The first research question explored the role of the DIF grants in improving the provision, use and quality of decentralized family health services in Twubakane-supported districts. In this section, we consider respondents' general perceptions regarding the role of DIF in strengthening service delivery and the types of activities that were deemed most "successful," the perceived impact of DIF activities on the quality of health services, performance indicators related to service use, and the number of health services-related activities funded by DIF.

Perceived Impact of DIF on Strengthening Health Services

One of the core requirements of the DIF grant mechanism was that activities proposed for DIF funding respond to actual district health needs. A central-level respondent commented on this opportunity for districts to target DIF funds to district priorities:

The DIFs are demand-driven, not only for the decision of what activities to fund but also in the execution. This is really positive, more efficient. The districts ask for what they want and need. [...] [The DIFs] ensure that funds actually reach the beneficiaries...ensure that money is being used in a proper manner for the defined activities. [It is] a mechanism that protects the beneficiaries.

-Provincial governor

Within this general framework, stakeholders at MINISANTE and other central-level agencies reported especially valuing the grants' "flexibility and adaptability," citing the DIF awards as a means of "strengthening the entire health system" (as opposed to earmarking funds for a specific disease or program). District-level respondents shared this appreciation for the fluidity of the DIF funding mechanism. One respondent described a "substantial improvement in health services" and suggested that the progress could be largely attributed to "being able to choose our own projects." In a focus group discussion, another district representative called attention to the DIF grants' "flexibility," commenting that "[other] partners have a tendency to compel us [to implement] activities that are comparable and thus repetitive." Finally, an interviewee straightforwardly remarked that DIF had "helped enormously to support and finance missing or inadequately funded health services."

In the seven districts where decision-makers shared opinions about the DIF program via self-administered questionnaire, respondents (N=46) were asked two questions about the impact of DIF on the health care system. On a scale of 1 (“no improvement”) to 5 (“much improvement”), respondents (on average) ranked as “4” DIF-related improvements in service delivery and service use, suggesting that there is widely shared agreement that DIF grants have played an important role.

Some respondents emphasized the importance of viewing the DIF grants within the broader context of the Twubakane Program and its goals of integrated and improved family health services at decentralized levels. As one district focus group participant stated, “the successes of the DIFs are inseparable from the other components of Twubakane.”

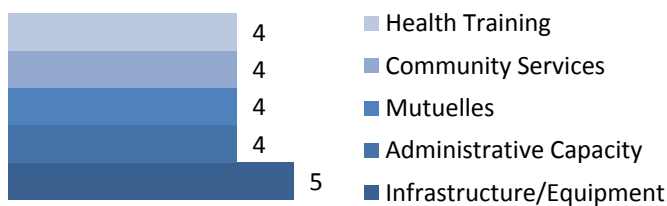
When asked to describe successful DIF-supported activities directed at health services delivery, study participants at all levels mentioned the procurement of equipment (for hospitals and health centers) and health facility renovations or infrastructure improvements as among the most important examples of success. These two activities were cited by central-level respondents as well as by participants in all five district interviews and most of the focus group discussions.

Focus group participants also discussed other categories of DIF grant impact, including positive impact on health facilities (better equipment, improvements of infrastructure, renovations), on the use of services and *mutuelles* (increased use of services by *mutuelles* members, increased *mutuelles* membership), and on community participation and collaboration in the health sector (such as better support to community-provider partnership, or PAQ, teams, increased provider trainings).

Consistent with the qualitative results, district stakeholders participating in the self-administered survey also highlighted infrastructure and equipment as key areas of DIF impact. In response to a question about “which DIF-funded activities were most successful,” respondents gave the highest possible score (5) to “infrastructure or administrative improvements (such as public hygiene facilities, communication technology, and medical equipment)” (see Figure 4 below).

In the district survey, similar categories of activities to those mentioned by focus group respondents also received a relatively high rating of “4” (see Figure 4 below). Calling attention to increased use of services, one focus group participant commented that the DIF grants had had “a remarkable and positive impact [on service use]—suddenly, the population more readily seeks care in the district rather than going elsewhere.” A donor representative straightforwardly credited DIF grants with achieving targeted levels of participation in the *mutuelles*.

Figure 4. Average score for successful DIF-funded activities, district survey (N=46)



Quality of Health Services

In describing DIF successes, a small number of respondents referred to the impact of DIF-funded health activities on the quality of health services. Some respondents also equated enhanced quality with improvements such as new equipment: “Clients receive quality services [at the health post] thanks to the acquisition of equipment. Many clients now begin at the health posts instead of going straight to the health center.”

Focus group participants highlighted several ways in which DIF-supported activities had supported quality improvement, including through:

- Health post renovations
- Improved reception of clients
- More rapid transportation to health facilities
- Support for PAQ teams.

Performance Indicators: Service Use

Given the rapidly changing health and decentralization environment in Rwanda during the period of the Twubakane Program and the fact that the DIF grants allowed districts to select activities that responded to their needs, it is very difficult to establish direct links between indicators for district performance and health services use. We can draw inferences about the influence of DIF grants on health service use by examining two indicators from the Twubakane performance monitoring plan.

As Table 6 shows, the proportion of national couple years of protection (CYP, a proxy indicator for use of modern contraception) represented by Twubakane-supported districts was unusually large from 2006 to 2009, particularly in 2007. One possible interpretation for this initial difference is that Twubakane efforts, including notable DIF-funded interventions on family planning secondary posts and other family planning-related activities, have had a considerable influence on increased utilization of family planning services. However, changes in the proportion of national CYP in the Twubakane-supported districts since 2007 may indicate that the rest of the country is “catching up” in response to the national emphasis on modern contraceptive use, as well as efforts by MINISANTE, other projects, and requirements within the *imihigo* contracts.

Table 6. Couple years of protection offered by public facilities in Twubakane districts, 2006-2009

Year	Twubakane population as proportion of national population (3,503,699/9,895,627)	Twubakane CYP as proportion of national CYP	% greater than expected proportion of national CYP in Twubakane districts (percentage point difference between expected and actual)
2006	35.4%	38.6%	9.1% (3.2%)
2007	35.4%	54.6%	54.3% (19.2%)
2008	35.4%	46.4%	31.0% (11%)
2009	35.4%	43.2%	22.2% (7.8%)

Another indicator related to the influence DIF grants had on health service use is the utilization rates of health services by *mutuelles* members, as show in Table 7. A substantial number of DIF-funded activities focused on increasing membership to *mutuelles* across all districts. Prioritization and

selection of *mutuelles*-focused activities reflects the districts' understanding of this important health insurance program, the nationalization of the program (which occurred in 2007) and the desire of members to benefit from their membership. While utilization increased overall, the data remain uneven across districts (some positive utilization, some negative) reflecting the effect of other factors on utilization of services.

Table 7. Utilization rate of health services by mutuelle members, 2008-2009 (average number of visits per member per year)⁴

District	2008 Results	2009 Results	% Change
Gasabo	0.76	0.70	-8%
Kicukiro	0.50	0.71	42%
Nyarugenge	0.83	0.95	15%
Kayonza	0.69	0.86	24%
Rwamagana	0.79	0.70	-11%
Ngoma	0.66	0.90	36%
Kirehe	0.61	0.70	15%
Ruhango	0.56	0.62	11%
Muhanga	0.63	0.66	4%
Kamonyi	0.48	0.39	-19%
Nyamagabe	0.55	0.57	5%
Nyaruguru	0.65	0.65	-1%
Project Totals	0.64	0.68	7%

DIF Support for Health Services

Between 2006 and 2009, the DIF grants funded 103 activities aimed at improving local health services, representing about half (49% or 103/212) of the total number of DIF grants awarded. (The remaining DIF grants targeted the initiative's other objectives of district capacity-building and stakeholder participation or collaboration.) The total monetary value of the 103 activities was about 3,303,650 USD. In addition to significant investments in facility renovations to improve overall service access and quality, a wide range of activities received DIF grant support in accordance with district needs, including:

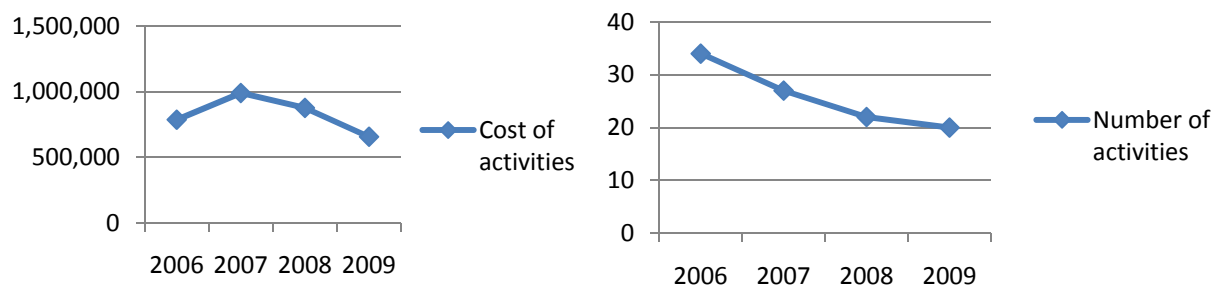
- **Malaria prevention**, including removal of standing water, distribution of insecticide-treated nets, education about malaria symptoms
- **Reduction of diarrheal diseases**, including hygiene and education efforts
- **Nutrition enhancement** through community gardens
- **Promotion of family planning** through training, support and materials for local leaders and community health workers
- Support for **maternal health** through improved transport for health facility-based **labor and delivery services**.

Although the health services category was the largest award category overall, the proportion of DIF monies allocated to health service improvement declined over the four-year period (Figure 5). In 2006, the number of activities was the highest that in any subsequent years, whereas the funding

⁴ Number of visits from January through August only

only more than that of the very last year of DIF activities. This reflects the statement made by some district focus group respondents and by Twubakane staff that, in 2006, at the beginning of the DIF, district stakeholders were unsure what priorities health-related activities would be acceptable and would have an influence on health services. In 2007, there was a large emphasis by districts on renovations of health facilities (all levels), a costly investment but on a lower number of activities. By 2008 and 2009, many of the most urgent and needed renovations had been accomplished and districts focused on other types of health inputs, which tended to be less costly (see Figure 5).

Figure 5. Number and dollar value of health services activities funded by DIF, 2006-2009



4.4. DIF Impact on District Capacity

The second research question examined the DIF grants’ success in building and strengthening districts’ capacity to carry out planning, budgeting, management and reporting functions within the structure of decentralization. In this section, we consider respondents’ general perceptions regarding the role of DIF grants in building district capacity and perceptions about “successful” capacity-building activities; indicators related to district capacity; and the number of capacity-building activities funded by DIF grants.

Perceived Impact of DIF on Strengthening District Capacity

The DIF grants were one of the Twubakane Program’s principal tools to build district capacity to plan, budget, and carry out key administrative functions related to health and other services. Somewhat paradoxically, districts were required to have some baseline planning, budgeting and management capacity to successfully apply for DIF grants, but also were expected to prioritize capacity-building as a key DIF objective. Throughout the implementation of the DIF grants, the Twubakane Program provided technical assistance to ensure districts’ ability to carry out planning, implementation and monitoring activities, and to help district staff build necessary capacity in accounting, financial and project management, and reporting.

From the perspective of central-level respondents, increased administrative capacity was a noticeable contribution of the DIF grants. One respondent stated,

The DIFs helped districts improve the financial management of funds received through other partners. Additionally, DIFs helped districts increase their capacity to manage projects and to justify expenditures. We see this when we see the proposals submitted, the technical and financial reports, and justification mechanisms for expenditures. [...] The capacity building in financial management, line item respect, non misuse of resources...helped other donors...[and] has increased trust in the districts’ ability to manage resources.

-Central-level respondent

In focus group discussions with district representatives, district-level respondents also expressed general appreciation for DIF grants' contributions to capacity, particularly as compared with other development efforts. An official commented,

Districts prefer the DIF mechanism because the committed funds are decentralized and managed by district authorities in collaboration with sector officials who know the needs of the population. [...] Through the DIFs, the district has a chance to prepare an action plan and take responsibility for project implementation, unlike other projects that keep control of the management and funding. This has allowed us to improve our capacity. ... Other partners finance... projects but they do not work with the districts to monitor the projects, and when there are problems, it is the district that suffers.

-District focus group

Most study participants highlighted the DIF grants' contributions to successful implementation of the performance contracts (*imibigos*) established between districts and the central level. In a few instances, DIF support facilitated the *imibigo* process. A focus group participant stated: "With the support of the DIFs, we developed the *imibigo* objectives as a group, and then the person in charge presented the objectives at the central level. Halfway through, we evaluated the *imibigo* financed by the DIFs." At a practical level, an interviewee noted that laptops provided with DIF monies had facilitated the preparation of *imibigo*, because "everyone comes with his or her laptop and that makes it easier to present and share information."

A greater number of respondents focused on the DIF grants' impact on actually achieving performance objectives. In one interview, a district representative remarked that the projects financed by the DIF were drawn from those listed in the *imibigo*. Another district reported achieving *mutuelles* membership of "nearly 100%" with DIF support, an *imibigo* objective. The same district also won a prize for attaining another *imibigo* objective—establishing a communication network between the district and the sectors. In yet another district, an interviewee credited the DIF grants with "improved [achievement of] *imibigo* targets from year to year." As this individual further commented, "DIF grant activities were included in annual *imibigo* contracts, and helped the district to meet requirements and report on results."

Planning

District stakeholders participating in the self-administered survey were asked how the DIF grants contributed—in the context of the second phase of decentralization—to "planning, management and budgeting capacity in the health sector and in other sectors." On average, respondents gave the highest possible score (5 = much improvement) to "health sector budgeting capacity"; however, respondents ranked capacity improvements in the other areas nearly as high (4), suggesting that most district officials perceive across-the-board gains in capacity. This conclusion is supported by survey respondents' equally high ranking (4) of "development of district administrative capacity" when asked to rate the most successful DIF-supported activities.

In interviews and focus groups, respondents particularly emphasized the DIF grants' impact on districts' capacity to conduct planning activities. Respondents in all five districts reported that, in early 2006, the newly created districts lacked leadership, tools, incentives, and planning skills. As one focus group participant stated, "In 2006, the planning process was not driven by priorities, but just by vague ideas." Calling attention to progress in this area, another focus group participant celebrated

the completion of the district's first-ever three-year strategic plan, and commented that "district officials at all levels [now] have planning capabilities—even when the directors are absent, the district is capable of going through the planning process."

Strengthened by the support of the DIF grants, respondents indicated that all districts now have District Development Plans (DDPs), Medium-Term Expenditure Frameworks (MTEFs), and annual plans. These plans are periodically reviewed by district personnel who have attended DIF-organized planning workshops and trainings. Some respondents went so far as to suggest that DIF had brought about a shift in the institutional mindset. In interviews, a district representative noted that "planning has practically become a new idea," while a district mayor remarked, "The planning process has become part of the district's very culture." Elaborating on the wider ramifications of improved planning, the mayor continued:

Planning has become a habit for the district, and is institutionalized. There are regular planning sessions every trimester. Every proposal is considered by all the different participants, and opinions are gathered around the table before any activities are selected. [...] Moreover, district staff members now have the capacity to help the sectors with their planning processes.

-District interview

A number of study participants discussed the funding of modern communication technology as a DIF outcome that facilitated planning. According to respondents, the DIF grants enabled districts to procure ICT equipment (including laptops and modems) not only for the districts but also for sectors and health facilities, allowing stakeholders to more rapidly and effectively coordinate planning. Focusing on the motivating effect of these practical supports, a focus group participant remarked that with the funding of electronic planning tools at health centers and sector offices, "health personnel can no longer complain that there are no modern instruments available [for planning and prioritizing district activities]." As a district representative explained,

The internet communication that has been established thanks to the DIFs has improved collaboration between districts and sectors. In the past, an official letter from a district to a remote sector could take one or two days to arrive. Today, thanks to the internet, the information is communicated instantly.

-District interview

In the course of considering the DIF grants' impact on planning capacity, some respondents were frank enough to discuss the shortcomings of early planning efforts and their consequences for the budgeting and implementation processes. In one focus group, a district representative described a not uncommon scenario, noting that "Certain activities were too difficult to execute and had to be replaced by others." In another district, a focus group participant described a failed attempt to build latrines: "The location of the latrines was not well thought out; they were built in the wrong public places, on access routes." In a similar example raised in a central-level interview, a respondent noted that a waste removal project "obviously [had not been] studied and was located too far from the market center; businesses were not pleased that they needed to travel so far (and consume fuel) to take care of waste removal."

Budgeting

Study participants shared some comments about the impact of the DIF grants on districts' ability to prepare detailed and accurate budgets. Respondents acknowledged that budgeting skills were generally poor at the outset of DIF, although some noted that the flexible nature of the DIF funds had allowed districts to tailor their efforts "in accordance with their financial strengths and weaknesses." Respondents credited DIF technical assistance and support with contributing to a shift towards stronger budgeting as well as "improved financial management of funds received through other partners."

Although districts participating in DIF initially were required to secure a 15% cost share, the actual cost share figures attained varied considerably over time and among districts. Some districts displayed an improved ability to meet the cost share requirement in 2008 and 2009. Although some districts indeed did not meet the 15% cost share target, aggregate cost share from the DIF grants program amounted to 1,378,785USD for a total initiative of 5,311,308USD, or nearly 26%.

Reflecting these varied figures, the cost-sharing component of DIF invited a number of comments from district representatives. For example, one respondent framed the cost share requirement in positive terms as "an opportunity for districts to demonstrate and assess their ability to mobilize their own resources" and "encourage partnerships and mobilize cost share from other district partners." In a similar vein, another individual suggested that "when districts invest some of their own money in an activity, it motivates them to obtain good results, and promotes a stronger sense of ownership." However, a respondent who endorsed cost sharing as a "good principle" and reported "understanding the concept very well" admitted that the district had not succeeded in collecting "100 percent of the cost share." Another respondent evoked the potential for the cost share element to place an undue burden on districts:

The cost share is not a burden to the extent that districts are well informed and take measures to prepare for it. [...] You have to clearly define the cost share to avoid having it become a surcharge. If districts don't have a [cost share] strategy in place, then the cost share becomes burdensome.

-District interview

Reporting and Management

Perhaps unsurprisingly, study participants described reporting as a major difficulty associated with the DIF effort. Nearly one third of respondents participating in the self-administered survey (30% or 14/46) described "timely submission of financial reports" as a challenge. A smaller proportion of respondents (9% or 4/46) perceived submission of complete and/or accurate technical reports to be challenging. District representatives participating in the focus group discussions agreed with survey respondents that reporting requirements posed a number of difficulties. As one focus group member openly admitted, "At the very beginning, we began to wish that the DIFs would end because management [of the DIFs] was too hard, but we were able to get some software that helped us better manage the activities."

District-level respondents identified inadequate staff capacity as one key factor contributing to financial and technical reporting challenges. As one interviewee commented, "Sometimes we lacked the technical capacity to prepare the technical and financial reports and to develop projects, partly

because we underestimated the time needed. As a result, we were not able to comply with the reporting and performance schedule.” Some respondents added that the reporting challenges were particularly acute in the context of the rapid administrative changes and staffing reforms associated with decentralization. Highlighting the low initial capacity of accountants and other staff, one interview respondent observed,

The second phase of decentralization in 2006 caused problems and required staff to learn new roles and responsibilities and ways of working in a decentralized context. Districts had to learn quickly and were dealing with a lot of changes. [...] 2006 to 2007 was a difficult and shaky period of time for the staff.

-District interview

Counterbalancing this perspective, a central-level respondent suggested that the timing of DIF had been “fruitful”:

In 2006, the districts were becoming aware of all the conditionalities and requirements of funding sources; the fact that DIF was there to accompany the districts to fill their new roles was important. ... Twubakane played a key capacity strengthening role and created a positive interaction with the districts.

-Central-level interview

Related to the problem of staff capacity were the dual problems of staff turnover (particularly of accountants) and staff workloads. In the self-administered survey, “staff turnover or transfer” and “unavailability of personnel due to workload” were the two most strongly endorsed DIF challenges, mentioned by 52% and 65% of respondents (24/46 and 30/46), respectively. One district representative compared a lengthy period of time without a planning officer as being “like a car without a driver.” Because planning officers are responsible for compiling and preparing reports, the absence of this position had an impact on the district’s ability to fulfill DIF reporting requirements. Another focus group participant cited the example of an accountant who quit two months after being trained. Describing the problem of overwork, a respondent in another district noted that “[At the beginning] there was only one poor accountant who was so overwhelmed with work that we had to find an assistant to lighten the load.”

As the preceding comments suggest, study participants were more likely to describe challenges than to discuss increases in capacity in the areas of reporting and project management. However, a focus group participant observed that “technical assistance (TA) for financial reporting was always available,” and added that the TA had not only resulted in “improvements in the quality and [timely] submission of the reports” but had also provided the district accountant with a template useful for managing other district funds. Also along favorable lines, an interviewee remarked that the “reasonable” scale of the DIF grants made it easier for districts to “manage and own the projects.”

Performance Indicators: Capacity-building

Performance indicators of district capacity to carry out planning, budgeting, management and reporting functions were difficult to assemble. However, responding to the described challenges associated with DIF reporting, we examined the percentage of Twubakane-supported districts that have mechanisms in place for public reporting on health sector financial performance. As Table 8 shows, two and a half times more districts had established health sector reporting mechanisms in 2009 (42%) as compared with 2006 (17%), when the DIF initiative was first launched.

Table 8. Percentage of districts with mechanisms in place for public reporting on health sector financial performance, 2006-2009

District	2006	2007	2008	2009
Gasabo	Yes	No	No	No
Kicukiro	No	No	No	No
Nyarugenge	No	Yes	Yes	Yes
Kayonza	No	No	Yes	No
Rwamagana	No	Yes	Yes	No
Ngoma	No	No	Yes	Yes
Kirehe	No	No	No	No
Ruhango	No	Yes	No	No
Muhanga	No	No	No	Yes
Kamonyi	Yes	Yes	No	Yes
Nyamagabe	No	No	No	Yes
Nyaruguru	No	No	Yes	No
Total	17%	33%	42%	42%

A second, more general indicator of district performance is provided by the annual evaluation of a district's performance against its *imibigo*, or performance contract. During the annual *imibigo* process, districts set performance targets in four areas: good governance, justice, economic development and human development. A district's capacity to plan, implement, monitor and report on *imibigo* activities for the annual *imibigo* evaluation requires precisely some of the types of skills and capacity fostered by the DIF.

Table 9 lists the country's top 10 districts as defined by *imibigo* performance for the years 2008 and 2009. In both years, half or nearly half of the country's top 10 districts were DIF grant beneficiaries. Also included among the top 10 in 2009 are two of the four Twubakane districts that received an additional 25,000 USD grant because of their strong and timely management of the first two 2009 DIF grant disbursements. A central-level respondent commented, "We really appreciate how the representatives of Twubakane are participating actively in the provincial partners' forum, supporting the *imibigo* with the district, helping to monitor and give advice. It wasn't by accident that [a southern province's district] was awarded as the best-performing district twice in two years."

Table 9. *Imibigo* performance in Rwanda, top 10 districts (2008-2009)

2008		2009	
District Name	DIF-supported?	District Name	DIF-supported?
1. Nyamagabe	√	1. Nyamagabe	√
2. Rulindo		2. Rulindo	
3. Nyagatare		3. Rutsiro	
4. Gasabo	√	4. Burera	
5. Gisagara		5. Muhanga	√
6. Rutsiro		6. Nyagatare	
7. Nyarugenge	√	7. Rubavu	
8. Kirehe	√	8. Gasabo	√
9. Burera		9. Ngoma	√
10. Nyamasheke		10. Nyarugenge	√

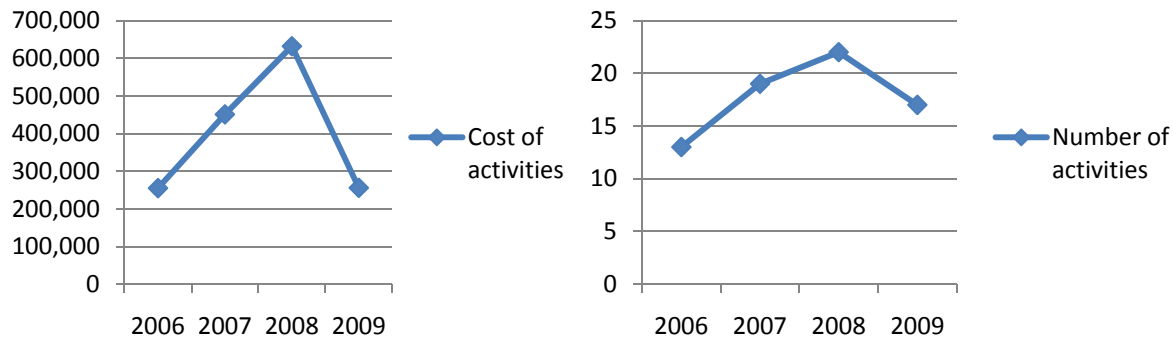
DIF Support for Capacity-building

Between 2006 and 2009, the DIF program funded 71 activities aimed at improving district capacity to plan, budget, manage and report on projects, representing a third (33% or 71/212) of the total number of DIF grants awarded. The total monetary value of the 71 awards was about 1,593,500USD. DIF funds were allocated to a wide range of activities to strengthen district planning and budgeting capacity, including:

- Support to update **taxpayer data bases**
- Purchase of **office equipment** and provision of **information technology (IT) training** to improve communication between district staff and stakeholders, and between districts and sectors
- Renovation of **municipal infrastructures**
- Support for production of **district development plans**
- Revision of **medium-term expenditure frameworks**
- Production of urban habitat **planning and zoning documents**
- Capacity-building for district technicians for 2009-2012 **budget and planning cycle**

In contrast to the pattern of decreasing funding for health services-related activities from 2006 to 2009, the number of capacity-building projects funded by DIF increased for the first three years, then dropped off in the final year (see Figure 6).

Figure 6. Number and dollar value of capacity-building activities funded by DIF, 2006-2009



4.5. DIF Impact on Collaboration and Participation

The third research question considered whether the DIF grants supported and facilitated collaboration and participation between stakeholders to plan and prioritize health activities. There were fewer comments pertaining to this objective as compared with the other two DIF objectives. In this section, we consider respondents' general perceptions regarding the role of the DIF grants in promoting collaboration and perceptions about "successful" activities, performance indicators related to participation and collaboration, and the number of activities funded by DIF that focused on collaboration.

Perceived Impact of DIF on Fostering Collaboration and Participation

Identifying health care priorities and determining how best to apply the DIF grants in response to identified needs was, by definition, a process that called for meaningful collaboration between a range of DIF stakeholders. General comments about collaboration focused on this improved ability to garner stakeholder input and identify priority health needs. A district focus group participant summarized the collaborative aspect of DIF in this way: “DIF has promoted collaboration among the district, the hospital, sectors and the health centers to provide health services that meet the priority needs of the population.” A focus group participant in a different district had similar comments: “The DIFs have allowed for a participatory planning process, because we bring everyone involved together in a positive atmosphere: health centers, sectors, PAQs, hospitals, and district representatives.”

District representatives who completed the self-administered survey generally gave high ratings to questionnaire items about the DIF impact on “collaboration in planning and setting priorities.” On average, respondents gave the highest score (5 = much improvement) to “collaboration between districts and hospitals.” A relatively high average score of 4 was obtained for collaboration between districts and all other stakeholder categories (e.g., health centers, public/private sectors, community representatives, central level). Echoing these scores, focus group participants highlighted the “meaningful involvement of officials at all levels” as a particular strength of the DIF approach.

In interviews and focus groups, comments about increased participation and collaboration focused primarily on collaboration between districts and community entities, and PAQ teams in particular. One focus group participant defined the DIF grants (somewhat narrowly) as “funds that help districts finance small-scale PAQ projects.” The partnership approach is inherent to the concept of the PAQ teams—community-provider partnerships that seek to increase community involvement in health center decision-making and management, and improve access to and use of high-quality family health services. As one central-level respondent put it, “This PAQ component [of Twubakane] is important because it helps people to serve themselves, to understand their problems and look for [community-based] solutions... It changes mindsets..., [and] integrates well with decentralization.” Because the PAQ approach incurs some costs (such as transport for members, meeting materials, improvements for facilities), some districts chose to commit DIF monies to their health centers’ PAQ teams. In these cases, the funds were allocated to income-generating activities that would allow the PAQ teams to operate sustainably over the longer term.

Along the same lines, a focus group participant discussed the cost of *mutuelle* membership and noted, “Rather than directly supporting the *mutuelles*, [the DIFs] support the population through income-generating projects that will allow them to pay for the *mutuelle* themselves.”

Performance Indicators: Collaboration and Participation

Although no performance indicators are available to capture the collaborations that may have been invited by the DIF process, two indicators address trends in community participation. The indicator pertaining to the percentage of districts that have plans and budgets documented to reflect citizen input increased from 92% in 2006 to 100% every year thereafter. Thus, community input into planning and budgeting appears to have been high at the outset of the DIF program, and has remained high over the ensuing years.

The performance indicator pertaining to the percentage of health centers with active PAQ teams shows more mixed results (Table 10). Overall, the percentage of active PAQs increased from 2006 to 2009, growing from 72% to 85% of health centers. However, these global percentages mask opposing trends in individual districts. Four districts (Kamonyi, Kicukiro, Nyarugenge, Rwamagana) experienced noteworthy increases in PAQ activity from 2008 to 2009. However, in four other districts (Gasabo, Kayonza, Kirehe, and Nyamagabe), PAQ activity dropped by 10% to 25%, and in the remaining four districts (Muhanga, Ngoma, Nyaruguru, Ruhango), PAQ activity remained unchanged from 2008 to 2009.

Table 10. Percentage of health centers with an active mechanism for community input on quality of services

District	2006 ⁵	2007 ⁶	2008	2009
Gasabo			90%	73%
Kicukiro			43%	57%
Nyarugenge			63%	88%
Kayonza			100%	92%
Rwamagana			82%	91%
Ngoma			92%	92%
Kirehe			100%	75%
Ruhango			100%	100%
Muhanga			85%	85%
Kamonyi			82%	91%
Nyamagabe			85%	75%
Nyaruguru			85%	85%
Total	72%	80%	86%	85%

DIF Support for Collaboration and Participation

Between 2006 and 2009, the DIF program funded 38 activities aimed at fostering participation and collaboration, representing about a fifth (18% or 38/212) of the total number of DIF grants awarded. The total monetary value of the 38 awards was roughly 414,350USD.

DIF funds were allocated to a wide range of activities to promote participation and collaboration on health, including:

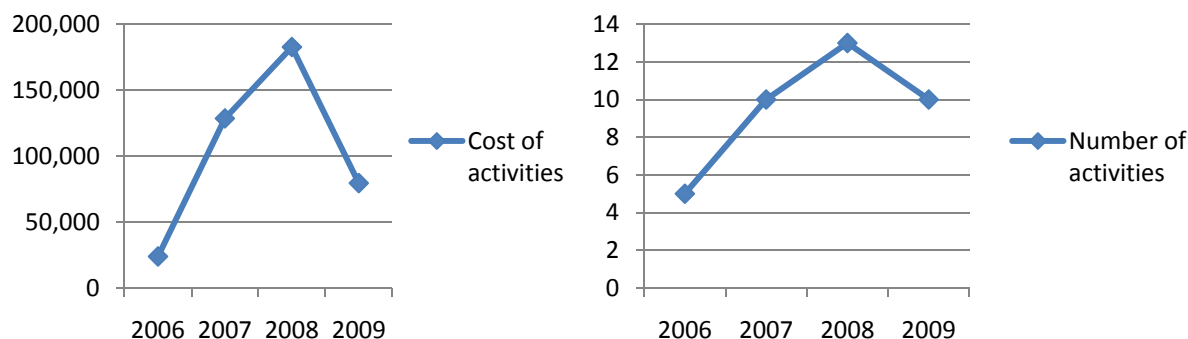
- Strengthening **PAQ teams** through income-generating activities to enable self-sufficiency
- **Developing radio broadcasts** on decentralization and health issues, including encouragement to participate in *imihigo* reporting
- **Educating local leaders** on health and social topics (including gender and gender-based violence issues)
- **Working with religious institutions** to raise community awareness of family planning
- **Training community health workers** on best practices for public hygiene campaigns
- Conducting **information campaigns** on health center deliveries.

⁵ Based on a sample of 60 health centers, which does not allow district percentages to be provided.

⁶ Ibid.

Similarly to the pattern of funding for capacity-related activities from 2006 to 2009, the number of DIF projects focused on participation and collaboration increased for the first three years, declining slightly in the final year (see Figure 7).

Figure 7. Number and dollar value of participation/collaboration activities funded by DIF, 2006-2009



4.6. Challenges

At the conclusion of each of the five focus groups, participants summarized challenges and weaknesses relating to the DIF program. Individual interview respondents also addressed similar topics. Comments clustered into five broad types of challenges (see Table 11): policy and the broader sociopolitical environment; DIF characteristics; DIF implementation; administrative capacity; and sustainability. Although some of the examples mentioned resided outside of project or district control, others were amenable to correction and change.

Table 11. Perceived challenges of DIF program

Type of Challenge/Weakness	Examples
Policy/sociopolitical environment	<ul style="list-style-type: none"> ▪ Lack of political will ▪ Rapid pace of change (decentralization) ▪ Multiple reporting requirements imposed by partners/donors
DIF characteristics	<ul style="list-style-type: none"> ▪ Stringent reporting timelines and requirements ▪ Funding/time period inadequate for needs ▪ Narrow scope (health and governance)
DIF implementation	<ul style="list-style-type: none"> ▪ Inappropriate selection of projects ▪ Unreliable contractors/suppliers ▪ Inadequate resources for supervision ▪ Inadequate local resources/revenues ▪ Inadequate evaluation and follow-up
Administrative capacity	<ul style="list-style-type: none"> ▪ Staff/accountant turnover ▪ Staff/accountant workloads ▪ Insufficient involvement of sectors
Sustainability	<ul style="list-style-type: none"> ▪ District dependency on DIF funds ▪ Overreliance on DIF to meet <i>imihigo</i> targets

Policy and Sociopolitical Environment

Although many respondents appreciated the opportunities for innovation and bottom-up participation offered within the context of decentralization, others acknowledged that it was sometimes difficult for districts to keep up with the rapid pace of social and administrative change. The Twubakane DIF Field Coordinators also identified confusion about roles, responsibilities, and lines of authority among district authorities as an early obstacle to DIF success. In the immediate aftermath of redistricting, district officers, district hospital directors and other health facility managers were sometimes unclear on their roles, as well as lacking experience collaborating on district planning and budgeting processes for health. Moreover, district officials consumed with multiple duties sometimes had difficulty identifying appropriate health projects and dedicating staff to manage the DIF grant process. Because of this, DIF proposals in 2006 were somewhat limited in their scope. Over time, the DIF team reported improvements in many of these areas. With growing stakeholder input through mechanisms such as the Joint Action Development Forum (JADF) and increased sector involvement, DIF proposals evolved towards a greater focus on activities to improve health services.

In addition to the policy environment, some respondents discussed DIF in the context of other development initiatives and development partners. One respondent took issue with DIF reporting requirements against the backdrop of other donors' reporting requirements: “[There is] no harmonization among donor agencies. ...With increased funding the number of reports [required by] funding agencies will grow and we will be swamped with different reporting requirements.”

DIF Characteristics

Some respondents voiced dissatisfaction with some elements of the DIF grants, including their perceived limited scope and focus, the level of available funding, and reporting timelines and requirements. Participants in two of the group discussions perceived the DIF grants' scope of intervention and focus on health and governance to be too restrictive. Other focus group participants, however, suggested that DIF offered an exciting model with the potential to be applied to other domains, including education, agriculture, and local cooperatives. Moreover, the number of respondents who voiced appreciation for the DIF grants' flexibility and focus on capacity-building far outweighed those perceiving DIF to be limited in scope.

DIF Implementation

The majority of comments about DIF-associated challenges were related to logistic factors affecting implementation. Among these, the most frequently mentioned problem had to do with the trustworthiness and reliability of contractors and suppliers selected by the districts themselves. As one focus group participant stated, “Dishonest contractors who did not honor their commitments were a problem; they caused work delays and also affected quality.” A focus group participant in another district added that contractors' delays had implications for reporting: “When contractors do not respect their commitments to complete work within an agreed-upon time frame, this has an impact on the district, which has to report expenditures...under a strict timetable.” Over time, some districts reported improvements in contractor performance due to heightened vigilance by the districts. One focus group participant reported, “During the health center renovations, we supervised the worksite and monitored the construction work in tandem with Twubakane agents, because certain contractors do not respect the terms of their contracts.”

In instances of externally caused delays brought about by poor-quality contractors or internal delays caused by poor planning, the Twubakane field coordinators placed increased emphasis on training and capacity-building activities to enable district staff to better manage procurement processes and better plan their projects.

In 2009, procurement challenges were heightened due to the compressed timetable created by the imminent closeout of the Twubakane Program at the end of the year. As a result, in two cases, the district requested that the Twubakane Program modify the subgrant and that Twubakane itself procured equipment on behalf of the districts. This ensured that the two districts benefited from the DIF monies and received needed equipment, while minimizing financial risk and ensuring that activities were completed and funds were accounted for.

Providing informal feedback on DIF start-up and implementation, the Twubakane DIF field coordinators noted that territorial reform and redistricting caused the DIF grants to begin mid-year rather than in January. As a result, the first-year timeline for project start-up (e.g., preparation of proposals, budgets, and contracts) was shortened, contributing to some initially “mediocre” results. The field coordinators also observed that it was somewhat difficult to “catch up” in subsequent years, as the delays of the first year spilled over into the next. This reality is important to consider in light of various comments by respondents who suggested that the DIF mechanism use a multiyear rather than annual budgeting process.

Administrative Capacity

As noted in the section on capacity-building, respondents perceived district staffing issues as a prominent challenge to successful DIF implementation. District accountants, in particular, were described as having had a hard time setting priorities and managing their large workloads. District accountants report spending up to 30% of their time each month in training programs and meetings that take them away from their office and their district. These staffing challenges resulted in a range of accounting problems that delayed the disbursement of subsequent funding installments. Each delayed payment resulted in further delays in the implementation of activities, making it difficult for districts to manage external contractors in a timely manner. Problems included awkward accounting procedures, inaccuracies in expense reports, lack of proper receipts and documentation, lack of timely expense reconciliation, and delayed reporting on cost-share figures.

Survey respondents suggested a number of strategies to overcome financial and technical reporting challenges, summarized in Table 12. Strategies focused on concrete steps such as training and hiring appropriate staff and streamlining the reporting process, as well as less tangible steps such as raising expectations and instilling a “culture of responsibility.” In the focus groups, a participant commented that some reporting problems could be alleviated by simplifying and harmonizing reporting requirements, not only within DIF but across partners:

The financial reports should be simplified to make it easier for the district accountants, especially since the reporting requirements are not harmonized among the various partners. For DIF we have five reports to complete—perhaps one would be enough. Having partners establish common reporting formats is quite important.

-District focus group

On a more positive note, some district respondents admitted using tools developed and provided by Twubakane to manage other district budgets or management activities.

Table 12. Strategies to improve DIF reporting (open-ended survey responses)

Type of Strategy	Specific Suggestion
Increased stakeholder involvement	<ul style="list-style-type: none"> ▪ Regular meetings between key stakeholders ▪ Involvement of sectors and health centers
Staffing	<ul style="list-style-type: none"> ▪ Increased staffing (new hires or transfers) ▪ Staff training and supervision
Reporting process	<ul style="list-style-type: none"> ▪ Working in teams to develop reports ▪ Tighter controls and regular reminders ▪ Oversight of reports to correct errors
Institutional culture	<ul style="list-style-type: none"> ▪ Develop a “culture of responsibility”

Sustainability

Sustainability was mentioned, in some way or another, by all district focus groups respondents. The long-term sustainability of the DIF grants was a concern for most respondents. During interview, respondents voiced two distinct levels of concerns related to sustainability.

On one level, there is sustainability of the DIF activities that extends beyond the period of implementation. This includes those activities with the specific purpose to build the capacity of the districts in planning and budgeting, or those which encouraged districts to develop partnerships with local stakeholders (such as JADFs). These activities, as reflected by respondents’ comments, seem to have had a positive impact and resulted in mindset change on the part of the districts which should be long-lasting.

On the other level, there is the issue of sustainability of the DIF mechanism itself, which is coming to an end when the Twubakane Program ends. From 2006 to 2009, the DIF mechanism was made possible by USAID funds made available through the Twubakane Program. In addition to these funds, the GOR and other partners contributed to funding and implementation (reflecting in-kind contributions) of activities. For this type of grants mechanism to be sustainable, other funding sources are needed to continue funding activities. One criticism, however, with continuing such a funding mechanism that requires selected activities to be tied to the districts’ performance contracts – *imihigo* – is that, district become too dependent on them to cover basic budgetary needs. In addition, a comment was made that the districts became overly reliant financially on the DIF grants as a way to meet their *imihigo* targets.

5. Discussion

Across interviews, focus groups, and survey responses, the District Incentive Funds were broadly praised. Our assessment results indicate that, in synergy with multiple other local health initiatives, it is highly likely that the DIF grants mechanism contributed to progress in the areas of health services, district capacity, and participation/collaboration. Moreover, the proportion of activities funded in

each of the three categories displayed interesting trends over time. In 2006, over three-fifths (63%) of the activities funded by DIF focused on relatively “easy” and straightforward health services interventions such as equipment and infrastructure improvements but, by 2009, health services activities represented only 43% of all activities funded in that year. In comparison, the number of activities intended to strengthen capacity and build collaboration and participation increased over the first three years of DIF funding: capacity-building activities went from 25% of DIF grants in 2006 to 39% in 2008 (dropping to 36% in 2009), and grants to enhance participation and collaboration rose from 12% of 2006 awards to 23% of the grants awarded in 2008 (again dropping in 2009 to 21%). These trends suggest that districts were able to shift their focus, over time, to more complex projects likely to leave a lasting impact.

Within the dynamic context of decentralization, study participants especially appreciated the DIF grants’ flexibility, and valued the opportunities for innovation offered by DIF. Even though many challenges to the success of the DIF grants were triggered by the rapidly changing decentralization, redistricting, and shifting geopolitical setting in Rwanda, the DIF initiative was largely viewed as timely. As study participants noted, the DIF initiative afforded district staff with opportunities for technical assistance and administrative capacity-building support, along with the actual funding, that were helpful in coping with changing roles and responsibilities.

As districts and the GOR consider how best to move forward, there are a number of lessons that can be learned from the Twubakane DIF experience. In this section, we share lessons and recommendations concerning the ability of granting mechanisms such as DIF to strengthen decentralized health systems.

5.1. DIF Approach

As noted previously, many districts expressed appreciation for the opportunity to use non-earmarked funds to address health needs and priorities identified internally rather than imposed externally. In the words of a district mayor, “The DIF mechanism gives districts the chance to propose the budget and activities that suit the district. If all partners did things this way, we would have fewer problems at the local level.” A central-level respondent also emphasized the advantages of having districts “manage the [DIF] funds themselves,” continuing:

The management of the funds was integrated in the district system. No parallel system was established. This allowed the strengthening of districts and an assumption of responsibilities by districts. It strengthens districts even if using this system sometimes takes longer.

-Central-level interview

The DIF initiative was supported by the five Twubakane Program field coordinators (and their assistants), who functioned as intermediaries between Twubakane and the districts and offered TA, helping districts maximize their performance while seeking to avoid creating dependencies. The field coordinators played an important role in building districts’ capacity to prepare proposals, write reports, conduct site visits, and carry out other aspects of project management. The diligent programmatic and technical assistance provided by the field coordinators and other Twubakane staff was perceived to distinguish the DIF grants from other types of funding offered without any accompanying TA. As a representative of a partner organization commented,

The DIFs combine financial and technical assistance. This is the novelty of the program, where other donors have always done one or the other. This approach has permitted capacity strengthening and the rational use of resources. This, [in turn,] has had an impact on the quality of services, a change in attitudes and bringing government services closer to the grassroots people.

-Partner organization

Indeed, a key feature of the DIF approach is that it builds incentives for the immediate application of capacity to achieve results. The DIFs have had positive impacts on accountability, responsiveness, efficiency, and effectiveness. They represent an important mechanism for the transfer of resources to decentralized units in way that reinforce incentives for good governance and for performance.

A district council member similarly observed that “The DIFs were characterized by a strong [Twubakane] presence and frequent technical support as much as by the actual funds awarded.” These observations suggest that the practical and flexible capacity-building focus of the DIF approach—which also monitors and seeks to correct identified staff and system weaknesses—has the potential to contribute to the long-term sustainability of at least some DIF-initiated activities.

Recommendations:

- Ensure that granting mechanisms have the flexibility to be tailored to local needs and priorities, as determined by strategic development plans or other planning documents.
- Accompany decentralized granting mechanisms with regular technical support to build long-term capacity for planning, budgeting, and reporting.

5.2. Scope of Activities

In general, respondents appreciated the DIF grants’ focus on health and decentralization goals. As one respondent stated, “Health and decentralization are significant and key domains. The support for decentralization should continue.” However, presented with the opportunity to make recommendations for the future, this same respondent and others stated that they would also welcome an extension of the DIF approach to other sectors.

Survey respondents shared a long list of suggestions in response to the question, “What type of DIF activity would you recommend implementing in the future?” As shown in Table 13, respondents displayed an interest in maintaining an emphasis on the two core areas of capacity-building and health services support, but also envisioned a broader range of uses of DIF-type funds at the community level.

Table 13. Activities most frequently recommended for future DIF support, survey respondents

Type of Activity	Examples
Health services	<ul style="list-style-type: none"> ▪ Health facility infrastructure ▪ Medical and IT equipment ▪ Access to care for vulnerable groups
Capacity-building	<ul style="list-style-type: none"> ▪ General capacity-building ▪ Staff training ▪ Development of management skills ▪ Planning workshops ▪ Support for decentralization/sectors

Community activities	<ul style="list-style-type: none"> ▪ Income-generating projects for PAQs/CHWs ▪ Support for local cooperatives/rural economies ▪ Support for schools (health and hygiene) ▪ Youth programs ▪ Environmental protection and improvements
-----------------------------	---

Regardless of the type of activity funded, most study participants appeared to agree that it was important for grant mechanisms such as DIF to respond to bottom-up, district-determined priorities. In a few instances, respondents also recommended that DIF grants address health targets that can be evaluated through established indicators.

Recommendations:

- Maintain the DIF grants as a mechanism for the transfer of resources to decentralized units to reinforce good governance and performance.
- Retain a rigorous granting structure that promotes accountability, responsiveness, efficiency and effectiveness.
- Determine in close collaboration and consultation with the beneficiary district what scope of activities respond on the needs of the districts and to the requirements or limitations of the funding source.

5.3. Financial Management

The challenges associated with ensuring appropriate and timely financial management represented a key theme of the DIF assessment results. Throughout the DIF implementation period, financial reporting was one of the main culprits in causing delays. Notwithstanding these commonly reported challenges, many districts improved in their capacity to administer and justify DIF grant monies over time. Some respondents who rose to the occasion even reported proactively consolidating their financial procedures by using DIF financial management tools and skills to manage other district budgetary activities. As districts become responsible for larger sums of money through central and partner mechanisms, it will be increasingly important to help them streamline financial reporting so that grants management does not become an excessive time management burden.

Discussing the specifics of DIF amounts and schedules, a district vice mayor acknowledged that DIF placed “pressure...on the staff to provide timely and accurate financial and technical reports,” but suggested that the district could have handled “progressively increased amounts from year to year as [its] capacity to manage the funds and activities increased.” Other respondents proposed changes to the disbursement schedule and procedures to facilitate DIF financial management, such as allowing disbursements to be made at the completion of each milestone rather than in fixed, predetermined amounts. In addition, some objected to quarterly disbursements as too frequent, suggesting that going from four to three installments would “facilitate a vigorous start-up of activities and would prevent delays from occurring before the activities have even gotten off the ground.”

Recommendations:

- Work with other partners to harmonize financial reporting requirements.
- Work with district staff to streamline financial management tools and procedures across different funding streams.

- Include cost share as a requirement but provide support as needed for districts to secure their share.
- Tailor disbursement amounts and schedules to district financial capacity.

5.4. Decentralization

Although respondents highlighted many benefits of district-level capacity-building, some central-level respondents pointed to the need to extend the momentum of decentralization to the sector level. A donor representative suggested that the DIF grants had stopped short of reaching out to sectors:

With the second phase of decentralization, [we] needed to focus more on sectors and the DIFs did not do this enough. The DIFs mainly involved district officials and there should have been more implication of sector people.

-Central-level interview

A provincial governor shared the recommendation to “get the sector officials more involved,” remarking that “district staff do not always have time and this leads to delays.” Although a few district-level respondents agreed with calls for greater sector involvement in DIF-type initiatives, others debated whether sectors currently have the capacity to take on such responsibilities. A district vice mayor recommended that the training and capacity-building focus of DIF “eventually” be directed at sector administrative staff as well as district staff.

Recommendations:

- Maintain the focus of funding, technical assistance and capacity-building efforts at the district level for the time being, consolidating the gains achieved by districts over the four-year DIF period.
- Consider granting mechanisms that support greater involvement of sectors (“Sector Incentive Funds”) only after decentralization has been well established at the sector level, and sectors have acquired adequate staff and capacity to be able to handle such funds.
- Strengthen districts’ ability to monitor sector activities.

5.5. Sustainability

During the four years of DIF implementation, both the Twubakane Program and participating districts learned how to tailor the DIF to the realities of administrative change and rapid decentralization. Many respondents indicated that, over time, districts evolved in their ability to work within the decentralized system. As a result, respondents generally were in favor of continuing or replicating the DIF approach. As one district mayor summarized,

After two or three years of trial and error, the system is working and is ready to be optimized. We learned some important lessons. Now, we know what works and what doesn’t work, we have our strategies. We should not go back to square one, this is an opportune moment to continue.

-District mayor

As noted previously, a few respondents cautioned against district overreliance on DIF as a means to pursue district goals, and worried about the imminent termination of DIF monies. However,

because the DIF model worked with—and enhanced—existing district systems rather than creating parallel systems, it leaves an infrastructure in place that can continue beyond the DIF funding cycle and can be adapted for other purposes. It is hoped that the GOR and its partners will continue to explore various options, including cost sharing, to ensure that resources are available at decentralized levels to support health and other social services.

Recommendations:

- Maintain or increase a cost-share requirement, accompanied by active technical assistance for districts that have difficulty meeting the requirement.
- Any future funding mechanism should continue to work within existing district systems rather than creating parallel systems.

5.6. Conclusions

The District Incentive Fund grants mechanism was greatly appreciated by district grant recipients and other stakeholders. Although the DIF grants required important investments in oversight and support from the Twubakane Program team, the grants were implemented at a time when the districts were newly created and needed significant support. Our comprehensive assessment of the Twubakane Program’s DIF initiative suggests that the grants:

- provided much-needed resources to districts;
- promoted good governance, accountability, and responsiveness to local populations;
- strengthened district capacity in planning and budgeting;
- enhanced district resource mobilization; and, apparently,
- had a positive impact on the quality of and access to health services.

The DIF grants mechanism is a promising practice, one that should be considered by USAID for future projects, and by the Government of Rwanda and its partners as a means of providing financial and technical resources to decentralized levels.

The government’s commitment to managing for results and emphasis on performance is admirable. As the current emphasis on replicating best practices goes along with the government’s performance and results-based approach, it is in this spirit that we recommend that the DIF mechanism be identified as one such practice that could be turned into national policy, after necessary adaptation and gradual modification to fit local and level circumstances.

Annex A. Study Design

Methods

The assessment used a mixture of qualitative and quantitative methods to gather key stakeholders' opinions and experiences, and to examine the impact of the DIF grants. The four data collection methods (described in greater detail below) included:

- 5) Review of **project documents** to consider the background and evolution of the DIF grants.
- 6) **Interviews and focus group discussions** with key stakeholders at the central level and in five districts.
- 7) **Self-administered questionnaires** in 7 districts.
- 8) Cross-checking of results with district and project **performance indicators** tracked since the project's inception.

All study instruments were tested by the DIF field team for clarity, cultural appropriateness, and ease of administration. The tools were then revised accordingly. Some of the questions were purposefully redundant across the different stakeholder groups to triangulate responses and clarify the accuracy of the information provided.

Document Review

The document review process included a desk review of a wide range of internal Twubakane and DIF project documents, summarized in Table 5.

List of documents reviewed for 2009 DIF assessment.

	Type of Document	Description/Comments
Twubakane	Quarterly/Annual Reports	Reports include: <ul style="list-style-type: none"> - Section on progress made and challenges faced by districts in managing DIF grants - DIF annex describing progress of individual activities implemented during reporting period
	2007 Continuing Application	<ul style="list-style-type: none"> - Continuing application for second half of 5-year Twubakane Program (presented to USAID and GOR) - Developed with stakeholder/partner input - Focus on results, lessons learned, best practices
	2009 Health Governance Assessment	<ul style="list-style-type: none"> - Impact assessment of Twubakane efforts on health governance and health outcomes
DIF	District Proposals	<ul style="list-style-type: none"> - Annual proposals and budgets submitted by districts for DIF funding
	Financial and Technical Reports	<ul style="list-style-type: none"> - Quarterly reports submitted by districts as part of DIF monitoring requirements
	Field Visit Reports	<ul style="list-style-type: none"> - Documentation of progress and challenges compiled during/after DIF field visits
	Flashes/Success Stories	<ul style="list-style-type: none"> - One-page briefs (called "flashes") highlighting DIF successes
	Workshop Outputs	<ul style="list-style-type: none"> - Minutes and notes from DIF workshops

Interviews and Focus Groups

The assessment included a small number of interviews with central-level stakeholders, as well as focus groups and individual interviews in five districts. For the three sets of interviews and stakeholders, we developed three similar (and complementary) interview guides in both French and English (see Annex B). In general, the interview guides asked respondents to describe:

- The DIF mechanism
- The DIF grants' contributions to overall results in decentralization, health and capacity-building
- Activities implemented by the DIF grants
- Potential for DIF mechanism to be recommended as a promising or best practice to the GOR and other development partners.

The focus groups targeted a range of district officials and others to capture not only district administrative and health perspectives but also sector and the *Partenariat pour l'Amélioration de la Qualité* (PAQ) team perspectives.⁷ The rationale for conducting individual interviews in addition to focus groups in the five selected districts was twofold. First, the individual interviews allowed us to obtain more detailed and in-depth data from key district stakeholders involved with the DIF grants. Second, the use of both methods allowed us to obtain separate feedback from district mayors, vice mayors and other powerful figures whose opinions we valued, while ensuring a more homogeneous focus group composition that encouraged open and honest responses.

Separately from the district focus groups, we also organized two focus groups with Twubakane staff to collect information on their perceptions of and experience with the DIF grants. One group included staff from the finance and DIF teams, while the second group included the field coordinators.

Self-administered Questionnaires

For the seven Twubakane-supported districts that did not participate in focus groups and individual interviews, we developed a self-administered questionnaire (see Annex B). To minimize respondent burden and maximize our response rate, the questionnaire primarily consisted of closed-ended items. Closed-ended responses were either on a 1 to 5 scale (1 = no improvement, 5 = much improvement), yes/no, or “please circle all that apply.” A small number of items allowed for open-ended responses. Districts were asked to return the completed questionnaires in 10 to 12 days' time.

Performance Indicators

The DIF grants were a component of the larger Twubakane Program—which, in itself, was a part of the GOR's strategy for health and decentralization in Rwanda. To situate district performance within the context of these broader efforts, we reviewed selected indicators from the Twubakane Program performance monitoring plan (PMP) that have been tracked since the inception of Twubakane and DIF.

⁷ These are community-provider quality improvement teams based at each health center.

Participants

Five broad categories of informants participated in the interviews, focus group discussions, and survey: central-level representatives, district administrators, sector administrators, health center managers (*titulaires*), and PAQ representatives.

Central-level Representatives

The central level was defined to include national and provincial representatives from the GOR (MINISANTE, MINALOC, RALGA, City of Kigali and Southern Province), as well as donor/partner representatives from USAID and GTZ (a non-USG partner operating in Twubakane districts).

District Administrators

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

Sector Administrators

Sector administrators are responsible for the management and oversight of all health activities in the sector. Sector representatives also are accountable for achieving health targets in health centers or posts.

Health Center Managers (Titulaires)

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

PAQ representatives

PAQ teams are composed of health center managers, providers and community representatives, who meet regularly to identify gaps in quality of health services at a particular health center and solutions for meeting those gaps.

Data Collection

The assessment was conducted by an internal Twubakane Program field team, with assistance from technical and monitoring and evaluation (M&E) staff from the IntraHealth and RTI home offices (see Annex C for a complete list of DIF assessment team members).

For the district interviews and focus groups, data collectors received training from the Twubakane assessment team on use of the interview guides using classroom role plays. Data collectors then visited the five assigned districts in three teams of four. One or two data collectors served as interviewers, while the others served as notetakers and/or backups.

The data collectors used paper questionnaires to administer the interviews, which ranged in length from one to two hours. Most interviews were conducted in French, although a few were in English. When necessary, clarification or in-depth tangents took place in Kinyarwanda and were subsequently translated into French or English by the interviewers or notetakers. The notetakers captured all responses verbatim during the interviews, and reviewed and corrected their notes shortly afterwards.

Sampling

Sampling was done purposefully to capture the Twubakane Program's 12 districts as well as central-level stakeholders most involved with or significant to the DIF process.

Districts

Out of the 12 Twubakane-supported districts, five districts were chosen for in-person interviews and focus group discussions, while the remaining seven participated in the self-administered survey. The five districts were selected on the basis of geographic representation and district performance. Specifically, five districts were chosen that represented all three Twubakane zones, and had either experienced notable *successes* or had faced particular *challenges* with DIF implementation. As noted elsewhere, respondents in the remaining seven districts received self-administered questionnaires.

Central Level

Central-level stakeholders were identified based on their involvement over the life of the DIF grants initiative. This category of stakeholder was selected to represent national/provincial government perspectives as well as donor/partner perspectives.

Analysis

Individual Interviews and Focus Groups

After completing data collection, team members compared and compiled their notes. As the next step in data analysis, team members then organized the data into three sets of summary files covering (1) district-level responses from the individual interviews, (2) district-level responses from the focus group discussions, and (3) central-level responses from individual interviews. Within each file, responses were grouped into three basic topic categories: background/context of the DIF program; impact of DIF program on health services, district capacity, and collaboration; and lessons

learned or recommendations. In addition, each of the five district focus group files included a summary analysis of strengths, weaknesses, opportunities, and threats (SWOT).

Self-Administered Questionnaires

The closed-ended data from the self-administered questionnaires were entered directly into Microsoft Excel to calculate average scores and frequencies. Open-ended responses were compiled and grouped by questionnaire item.

Protection of Human Subjects

Because the assessment explored respondents' opinions and subjective perceptions, the research posed no to minimal risk to participants. Data collectors were trained on research ethics. Informants were asked permission to take notes and were given the opportunity to ask questions about the assessment.

Annex B. Interview Guides and Self-administered Questionnaires

Niveau Central - ENTRETIENS INDIVIDUELS

Le Programme Twubakane de décentralisation et de santé, financé par l'USAID et mis en œuvre par IntraHealth International, RTI International, l'Université de Tulane, ainsi que d'autres partenaires, est un programme quinquennal doté de 24 millions de dollars USD chargé de renforcer la gouvernance locale décentralisée pour répondre aux besoins locaux et promouvoir l'utilisation durable des services de santé communautaires.

Le Programme Twubakane, qui a été lancé début 2005, arrivera à terme fin janvier 2010. Afin de conduire une partie de l'évaluation finale concernant l'impact du Programme sur la décentralisation et la santé au Rwanda, nous étudions le mécanisme de subvention des Fonds d'incitation des districts, une composante essentielle du Programme. Cette étude servira à analyser le rôle général joué par les subventions dans les résultats relatifs à la décentralisation des services de santé, d'examiner quelques réussites et défis rencontrés durant la mise en œuvre du programme et de se pencher sur les enseignements tirés de cette expérience.

Nous aimerions vous poser aujourd'hui une dizaine de questions au sujet du mécanisme de subventions DIF. Notre discussion devrait durer environ une heure. Vos réponses ne seront pas identifiées dans le rapport. Nous voudrions plutôt obtenir votre point de vue dans le cadre de notre processus de documentation et vos idées concernant la manière dont ce système a pu apporter quelque chose au Rwanda.

- 1) Avez-vous entendu parler des subventions accordées aux districts par le Programme Twubakane, plus connues sous le nom de Fonds d'incitation des districts ou DIF ?

Objectif 1 : Décrire le mécanisme de subvention DIF

- 2) D'après ce que vous connaissez des DIF, quelles vous semblent être les forces et les faiblesses de ce mécanisme ?
- 3) Quels changements avez-vous pu observer, si c'est le cas, au cours des quatre dernières années dans la capacité des districts à gérer des subventions ? Si ce n'est pas le cas, de quels changements auriez-vous entendus parler ?

Objectif 2 : Evaluer le rôle des DIF dans l'obtention des résultats généraux en termes de décentralisation et de santé

- 4) Pensez-vous que les subventions DIF aient aidé les districts à atteindre les objectifs de leur imihigo ?
- 5) Quelle est votre impression concernant l'intégration ou la liaison des activités DIF à l'ensemble du programme Twubakane ? Pourriez-vous partager des exemples pertinents ?
- 6) Pensez-vous que le mécanisme de subvention DIF et les projets mis en œuvre ont contribué aux différents résultats de la deuxième phase de la décentralisation et aux rendements et accès aux services de santé ?

Objectif 3 : Documenter les activités mises en œuvre par le biais des DIF

- 7) Pouvez-vous citer une activité DIF qui a été particulièrement réussie ou particulièrement difficile à exécuter ?

Objectif 4 : Etudier si le mécanisme DIF peut être proposé comme pratique prometteuse ou meilleure pratique au gouvernement rwandais et d'autres partenaires au développement en vue d'être reproduite

8) Qu'avez-vous aimé ou pas concernant le mécanisme des subventions DIF, par rapport aux autres mécanismes soutenus par les partenaires au développement pour apporter un soutien direct au district ?

➤ **Question pour les partenaires de développement**

9) Décrivez le niveau de collaboration que vous avez eu avec les DIFs ?

➤ **Question pour les interlocuteurs au niveau Central ou Provincial ou Regional**

10) Avez-vous joué un rôle pour faciliter la collaboration entre les partenaires de développement et les DIFs ?

11) Pensez-vous que les subventions DIF devraient devenir une des initiatives de financement diversifié vers les districts pouvant faire partie du financement du Common Development Fund ou du Rwanda Decentralized Local Sustainability Fund ?

12) Pensez-vous que le mécanisme DIF puisse être recommandé au gouvernement rwandais et à d'autres partenaires au développement en vue d'être reproduit ou pas ? Pourquoi ? Pourquoi pas ? Si oui, comment envisagez-vous la promotion de cette reproduction ? Si non, que proposez-vous pour améliorer le mécanisme des DIFs ?

13) Avez-vous d'autres suggestions ou commentaires ?

Niveau District - ENTRETIENS INDIVIDUELS

Le Programme Twubakane de décentralisation et de santé, financé par l'USAID et mis en œuvre par IntraHealth International, RTI International, l'Université de Tulane, ainsi que d'autres partenaires, est un programme quinquennal doté de 24 millions de dollars USD chargé de renforcer la gouvernance locale décentralisée pour répondre aux besoins locaux et promouvoir l'utilisation durable des services de santé communautaires.

Le Programme Twubakane, qui a été lancé début 2005, arrivera à terme fin janvier 2010. Afin de conduire une partie de l'évaluation finale concernant l'impact du Programme sur la décentralisation et la santé au Rwanda, nous étudions le mécanisme de subvention des Fonds d'incitation des districts, une composante essentielle du Programme. Cette étude servira à analyser le rôle général joué par les subventions dans les résultats relatifs à la décentralisation des services de santé, d'examiner quelques réussites et défis rencontrés durant la mise en œuvre du programme et de se pencher sur les enseignements tirés de cette expérience.

Nous aimerions vous poser aujourd'hui une vingtaine de questions au sujet du mécanisme de subventions DIF. Notre discussion devrait durer environ une heure. Vos réponses ne seront pas identifiées dans le rapport. Nous voudrions plutôt obtenir votre point de vue dans le cadre de notre processus de documentation et vos idées concernant la manière dont ce système a pu apporter quelque chose au Rwanda.

- 14) Depuis quand êtes-vous impliqué dans le programme de subventions DIF ?
- 15) Quel rôle avez-vous joué concernant les subventions DIF ?
- 16) En quelques mots, comment définiriez-vous les subventions DIF avec vos propres termes ?

Objectif 1 : Décrire le mécanisme de subvention DIF

- 17) Décrivez de quelle manière votre district a décidé quelles activités proposer et lesquelles choisir en priorité
 - a. Piste : Comment les propositions ont-elles été développées ?
 - b. Piste : Comment les budgets ont-ils été développés ?
 - c. Piste : Quels changements sont intervenus dans la planification et la priorisation, si c'est le cas, entre 2006 et 2009 ?
- 18) Décrivez de quelle façon le district a géré et suivi la mise en œuvre des activités ?
 - a. Piste : Comment le processus de mise en œuvre a-t-il été suivi ?
 - b. Piste : Comment les activités ont-elles été suivies ?
 - c. Piste : Comment les rapports techniques et financiers ont-ils été préparés ?
 - d. Piste : De quelle manière la gestion et la mise en œuvre des activités se sont améliorées ou détériorées, si c'est le cas, entre 2006 et 2009 ?
- 19) A votre avis, quels membres du personnel de votre district ont été les personnels-clé dans les DIFs ?
 - a. Piste : Parmi ces personnes-clé, quels rôles ont-elles joués ?
- 20) Y-a-t-il des contraintes dans la gestion des ressources humaines rencontrées par votre équipe de district ont eu un impact sur la mise en œuvre des subventions DIF ?
- 21) Quel impact les coordinateurs de terrain Twubakane et le personnel des équipes DIF Twubakane ont-ils eu durant la mise en œuvre des DIFs ?

- 22) Votre district a-t-il réussi à mobiliser et répertorier le partage des coûts (cost share) ?
- Piste : Le besoin de partage des coûts du programme (cost share) de subventions DIF a-t-il été pour vous une surcharge de responsabilité ou une occasion pour votre district de mobiliser des ressources locales?

23) Avez-vous des suggestions pour l'amélioration du mécanisme et du processus de subventions DIF ?

Objectif 2 : Evaluer le rôle des DIF dans l'obtention des résultats généraux en termes de décentralisation et de santé

- 24) Pensez-vous que le mécanisme de subvention DIF et les projets mis en œuvre ont contribué aux différents résultats de la deuxième phase de la décentralisation et aux rendements et accès aux services de santé ?
- Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans la prestation des services de santé ?
 - Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans l'utilisation des services de santé ?
 - Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans les compétences des districts en termes de planification, de gestion et de budgétisation ?
 - Piste : Pensez-vous que les subventions DIF ont encouragé une participation collaborative dans la planification et l'agencement des priorités pour les activités au sein de votre district et des hôpitaux, des centres de santé, des secteurs public et privé, des représentants de la population et de la communauté et au niveau central ?
 - Piste : D'après vous, les DIF ont-ils aidé votre district à atteindre les objectifs de son imihigo ?
- 25) Pensez-vous que les subventions DIF ont encouragé une participation collaborative dans la planification et l'agencement des priorités pour les activités au sein de votre district et des hôpitaux, des centres de santé, des secteurs public et privé, des représentants de la population et de la communauté et au niveau central ?

Objectif 3 : Documenter les activités mises en œuvre par le biais des DIF

26) Y-a-t-il eu des succès ou réussites notables des DIFs. Si oui, lesquels et pourquoi ?

27) Y-a-t-il des contraintes et difficultés notables des DIFs. Si oui, lesquelles et pourquoi ?

28) Est-ce qu'il y a eu un autre type d'activité que vous auriez aimé mettre en œuvre ?

Objectif 4 : Etudier si le mécanisme DIF peut être proposé comme pratique prometteuse ou meilleure pratique au gouvernement rwandais et d'autres partenaires au développement en vue d'être reproduite

29) Qu'avez-vous aimé ou pas concernant le mécanisme des subventions DIF, par rapport aux autres mécanismes soutenus par les partenaires au développement pour apporter un soutien direct au district ?

30) Pensez-vous que le mécanisme DIF puisse être recommandé au gouvernement rwandais et à d'autres partenaires au développement en vue d'être reproduit ou pas ? Pourquoi ? Pourquoi pas ?

- Piste : Si oui, comment envisagez-vous la promotion de cette reproduction ?
- Piste : Si non, que proposez-vous pour améliorer le mécanisme des DIFs

Niveau District - ENTRETIENS AVEC LES GROUPES DE DISCUSSION

Le Programme Twubakane de décentralisation et de santé, financé par l'USAID et mis en œuvre par IntraHealth International, RTI International, l'Université de Tulane, ainsi que d'autres partenaires, est un programme quinquennal doté de 24 millions de dollars USD chargé de renforcer la gouvernance locale décentralisée pour répondre aux besoins locaux et promouvoir l'utilisation durable des services de santé communautaires.

Le Programme Twubakane, qui a été lancé début 2005, arrivera à terme fin janvier 2010. Afin de conduire une partie de l'évaluation finale concernant l'impact du Programme sur la décentralisation et la santé au Rwanda, nous étudions le mécanisme de subvention des Fonds d'incitation des districts, une composante essentielle du Programme. Cette étude servira à analyser le rôle général joué par les subventions dans les résultats relatifs à la décentralisation des services de santé, d'examiner quelques réussites et défis rencontrés durant la mise en œuvre du programme et de se pencher sur les enseignements tirés de cette expérience.

Nous aimerions vous poser aujourd'hui une dizaine de questions au sujet du mécanisme de subventions DIF. Notre discussion devrait durer environ deux heures. Vos réponses ne seront pas identifiées dans le rapport. Nous voudrions plutôt obtenir votre point de vue dans le cadre de notre processus de documentation et vos idées concernant la manière dont ce système a pu apporter quelque chose au Rwanda.

1) En quelques mots, pourriez-vous définir les subventions DIF avec vos propres termes ?

Objectif 1 : Décrire le mécanisme des subventions DIF

2) Décrivez de quelle manière votre district a décidé quelles activités proposer et lesquelles choisir en priorité

d. Piste : Comment les propositions ont-elles été développées ?

e. Piste : Comment les budgets ont-ils été développés ?

f. Piste : Quels changements sont intervenus dans la planification et la priorization, si c'est le cas, entre 2006 et 2009 ?

3) Décrivez de quelle façon le district a géré et suivi la mise en œuvre des activités ?

e. Piste : Comment le processus de mise en œuvre a-t-il été suivi ?

f. Piste : Comment les activités ont-elles été suivies ?

g. Piste : Comment les rapports techniques et financiers ont-ils été préparés ?

h. Piste : De quelle manière la gestion et la mise en œuvre des activités se sont améliorées ou détériorées, si c'est le cas, entre 2006 et 2009 ?

4) Quels rôles et responsabilités ont influencé l'exécution des DIFs ?

a. Piste: Y-a-t-il eu des membres-clés du personnel au sein de votre district qui ont été essentiels à l'exécution des DIFs ?

b. Piste : Y-a-t-il eu des contraintes en termes de ressources humaines au sein de votre équipe de district ont eu un effet sur la mise en œuvre des subventions DIF ?

c. Piste : Y-a-t-il eu des cas ou opportunités où vous avez pu déléguer la responsabilité de la gestion des activités DIFs ?

5) Y-a-t-il eu des défis pendant l'exécution des DIFs ?

a. PISTE : Si oui, de quelle nature ?

Objectif 2 : Mesurer le rôle des DIF sur l'obtention des résultats généraux en termes de décentralisation et de santé

- 6) Pensez-vous que le mécanisme de subvention DIF et les projets mis en œuvre ont contribué aux différents résultats de la deuxième phase de la décentralisation et aux rendements et accès aux services de santé ?
 - f. Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans la prestation des services de santé ?
 - g. Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans l'utilisation des services de santé ?
 - h. Piste : D'après vous, quel impact positif ou négatif y-a-t-il eu dans les compétences des districts en termes de planification, de gestion et de budgétisation ?
 - i. Piste : Pensez-vous que les subventions DIF ont encouragé une participation collaborative dans la planification et l'agencement des priorités pour les activités au sein de votre district et des hôpitaux, des centres de santé, des secteurs public et privé, des représentants de la population et de la communauté et au niveau central ?
 - j. Piste : D'après vous, les DIF ont-ils aidé votre district à atteindre les objectifs de son imihigo ?

Objectif 3 : Documenter les activités DIF

- 7) Y-a-t-il eu des succès ou réussites notables des DIFs. Si oui, lesquels et pourquoi ?
- 8) Y-a-t-il des contraintes et difficultés notables des DIFs. Si oui, lesquelles et pourquoi ?

Objectif 4 : Etudier si le mécanisme DIF peut être proposé comme meilleure pratique ou pratique prometteuse pouvant être recommandée au gouvernement rwandais et pouvant être reproduite par d'autres partenaires au développement

- 9) Pensez-vous que le mécanisme DIF puisse être recommandé au gouvernement rwandais et à d'autres partenaires au développement en vue d'être reproduit ou pas ? Pourquoi ? Pourquoi pas ?
 - c. Piste : Si oui, comment envisagez-vous la promotion de cette reproduction ?
 - d. Piste : Si non, que proposez-vous pour améliorer le mécanisme des DIFs ?

10) SWOT

Forces	Opportunités
Faiblesses	Menaces

Questionnaire pour l'Etude Finale des Fonds d'Incitation des Districts

Le Programme Twubakane de décentralisation et de santé, financé par l'USAID et mis en œuvre par IntraHealth International, RTI International, l'Université de Tulane, ainsi que d'autres partenaires, est un programme quinquennal doté de 24 millions de dollars USD chargé de renforcer la gouvernance locale décentralisée pour répondre aux besoins locaux et promouvoir l'utilisation durable des services de santé communautaires.

Le Programme Twubakane, qui a été lancé début 2005, arrivera à terme fin janvier 2010. Afin de conduire une partie de l'évaluation finale concernant l'impact du Programme sur la décentralisation et la santé au Rwanda, nous étudions le mécanisme de subvention des Fonds d'incitation des districts, une composante essentielle du Programme. Cette étude servira à analyser le rôle général joué par les subventions dans les résultats relatifs à la décentralisation des services de santé, d'examiner quelques réussites et défis rencontrés durant la mise en œuvre du programme et de se pencher sur les enseignements tirés de cette expérience.

Votre participation est essentielle à la conduite de cette évaluation finale. La sincérité de vos réponses aux questions ci-dessous nous permettra de mieux relater les différents succès auxquels ont permis d'aboutir les subventions DIF et d'envisager les meilleures solutions pour remédier aux problèmes que vous avez rencontrés. De manière générale, cela garantira que les prochaines subventions soient conformes à vos besoins et à vos attentes.

1. Quel(s) rôle(s) avez-vous occupé dans le programme de subvention DIF, de quelle date à quelle date et dans quel district ?					
Veuillez spécifier votre rôle, vos dates (mois et année) et votre district					
2. Comment les DIF ont-ils contribué à l'amélioration de la deuxième phase de la décentralisation et du rendement des services de santé au Rwanda ?					
					Veuillez entourer un nombre entre 1 = Aucune amélioration 5 = Nette amélioration
2a. Pensez-vous que les DIF ont amélioré la prestation de services sanitaires ?	1	2	3	4	5
2b. Pensez-vous que les DIF ont amélioré l'utilisation des services de santé ? &	1	2	3	4	5
2c. Pensez-vous que les DIF ont amélioré les compétences des districts en termes de planification...					
...dans le secteur de la santé	1	2	3	4	5
...dans d'autres secteurs ?	1	2	3	4	5

2d. Pensez-vous que les DIF ont amélioré les compétences des districts en termes de gestion...					
...dans le secteur de la santé	1	2	3	4	5
...dans d'autres secteurs ?	1	2	3	4	5
2e. Pensez-vous que les DIF ont amélioré les compétences des districts en termes de budgétisation...					
...dans le secteur de la santé	1	2	3	4	5
...dans d'autres secteurs ?	1	2	3	4	5
3. Les DIF ont-ils encouragé la collaboration entre les districts et d'autres entités ?					
					Veuillez entourer un nombre entre 1 = Aucun encouragement 5 = Net encouragement
3a. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et des hôpitaux ?	1	2	3	4	5
3b. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et des centres de santé ?	1	2	3	4	5
3c. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et des secteurs public et privé ?	1	2	3	4	5
3d. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et parmi les représentants de la population et de la communauté ?	1	2	3	4	5
3e. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et au niveau central ?	1	2	3	4	5
3f. Les DIF ont-ils encouragé une collaboration dans la planification et l'agencement des priorités pour les activités au sein de votre district et au niveau provincial et MVK ?	1	2	3	4	5
4. Quels membres du personnel au sein de votre district ont été essentiels à la réussite des activités DIF en termes de planification et d'exécution ?					
Veuillez spécifier la fonction					

5. Quels membres du personnel de votre district auraient pu être plus actif dans l'exécution des DIFs ?									
Veuillez spécifier la fonction									
6. Les coordinateurs de terrain Twubakane et le personnel de Twubakane ont-ils contribué à la mise en œuvre et exécution des DIFs et dans quels domaines ?									
					Veuillez entourer les réponses s'appliquant à votre cas				
Animation de réunions pour identifier les priorités des districts					A				
Développement et écriture de propositions					B				
Développement de budgets					C				
Suivi de la mise en œuvre des activités					D				
Soumission des rapports financiers					E				
Soumission des rapports techniques					F				
Autre (veuillez spécifier)					G				
Autre (veuillez spécifier)					H				
Autre (veuillez spécifier)					I				
7. Votre district est-il parvenu à mobiliser et répertorier le partage des coûts (costshare)?									
					Veuillez entourer les réponses s'appliquant à votre cas				
Oui					A				
Non					B				
Pas sûr					C				
8. Le besoin de partager le coût (cost share) du programme de subvention DIF a-t-il été une surcharge de responsabilité ou une occasion pour votre district de mobiliser des ressources locales?									
					Veuillez entourer les réponses s'appliquant à votre cas				
Occasion					A				
Surcharge					B				
Obligation contractuelle					C				
Autre (veuillez spécifier)					D				
9. Quel(les) activité(s) financée(s) par les subventions DIF ont été, à votre avis, les plus réussies ?									
					Veuillez entourer un nombre entre 1 = Echec 5 = Très réussie				
Développement des capacités au niveau administratif des districts					1	2	3	4	5
Soutien aux paiements durables des mutuelles pour les indigents					1	2	3	4	5

Améliorations apportées à l'infrastructure sanitaire et administrative ; hygiène publique ; équipement ICT ou médical	1	2	3	4	5
Renforcement du système de santé communautaire et de communication ; PAQ	1	2	3	4	5
Formation relative à la santé des autorités locales	1	2	3	4	5
Autre (veuillez spécifier) :	1	2	3	4	5
Autre (veuillez spécifier) :	1	2	3	4	5
10. Quel type de défi avez-vous rencontré avec ces activités ?					
	Veuillez entourer les réponses s'appliquant à votre cas				
Soumission de rapports de comptabilité à temps	A				
Soumission de rapports techniques complets	B				
Soumission de rapports techniques précis	C				
Suivi régulier	D				
Connaissance et respect des politiques et des procédures	E				
Rotation ou mutation du personnel	F				
Indisponibilité du personnel due à une surcharge de travail	G				
Incapacité de déléguer	H				
Désir de retenir et contrôler les ressources au niveau du District seulement	I				
Autre (veuillez spécifier) :	J				
11. Comment ces défis ont-ils été surmontés ?					
	Veuillez expliquer				
Soumission de rapports					
Suivi					
Connaissance et respect des politiques et des procédures					
Rotation ou mutation du personnel					

Indisponibilité du personnel due à une surcharge de travail	
Incapacité de déléguer	
Désir de retenir et contrôler les ressources au niveau du District seulement	
Autre (veuillez spécifier) :	
12. Quel type d'activités DIF recommanderiez-vous pour d'autres programmes de subvention à l'avenir ?	
Veuillez spécifier	
1.	
2.	
3.	
13. Quel type d'activités DIF recommanderiez-vous de ne pas reconduire pour d'autres programmes de subvention à l'avenir ?	
Veuillez spécifier	
1.	
2.	
3.	

14. De manière générale, quelles sont vos suggestions pour un programme de subvention dans votre district ?

Veillez expliquer

Annex C. Members of DIF Assessment Team

Alphonse Nzirumbanje – Kirehe-Ngoma Field Coordinator, Twubakane
Anatole Sentabire Kaboyi – DIF Grants Manager, Twubakane
Antoinette Uwimana – Decentralization Activities Coordinator, Twubakane
Catherine Fort – Deputy Director, Center for International Health, RTI
Charles Kayobotse – Kamonyi-Muhanga-Ruhango Field Coordinator, Twubakane
Dan Gerber – Senior International Development Specialist, RTI
Dean Swerdlin – Decentralization Policy, Resources Mobilization and Health Facilities Team Leader
Elyse Kalisa – Accountant, Twubakane
Emile Sempabwa – Community Participation Activities Team Leader, Twubakane
Evariste Nkunda – Nyaruguru-Nyamagabe Field Coordinator, Twubakane
Francoise Twahirwa – Decentralization Program & Finance Officer, Twubakane
Jana Scislowicz – Program Officer, IntraHealth
Jean Paul Kagarama – DIF Grants Associate Manager, Twubakane
Julienne Dieudonne – Chief Accountant, Twubakane
Laura Hoemeke – Chief of Party, Twubakane
Laura Hurley – Program Team Leader, Twubakane
Laure Almairac – Program Specialist, IntraHealth International
Marie Chantal Umuhiza – Rwamagana-Kayonza Field Assistant, Twubakane
Michael Hainsworth – M&E&R Technical Advisor, IntraHealth International
Philbert Ndaruhuste – MIS Coordinator, Twubakane
Sara Stratton – Director, MNCH/FP/Malaria Programs, IntraHealth International
Théophila Nyirahonora – Kigali Ville Field Coordinator, Twubakane

Annex D. Categories of Activities Funded with DIF Grants, 2006-2009

Indicator	2006 Results		2007 Results		2008 Results		2009 Results		Totals for all 4 Years	
	Number of Activities Implemented	Cost of Activities US \$\$	Number of Activities Implemented	Cost of Activities US \$\$	Number of Activities Implemented	Cost of Activities US \$\$	Number of Activities Implemented	Cost of Activities US \$\$	Number of Activities Implemented	Cost of Activities US \$\$
# of DIF grant supported activities that were implemented to improve the local government authorities, Administrative District, and Sector level capacity to provide services, with an emphasis on health services, to its population										
Activities that improved district capacity.	13	255,115.00	19	50,807.11	22	631,660.24	17	255,916.42	71	1,593,498.77
Activities that improved health services	34	785,069.00	27	88,775.47	22	874,846.71	20	654,965.28	103	3,303,656.46
Activities that improved participation	5	23,793.00	10	28,475.34	13	182,639.82	10	79,444.91	38	414,353.07
Totals for Each Year	52	1,063,977.00	56	1,568,057.93	57	1,689,146.76	47	990,326.61	212	5,311,508.30