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CASE STUDY: RWANDA'S TWUBAKANE DECENTRALIZATION AND HEALTH PROGRAM

February 2017

This publication was produced for review by the United States Agency for International Development. It was prepared by Cristina Sciuto for the Health Finance and Governance Project.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

February 2017

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Sciuto, Cristina. February 2017. *Case Study: Rwanda's Twubakane Decentralization and Health Program.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

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ACRONYMS

CFIR	Consolidated Framework for Implementation Research
CHIS	Community-Based Health Information System
COP	Chief of Party
DCOP	Deputy Chief of Party
DIF	District Incentive Funds
EONC	Essential Obstetric and Newborn Care
F&A	Finance & Administration
FP	Family planning
GOR	Government of Rwanda
HBM	Home-based management of fever
HFG	Health Finance and Governance Project
HRIS	Human resources information system
HSS	Health system strengthening
IMCI	Integrated Management of Childhood Illness
JADF	Joint Action Development Forums
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
MOH/MINISANTE	Ministry of Health
NDIS	National Decentralization Implementation Secretariat
NHA	National Health Accounts
PAQ	Partenariat pour l'Amélioration de la Qualité
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
RALGA	Rwandan Association of Local Government Authorities

REP	Replicating Effective Programs
RFA	Request for Applications
RH	Reproductive health
SWOT	Strengths, Weaknesses, Opportunities, Threats Analysis
TAG	Technical Advisory Group
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

USAID's Health Finance and Governance project (HFG) contributes to USAID's assistance to countries to deliver key health services and builds the evidence base around health systems strengthening (HSS). Under HFG's research portfolio, a series of retrospective, qualitative case studies were undertaken to understand the dynamics of successful HSS interventions by focusing on how HSS projects were implemented. This report presents the results for one of the five cases: Rwanda's Twubakane Decentralization and Health Program.

Twubakane was led by IntraHealth with support from RTI International, Tulane University, and EngenderHealth as the subcontractors. Numerous Rwandan counterparts, local implementers, and development partners supported smaller pieces of the contract. Originally funded at $24 million, the project received a total obligation of $28,379,327 from USAID. The project implemented a two-pronged health system strengthening approach where both health care delivery and governance were addressed through six components:

- Family planning and reproductive health;
- Child survival, malaria and nutrition;
- Decentralization policy, planning and management;
- District-level capacity building;
- Health facilities management; and
- Community engagement and oversight.

The project was meant to support health system financing, decentralization, and human resources for health. Only six months into the project in 2005, the geographic scope of the work changed when Mr. Paul Kagame initiated Phase II of Rwanda's decentralization efforts. Phase II aligned formerly unaligned administrative and health districts with single unified districts. In response, the project reprioritized to make district-level capacity-building its top priority. The projects' ability to accommodate this change in work plan facilitated project sustainability.

Critical features of the project were established early on. First, USAID engaged the Government of Rwanda during the Request for Application (RFA) development process to understand GOR priorities and establish a mutually respectful relationship. In doing so, Twubakane was able to align activities with existing GOR policies and initiatives from the beginning. Consequently, Twubakane staff were invited to participate in workgroups and steering committees to update outdated policies, which further strengthened project-GOR relationships. When ad-hoc needs were identified, like training police officers to raise awareness about gender-based violence or changing the geographic scope of the project, Twubakane staff knew who to speak with and how to navigate the process successfully. One project activity expanded an existing structure; community-provider partnerships, Partenariats pour l'Amélioration de la Qualité (PAQs), which were ultimately deemed a best practice by the GOR before the project ended. Second, IntraHealth promoted collaboration by making staff engagement a top priority. Everyone from drivers to the Chief of Party were expected to participate in staff meetings and annual retreats. This increased staff buy-in and ownership of the project, which ultimately increased team spirit. Finally, district officials were offered financial resources and the opportunity to manage them through District Incentive Funds. This increased district ownership over the planning, budgeting, and

management of resources which increased their adherence to the capacity-building opportunities offered by Twubakane.

The main challenges revolved around reporting requirements, data availability, and limited opportunities for innovation. Over the course of the project, multiple reporting requirements were expected from various GOR agencies at different times. Sometimes this limited staff availability to work on the implementation itself. A second limitation was the lag in the Demographic and Health Survey (DHS) data. While the project was able to conduct large-scale capacity assessments, their monitoring and evaluation efforts to assess health outcomes were limited due to the data lag. Finally, GOR preferred not to fund pilot activities unless they were evidence-based and scalable. This limited the amount of innovation Twubakane could introduce.

Among other outcomes, the project contributed to 1) a reduction in the infant mortality rate from 107 to 62 per 1000 live births, 2) an increase in couple years of protection by almost five-fold, and 3) the active engagement of a supervisor in 98% of the 136 PAQs.

Some lessons learned include the value in:

- Regular communication between team members and stakeholders;
- Building highly effective teams through regular communication and in-person retreats;
- Bottom-up stakeholder engagement in the planning and implementation process; and
- Convincing the target population of the importance of the activity.

1. INTRODUCTION

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. The project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. HFG's research portfolio enhances the ability of USAID to assist countries in delivering priority health services while simultaneously contributing to the global pool of knowledge on health systems strengthening (HSS).[1]

Under this research portfolio, the "Understanding the Dynamics of Successful Health System Strengthening Interventions" study seeks to bring into better balance our focus on "what works" in HSS with "how HSS works" to improve the performance of future HSS efforts. Our aim is to examine the dynamics of HSS project implementation, not to examine the cases as models for HSS interventions. We are pursuing this goal by initially conducting a set of five qualitative, retrospective case studies of successful USAID-supported HSS interventions and then producing a cross-case analysis to draw common patterns across cases.

The aim of this study to address four key questions:

1. How were a range of successful HSS interventions implemented in different countries?
2. What factors facilitated and constrained the successful implementation and documented outcomes of the interventions?
3. What were important factors about implementation that emerged across the different cases?
4. What are the implications of this study for future of implementing HSS interventions?

We chose five cases to examine a small sample of successful HSS initiatives in different places under different conditions and with different features in an attempt to tease out some of the policy setting, adoption, and implementation factors and processes that matter. While we remain attentive to the range of complex factors that affect success, we seek to distinguish those factors that decision-makers and implementers can control or influence. In so doing, we hope to develop and provide recommendations for adapting and sustaining HSS reforms in low-income countries.

This report presents one of the five case studies – on the Twubakane Decentralization and Health Program project. In Section 2, we describe the study methods. In Section 3, we present the contours of the context in which the intervention was implemented, basic information on the intervention, how it was designed, and its outcomes; the implementation process for the intervention, including implementation groundwork, key features of the implementation process; and how the intervention was

[1] As defined by the World Health Organization, we define HSS interventions as those that implement "changes in policy and practice in a country's health system" and improve "one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency" (WHO 2011: 9). HSS interventions are horizontal approaches that can address the root causes of health system constraints and impact multiple issues, rather than vertical service- or disease-specific interventions like health system support programs (Travis et al. 2004: 903).

sustained and disseminated. Finally, in Section 4, we present our synthesis of the primary factors that influenced the intervention's implementation and contributed to its success.

2. METHODS

The study, comprised of five case studies and cross-case analysis, was conducted in several phases, each of which is briefly described in turn. For a more detailed explanation of our case selection process and methods, please see the study design (Conrad et al. 2016).

2.1 Design and implementation

In the first phase of the study (October 2015-March 2016), we finalized the design and began implementation, which involved engaging USAID and selecting the case studies.

2.1.1 Design

The aim of this study was to address four key questions:

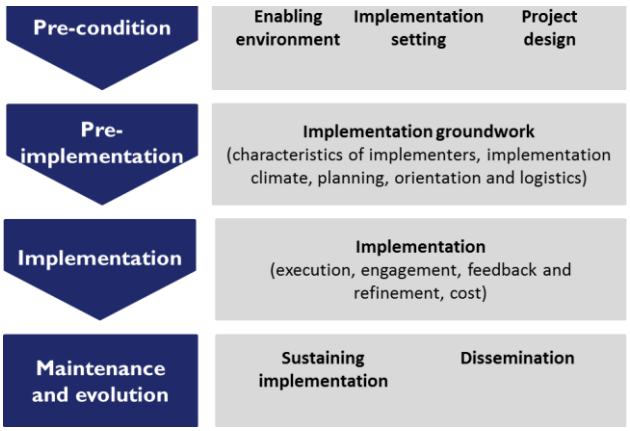
1. How were a range of successful HSS interventions implemented in different countries?
2. What factors facilitated and constrained the successful implementation and documented outcomes of the interventions?
3. What were important factors about implementation that emerged across the different cases?
4. What are the implications of this study for future of implementing HSS interventions?

To answer these questions, we designed a protocol to conduct retrospective, qualitative case studies. We used an implementation framework to guide the case studies. Our primary aim for applying the implementation framework was to determine which factors influence implementation that we needed to collect data on and consider during analysis. We combined two implementation frameworks to apply in this study – the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2009) and the Replicating Effective Programs (REP) framework (Kilbourne et al. 2007). Both CFIR and REP are based on implementation theories and empirical evidence of what affects the successful implementation of health interventions. We used CFIR to more broadly frame the intervention and we used REP as a framework that focuses on project implementation process. Figure 1 outlines the combined framework. See Annex A for detail.

As we assessed each implementation domain and factor, we also explored:

1. Decision-making processes associated with design and adoption of the intervention;
2. How the intervention was implemented, including how potential challenges or obstacles were addressed;

Figure 1: Outline of combined implementation framework



3. Expected and unexpected outcomes of the intervention, both positive and negative; and
4. Prospects for sustainability of the intervention, such as the degree to which the project activities have been institutionalized in the country.

Before we finalized the design, the team submitted the study design and data collection instruments to Abt's Internal Review Board (IRB) and JHSPH's IRB for review. Abt's and JHSPH's IRB exempted the study from review.

2.1.2 Sampling Process

To ensure that the case studies were of practical relevance, we set up a Technical Advisory Group (TAG) composed of experts and representatives from inside and outside USAID Bureau of Global Health to consult with on the study and provide expertise.

This case was selected for study from USAID's 2014 Global Call for Health System Strengthening Cases using a defined set of criteria and a systematic review and sampling process that we developed. The case was purposively selected from the available pool and the case is not representative or necessarily the most successful health system strengthening (HSS) project implemented in the region. Our objective in the case selection was to purposively select 6 cases from the 143 cases submitted to *USAID's 2014 Global Call for Health System Strengthening Cases* that are successful, robust examples of health system strengthening interventions.[2]

The reviewers engaged in a multi-stage sampling process consisting of four sequential selection rounds that excluded cases that did not meet the specified criteria in each round using the identified available data and the predetermined review method. The 4 selection rounds were as follows:

1. **Round 1:** Reviewers considered only those interventions that were fully implemented before the start of the selection process.
2. **Round 2:** Reviewers accepted the submitter's self-reported definition of health systems strengthening, labeled the intervention "provisional," and sought a determination of an "effective" intervention.
3. **Round 3:** Reviewers applied criteria to determine whether a provisional, effective health system strengthening intervention could be confirmed as health system strengthening.
4. **Round 4:** Reviewers applied criteria to determine whether a confirmed, effective health system strengthening intervention was robust (Figure 2)

Figure 2: Twubakane Decentralization and Health Program Qualifying HSS Criteria

Round	Criteria	Inclusion criteria	How met criteria
1 (implementation period)	Implementation completed	Submission states implementation period was completed by 10/2015	2010

[2] One of the six case studies was not completed, because we were unable to collect sufficient data to complete analysis.

Round	Criteria	Inclusion criteria	How met criteria
2 (impact and evidence)	Effective intervention	One of 13 identified types of interventions referenced	• Accountability and engagement interventions • Health insurance • Health worker training to improve service delivery • Pharmaceutical systems strengthening initiatives • Service integration • Strengthening health services at the community level • Task sharing/task shifting
	Health systems outcome	One of 4 health systems outcomes referenced	• Improved service provision/quality • Uptake of healthy behavior
	Health impact	Health impact referenced	Reduced morbidity and mortality
	Both health system outcome and health impact	At least one health system outcome and health impact referenced	Yes
	Verification of health impact and health system outcome achieved	One type of documentation is referenced for at least one health impact or health system outcome	Project M&E data
3 (HSS)	Multiple primary disease targets	At least 2 diseases targeted referenced	Family planning, reproductive health, child health, malaria, nutrition
4 (Robust HSS)	Multiple health system functions and sub-systems targeted	At least 2 HSS WHO building blocks targeted and at least 2 sub-systems functions targeted	*Building blocks:* • Financing • Health workforce • Leadership and governance *Sub-systems functions:* • Financing • Health workforce • Leadership and governance • Service delivery

Round	Criteria	Inclusion criteria	How met criteria
	Verification that intervention was successful HSS intervention	Intervention had health system outcome, health impact and targeted multiple diseases and health system functions	Yes
	Category D for HSS intervention type	Based on typology of HSS we developed, case addresses at least 2 health system functions and at least 3 sub-systems	Yes
	Category E for HSS intervention type (not inclusive of D)	Based on typology of HSS we developed, case addresses at least 2 health system functions and at least 4 sub-systems	Yes

2.2 Data collection and analysis

In the second phase, we conducted the case study research. We divided the case studies among our team members so that no team members conducted research on a project that their organization implemented. The case teams collected both primary and secondary data on retrospective (features 1-3 above) and prospective (feature 4 above) data that are described in more detail below. As applicable, we collected primary and/or secondary data on each implementation factor and domain.

For primary data collection, we conducted individual or joint interviews with key informants who possessed in-depth knowledge of the history and workings of the HSS intervention. We followed a common semi-structured interview guide for the interviews, but adjusted the questions posed as applicable for the respondent and their role in the project (see Annex B for the interview guide). Interviews were conducted in English or French, depending on the respondent's preference and comfort. We documented each interview through verbatim notes in English and audio recordings. We interviewed 11 key informants for this case study. Informants included representatives of USAID's implementing partners who sponsored the intervention, relevant Ministry of Health officials, and USAID mission staff with knowledge of the intervention, as appropriate.

The research team imported the interview notes into NVivo 11, qualitative data analysis software package, for coding and analysis. Analysts applied a single codebook developed prior to beginning the coding process and refined by coding a small sample of interview notes from several cases. The codes were informed by *a priori* concepts based on the domains and factors from the combined CFIR and REP implementation frameworks. To accommodate unexpected or context-bound themes and concepts emerging from the data, the codebook included a 'family' for each case to allow for inductive coding as needed for each specific country or intervention. We applied this common codebook for the purposes of reliability, quality control, and comparison across interview respondents and eventually across case and country contexts. All data is saved to Abt's secure server.

Once coding was complete, the analysts conducted iterative, exploratory analysis in NVivo using text analysis techniques (e.g., repetition, similarities and differences, word frequency, word co-occurrence, semantic network analysis, etc.) to explore themes, patterns, outliers, and trends, and conflicts between and among data sources.

We reviewed secondary data to capture different features of the intervention and contextualize the intervention. We conducted document review of the relevant published and unpublished documents about the intervention that we were able to obtain. To review the documentation on each case, we filled out a common document abstraction template (in an Excel spreadsheet) to systematically review the documents and synthesize salient data. Abstraction categories reflected domains from our combined CFIR and REP frameworks. We also conducted a focused literature review to identify the key contextual factors (e.g. socio-cultural, political, economic, etc.) relevant to the case and existing evidence about barriers to and success of health system strengthening and reform in the country. We used the literature and document reviews to build on and verify the interview data where possible and applicable (bearing in mind that written documentation represents the official record). We analyzed the findings from the literature and document reviews in conjunction with analysis of the primary data. We uploaded the document abstraction forms in NVivo for analysis with the interview data.

The research team ensured the reliability and validity (both external and internal) of our qualitative research in several ways. We revised our semi-structured interview guide and record review forms based initial use. We used experienced researchers and held team meetings to ensure that all team members had a consistent and thorough understanding of the research goals and intent behind each question and probe. We further used consistent data documentation procedures and structured, systematic analysis techniques using qualitative analysis software (e.g., NVivo) to ensure reliability, quality control, and cross case comparisons. Further, we triangulated primary qualitative data with secondary data to improve the validity of findings from primary data. Finally, we conducted member checking by asking a key informant, usually the project's Chief of Party, to review and comment on the case narratives regarding coherence and validity. We also had a TAG member review each case narrative to provide further expert review. We then finalized the case narratives based on this feedback.

2.3 Cross-case analysis

In the third phase of the study, we analyzed this and the other four descriptive case study narratives from Phase 2 to help generate explanations for successful HSS interventions. The cross-narrative analysis of Phase 3 sought to build or strengthen the evidence base for the "how" and "why" of what works in HSS by determining which implementation domains and factors from the implementation framework influenced the success of the interventions. We looked for common and divergent factors that were present or absent across cases and contexts, and we tried to determine the relationships between the implementation factors and domains based on our findings. As an exploratory study, we hope these findings can provide some comment on the factors that may be associated with successful HSS implementation and inform future studies of HSS interventions.

3. FINDINGS

The report describes the implementation experience of the Rwanda Twubakane Decentralization and Health Program supported by USAID, "to increase access to and the quality and use of family health services in Rwanda" (USAID 2010).

In this Section, first we outline the relevant features of the context within which the intervention was implemented, including key features of the socio-economic context, political system, and health system. Second, we describe the basic features of the intervention, including its primary goals, activities, design, and timeline. Third, we outline the main outcomes and impacts of the project. Fourth, we describe the implementation process, beginning with the implementation groundwork, implementation itself, and then how the project was sustained and disseminated.

3.1 Pre-conditions

3.1.1 Problem definition

The Twubakane project was, "designed to increase access to and the quality and use of family health services in Rwanda." While most respondents agreed that the project aimed to address, "pillars around the health system including financing, decentralization, and human resources for health" (Rwanda 06, MOH), respondents from different organization types differed in the weight they gave to various aspects of the project. Ministry of Health (MOH) and subcontractor representatives, those most engaged in capacity-building and governance, listed decentralization efforts first when describing the problems the project was trying to solve. Respondents from the prime organization listed improving health outcomes first.

While poor health outcomes (such as malaria as number one killer of children under five years of age and high maternal, child and infant morbidity and mortality rates in general, along with low use of modern contraception) were part of the problem, Twubakane first targeted system-level challenges, which arose from the government's rapid decentralization of the health system from the central to the district level. Due to these changes, the project focused on building the capacity of the newly-designated district officials to plan, budget for and deliver health services in order to positively impact health outcomes.

> *"Rwanda's a very centralized model. The problem they were also trying to solve was…improving the functioning of the health system at the district level with clear accountabilities of people, clear accountabilities to really provide the kinds [of] quality health services that populations needed."* (Rwanda 09, Implementer)

3.1.2 Enabling environment

The year Twubakane began, 2005, was a time of rapid change in Rwanda. In 2003, President Paul Kagame had come to power. With this shift in leadership came swift interest in the decentralization strategy, among other changes. One report indicates that decentralization spanned from 2000-2015 (USAID 2009, Rwanda 2011). Multiple respondents indicated that the decentralization process began 6

months into the Twubakane project, which involved decentralizing the MOH and creating new administrative districts. These replaced the former unaligned administrative and health districts with single unified districts. This required a rapid readjustment of the geographic scope of the project which involved multiple stakeholders. One implementer explained,

> *"Within 6 months of starting, the government announced that they wanted to fast-track decentralization, which meant they created brand new districts. Instead of having separate administrative districts and health districts, they were all aligned. Originally it was crazy. Every health district would have like 2 or 3 administrative districts within it. They decided to create 30 districts for the whole country, so every district had a locally elected mayor, which actually greatly facilitated the project at being a decentralization and health project…From then on, the annual work plans were really done with the national programs; whether it was the national malaria program, the family planning program, child survival in general, maternal health, but also had district-level activity plans that were approved by the district health officer and the district team. So it was very participatory."* (Rwanda 04, Implementer)

Several respondents referred to the first year of decentralization as a "mess" accompanied by significant staff turnover at the central government level and cultural shifts. Two tensions mentioned several times were that 1) many of the new, decentralized roles were taken over by younger, less experienced Rwandans and 2) the roles and responsibilities of these new positions were not always well defined. One respondent described these tensions:

> *"I know that there were issues with the MOH; let's just put it that way. You know, what their role was as things evolved; their stewardship role versus their implementation role. I'm sure there were issues there and as I mentioned, there [were] also issues of roles and responsibilities in the districts as the roles shifted. We had to do a lot of participatory workshops just to clarify who was doing what; what they thought their job was. You had the old, authoritarian hospital director versus this new kid on the block [who] was coming in to manage the health office. It wasn't always an easy transition, so that had to be sorted for sure."* (Rwanda 01, Implementer)

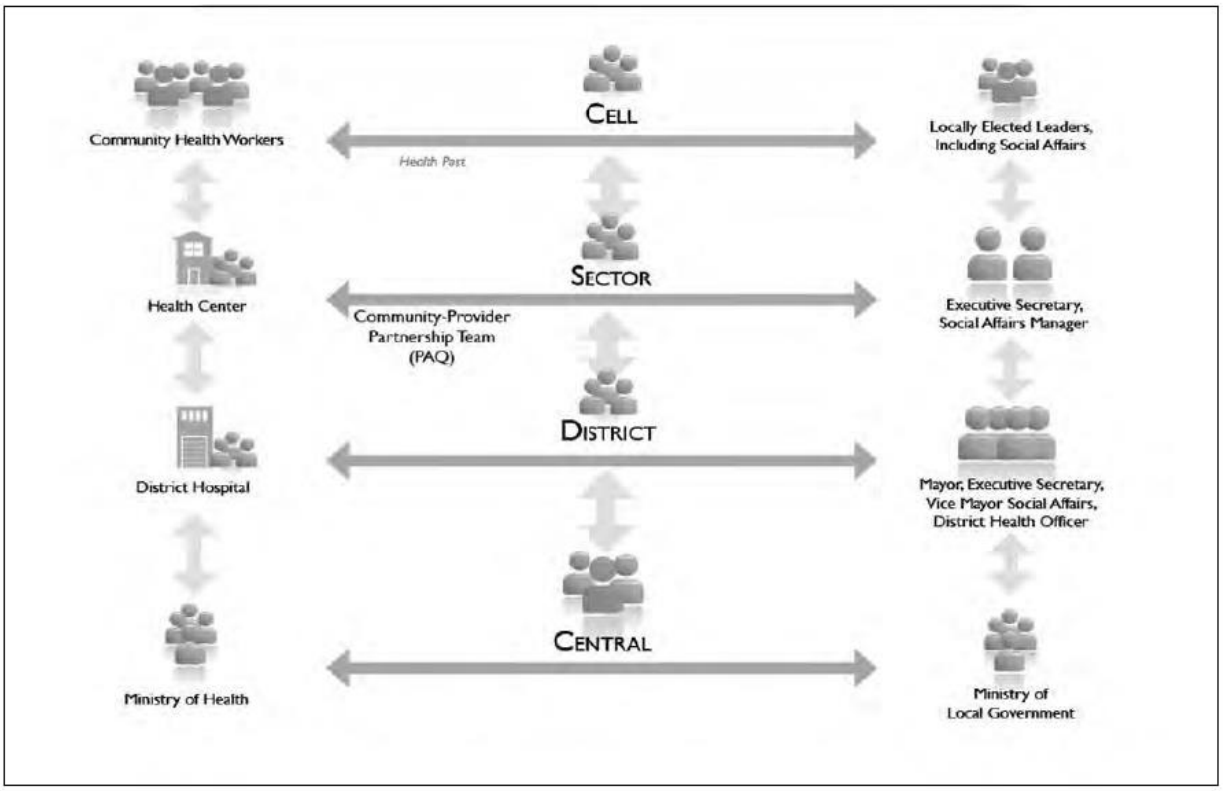
Though decentralization began as a somewhat chaotic transition, many respondents viewed Twubakane in a positive light. Given the focus of the project on health systems and governance, it "*came at the right time"* in Rwanda (USAID 2006:6). One respondent described Twubakane as "*responsive and timely*" (Rwanda 02, Implementer) to various opportunities in 2005 provided by health system decentralization. Further, the government was actively working towards and receptive to change.

Many government policies supported decentralization and Twubakane's work [Government of Rwanda (GOR)'s Health Sector Policy and Strategic Plans (2005-2009), the Decentralization Strategy (2004–2008), Vision 2020, and the EDPRS (Economic Development and Poverty Reduction Strategy) (USAID 2009)]. However, Twubakane's lack of funding for and focus on HIV was unusual for the GOR and resulted in minor tensions. One respondent is under the impression that in 2005, Twubakane was the only US government-funded project not receiving PEPFAR funding (Rwanda 04, Implementer). When the Executive Secretary of Rwanda's National AIDS Control Commission became the Minister of Health (NIH 2015), questions about why Twubakane was not collaborating with the National AIDS Control Commission increased (Rwanda 04, Implementer). The same respondent described being asked multiple times to remind officials why Twubakane was not focused on HIV. Each time, the respondent would reply that there were many NGOs already working on these issues and that Twubakane did not have PEPFAR funding, though it did receive some during the life of the project. Because it was only a nominal amount of funding, it did not significantly change project activities.

The government of Rwanda had a, "*desire to develop economically*" (Rwanda 09, Implementer) in 2005 and to rebuild after the 1994 genocide. The respondent further elaborated, "*Rwanda was still going through a*

lot of not 'healing' exactly, but you know what I mean". This desire to develop and heal provided a healthy participatory framework through which Twubakane was able to engage with project stakeholders and execute the work.

Figure 3: Rwanda Health and Decentralization Diagram



Source: USAID 2010:8

3.1.3 Implementation setting

The impact of decentralization was felt from the very top to the local administrative levels of governance and health systems. The staffing structure and job roles and responsibilities changed at the ministerial, provincial, and district levels, which led to significant changes in not only leadership, but overall who was in charge of what. One implementer explained,

> *"The MOH shrank by 30 people at the national level, which severely curtailed their ability to do a lot and power was shifting to the local levels, de-franchising provinces and really improving and strengthening the role of districts in all of this. The way health services were managed locally was [also] shifting. Traditionally it had been the heads of the provincial and district hospitals that were in charge, but because of the restructuring, they were creating new health offices and putting much younger people in charge of those offices. They were kind of colliding with the traditional health managers, the facility managers. All the while roles and responsibilities were really confused and confusing. Our project had to help sort all of that out and make sure that everyone was involved in that process from top to bottom." (Rwanda 01, Implementer)*

The ministries Twubakane worked with had unique organizational cultures and internal politics to navigate. In addition to the fast-paced staffing changes, there was a shift to doing business in English as opposed to French. While not mentioned in project documents, this was confirmed by an NPR article from 2008 which discusses the replacement of French with English as the, "*language of business, diplomacy, and scholarship*" in Rwanda. The author notes that this is due to the fact that those in power, including President Kagame, are English speakers because many were in exile after the genocide and learned English abroad (NPR 2008). One implementer noted that with the *"transition itself in terms of the bilingual between the French, English, and Kinyarwanda… there was lots of government [Ministries] where you had the Minister was [speaking] one language, the Deputy Minister came from another… they were really trying to do a lot of balancing there"* (Rwanda 09, Implementer).

The Rwandan culture is seen by many development partners as being one of compliance and a "*zero tolerance policy*" towards corruption (Rwanda 11, Implementer). This was both a facilitator and a barrier for the project. According to those interviewed, GOR staff largely complied with government policies. This high level of compliance facilitated swift decentralization, and even the abolishment of plastic bags almost overnight, according to one implementer. But this compliance seems to be a result of what some development partners see as the authoritarian-like governance of the GOR, which had an impact on implementing agencies, including the Twubakane program. For donors, being in compliance with the GOR meant accepting that their ideas had lesser weight in project-related decision making, even to project branding.

> *"I know there were some challenges in terms of the real, not just the buy-in, but the real ownership of some of the directions of the project, some of the visibility of the project and I think all of us working in this know of the challenge of too much attention called to a project versus the government's help and the project's TA to make the health sector perform better. I think at different times in that project there was tension around the whole branding. It was Twubakane and this USAID project as opposed to the government sort of health system...I think there were some people in the government who didn't like the fact - I don't know if they ever said it, that there was so much visibility around the project." (Rwanda 09, Implementer)*

Additionally, following the culture of compliance meant that implementers did not have the flexibility to test out as many new creative and innovative ways to implement as they and USAID would have liked. This also was a result of what the government sometimes called "pilotitis," as many development partners were eager to test out pilot approaches in specific geographic areas. As a respondent explained,

> *"I think the hardest part was when you wanted to do something innovative and they were – the only thing they didn't like and were always forbidding was pilot projects…if it was a good idea and they approved it, then you had to do [it] everywhere in the country and if it's not a good idea then we won't do it. That I felt like was a problem when trying to do something innovative—which USAID likes—because they [GOR] just didn't think pilot projects were necessary or needed."* (Rwanda 05, Implementer)

One respondent felt bureaucracy was an issue, citing there was, "*more bureaucracy than I've seen in some countries as far as getting approval… I felt it was hard to do any sort of research in the country because of the bureaucracy around that*" (Rwanda 05, Implementer). But overall, because the project "*followed Rwandan policy*" (Rwanda 05, Implementer), most respondents did not feel the government was prescriptive or restrictive.

According to one respondent, it was illegal to talk about the genocide in a way that one could be accused of "genocide denial" and to mention, by name, the major ethnic groups in Rwanda, (Rwanda 11,

Implementer) but its impact could still be felt. The project used an inclusive staffing approach to comply with this law and gain the trust of Rwandan stakeholders.

While the administrative and political changes underway complicated the implementation setting, the GOR handled the changes relatively well. According to multiple respondents, the GOR is known for making changes quickly, *"I think Kagame has even used this in his speeches. He talks about Rwanda being a country in a hurry. So when they would decide that something worked, they decided not to do sort of a gradual kind of scaling up, but to move quickly to sort of a national roll out" (Rwanda 11, Implementer).* As it turns out, family planning innovations, the community health insurance scheme called "mutuelles de santé" and the overall decentralization strategy, three of Twubakane's initiatives, were among those the government believed "worked," facilitating political support for the project.

3.1.4 Project features

The Twubakane project was implemented in Rwanda from 2005 to 2010 by a consortium led by IntraHealth International. The consortium included sub-contractors, (RTI International, Tulane University, and EngenderHealth), as well as local implementers RALGA, Pro-Femmes Twese Hamwe, and VNG. The consortium worked in partnership with GOR stakeholders, including the Ministry of Health, Ministry of Local Government, and District Mayors, in addition to other development partners such as GEZ and the Dutch SNV who helped implement the decentralization activities.

In collaboration with the aforementioned groups, Twubakane used 1) technical assistance, 2) capacity-building activities, and 3) grants to help the GOR decentralize its health system down to the district level. While the project name, "Twubakane Decentralization and Health" might suggest a siloed approach, the Kinyarwanda meaning of "Twubakane" is actually "let us build together." Respondents agreed that the project was collaborative, innovative and groundbreaking at the time. A project document from 2009 confirms this,

> *"Rebuilding service delivery capacity of the state was a key objective of the government following the genocide, and health services figure prominently among the services that citizens need and desire. The government's interest in decentralization is in part driven by the performance link between decentralization and improved service delivery."* (USAID 2009:5)

The following six components and associated objectives of the project (see Annex C for detailed activities) balanced a bottom-up approach to planning with close and consistent central-level government engagement to ultimately increase access to, quality, management and use of family health services (USAID 2010).

1. Family Planning and Reproductive Health

Project Profile

Title: Twubakane Decentralization and Health Program

Period: January 2005-January 2010

Funding: USAID

Budget: Over $34,871,226

Prime contractor: IntraHealth

Sub-contractors: RTI International, Tulane University, EngenderHealth

Rwandan Counterparts: Government of Rwanda, Ministry of Local Government, Ministry of Health, District Mayors, District Accountants, and other local administrators

Local implementers: RALGA, Pro-Femmes Twese Hamwe, VNG

Development Partners: GEZ [GED], the German cooperation, the Belgian technical cooperation, the Dutch SNV, B and G international, DFID, the Swiss technical cooperation, the Swedish development organization, and the Canadian Development Organization

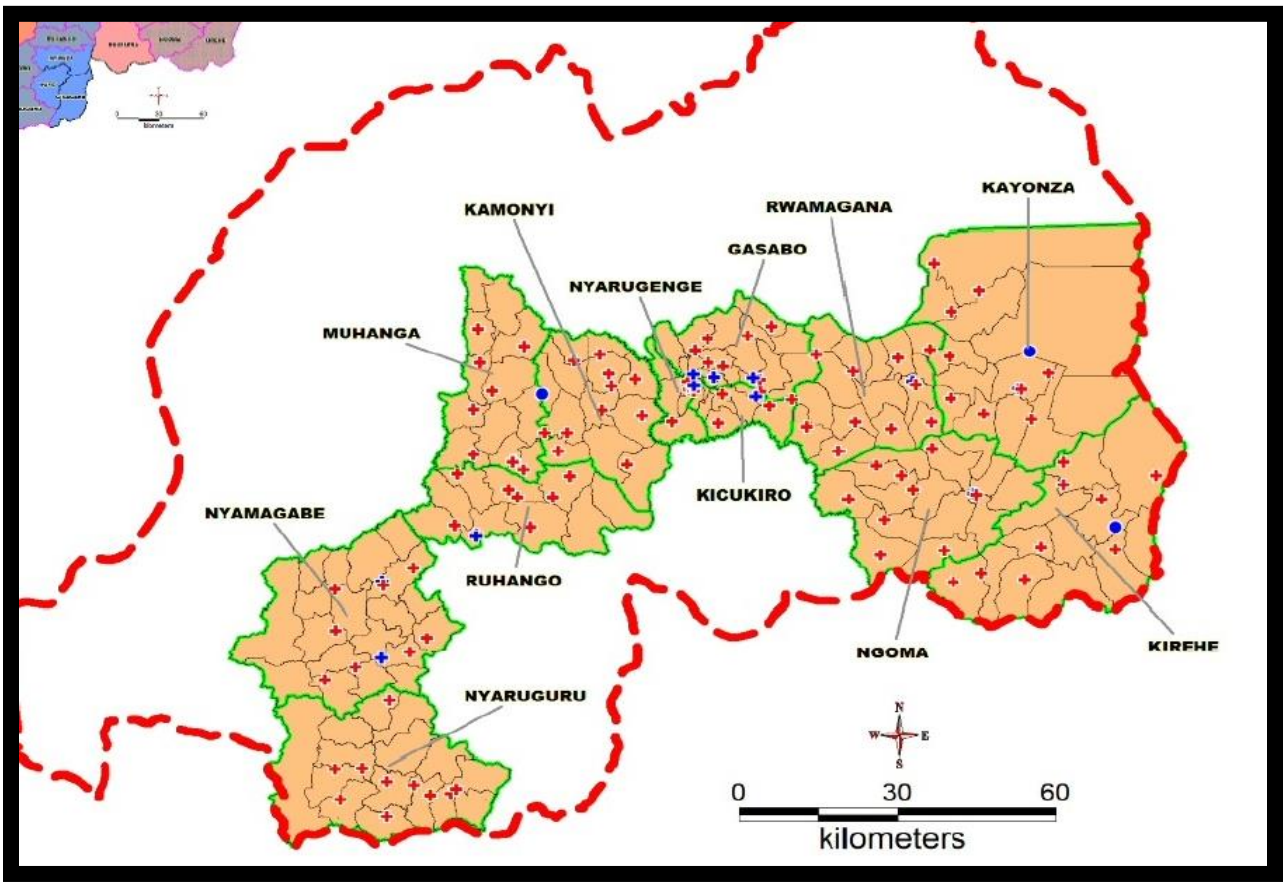
Focus: Local district management and financing to inform access to and quality of healthcare services

    a. Increase access to and the quality and utilization of FP and RH services in health facilities and communities

2. Child Survival, Malaria and Nutrition
    a. Increase access to and the quality and utilization of child health, malaria and nutrition services in health facilities and communities
3. Decentralization Policy, Planning and Management
    a. Strengthen central-level capacity to develop, support and monitor decentralization policies and programs, with an emphasis on health services
4. District-Level Capacity Building
    a. Strengthen capacity of districts to plan, budget, mobilize resources and manage services, with an emphasis on health services
5. Health Facilities Management
    a. Strengthen capacity of health facilities, including health centers and hospitals, to better manage resources and promote and improve the functioning of *mutuelles*
6. Community Engagement and Oversight
    a. Increase community access to, participation in, and ownership of health services

The project's approach was to improve access to and the quality of services, while improving the government's ability to maintain these services on their own. In the words of one implementer, the approach, *"was to build the capacity of the government of Rwanda at all levels – the central level, MOH, local governance, and Ministry of Finance quite honestly, as well as [the] district level to be able to prioritize health needs, budget and plan for meeting the health needs, and work with strong community engagement to improve health outcomes and improve governance"* (Rwanda 04, Implementer).

Figure 4: 2006 Revised Twubakane Intervention Zones (Twubakane Program)



Twubakane was a cooperative agreement implemented in 12 districts (see Figure 4). Several respondents felt that the nature of the cooperative agreement allowed Twubakane more flexibility and closer collaboration with USAID and GOR than contracts might.

The project supported more than a third of Rwanda's population (USAID 2010). According to one implementer, Twubakane worked in 14 hospitals and 56 health centers (Rwanda 03, Implementer). This was done with USAID funding, which increased over time. Twubakane was initially funded at $24 million, but received a total obligation of $28,379,327 from USAID (USAID 2010). In Year 3, Twubakane received PEPFAR and PMI funding. PMI funding was used to support more in-depth policy development and integration with existing malaria prevention activities. In Year 4, Twubakane discovered that the full anticipated funding from USAID was not available and thus revised 2009 workplans accordingly. As a result, some planned activities were postponed or cancelled (USAID 2010). At one point, a $1 million grant was awarded by the William and Flora Hewlett Foundation to engage parliamentarians and mayors in the project's family planning work (Rwanda 04, Implementer). In addition, a grant of $250,000 was awarded by the David and Lucille Packard Foundation specifically to support adolescent reproductive health. Ultimately, the project's cost-share and leveraging added approximately $6,491,899 of associated cash and in-kind programming to the budget for a total of $34,871,226 million over the course of the project (USAID 2010).

Twubakane's strategy was comprehensive yet targeted (IntraHealth, 2007). The project used a number of guiding principles to achieve its cross-cutting objectives. These strategies encompassed stakeholder engagement and criteria for improved decision-making, among others:

- *Capacity building* for existing systems, especially newly created districts.
- *Partnership* to privatize markets using DIF and engage stakeholders at all levels, from Community Health Workers and religious leaders to President Kagame.
- *Integration with GOR policies* (both existing and those that were developed during the life of the project). This involved a collaborative planning process to ensure district performance contracts reflected and aligned with these policies.
- *Creativity, innovation, and flexibility* by adapting interventions to both central- and district-level needs.
- *Gender equity* by including this as a criteria in District Incentive Fund (DIF) grant requests and MINISANTE's community health policy, requiring one female and one male community health worker per community (IntraHealth 2007:10).
- *Data-driven* informed decision making by 1) using Rwanda's Demographic Health Survey data (Rwanda 04, Implementer) to inform project planning, 2) contributing to an assessment of the national HMIS, 3) helping to computerize community health and mutuelles health information systems, 4) building district-level capacity to make data-driven decisions, and 5) contributing to the institutionalization of National Health Accounts (NHA).
- *Accountability and transparency* by building capacity for planning, budgeting, and financial and programmatic analysis capacity and promoting GOR's zero tolerance for corruption initiative in partnership with RALGA.
- *Community and individual participation* through government "accountability days", community participation in Partenariat pour l'Amélioration de la Qualité (PAQ) teams, mutuelles, and providing a platform for CHW elections.

Below we outline key events from the life of the project including major contextual or policy changes, and project milestones. These include, but are not limited to, the redistricting process of 2006, the evolution of the DIF, and the dates when major GOR policies were instated.

Table 1: Project timeline

Year	Event
2005	USAID awards Twubakane to IntraHealth and partners and launch of administrative reform and redistricting process.
2006	MINISANTE identifies PAQ as best practice; MINISANTE conducts first Joint Health Sector Review with Twubakane support; GOR's redistricting and territorial reform begins; first district mayoral elections held; Twubakane helps develop the first "imhigo", performance-based contract between the district mayors and the President of Rwanda; District Incentive Funds (DIF) grants initiative starts after initial delay; Rwanda joins the President's Malaria Initiative (PMI) which Twubakane supports via strategy and work plan development; GOR begins updating MPA/Complementary Package of Activities (CPA) for Family Health to expand the coverage of services; and partners contributing technically and financially to the NHA workplan sign Memorandum of Understanding (MOU).
2007	Government rolls out national health insurance coverage law; Twubakane holds workshop and presents a revised strategic proposal to USAID and GOR - in response, USAID/Rwanda raises budget ceiling to $30,689,199; Twubakane submits continuing application to GOR and USAID; and Community-Based Health Information System (CHIS) pilot tested in response to MINISANTE request.
2008	Citizen report cards obtained for a number of services across sectors; Adam Smith International conducts nationwide district capacity building needs assessment; Twubakane focuses on sustainability strategies for each program-supported intervention; Twubakane implements on-the-job training around FP services in hopes of making access to these sustainable; Twubakane conducts assessment of the financial viability of mutuelles. Results show about 70% of mutuelles from the Twubakane-supported districts risked bankruptcy in 2008 due to management problems or insufficient funding to pay health facilities' bills; Twubakane helps hospitals and health centers develop strategic plans and adapts health facility management manuals to local context; Mutuelle financial viability assessment results presented at national mutuelles workshop, prompting MINISANTE and development partners to conduct nationwide audit.
2008, 2009	Twubakane continues to participate in Health Sector Cluster Group and Decentralization Sector Cluster Group and supports initiation of new Health Development Partners Group.
2009	Full anticipated funding from USAID not available so Twubakane revises 2009 workplans accordingly; some planned activities are postponed or cancelled so funding leveraged from other development partners for some activities and a few districts take on the funding themselves; MINISANTE incorporates PAQ into National Quality Assurance Policy; Twubakane holds participatory stakeholder workshops with representatives from USAID, MINISANTE, MINALOC, National Decentralization Implementation Secretariat (NDIS), partners, and supported districts, hospitals, etc. where accomplishments and lessons learned are reviewed and a commitment is made to maintain momentum and ensure sustainability; End-of-Project Ceremony held with nearly 200 participants including the Minister of Health, the US Ambassador, etc.; and Revised MPA/Complementary Package of Activities (CPA) for Family Health still under review by MINISANTE.
Jan 2010	End of project

The project asserts that it contributed to the health improvements documented at a national level for the areas targeted by the project. For each relevant project component, we highlight these improvements below (USAID 2010):

1. Family Planning and Reproductive Health

a. Couple years of protection increased by almost five-fold between 2005-2009
b. Nationally, the use of modern contraception increased from 4% in 2005 to 27% in 2007/2008
c. Use of partograms in health facilities increased over 60%
d. ANC visits almost doubled between 2006-2009 (from 52, 519 to 92, 027)
e. FP secondary posts had measurably increased access to and use of modern contraception.

2. Child Survival, Malaria and Nutrition
    a. Between 2005 and 2008, the infant mortality rate reduced from 107 to 62 per 1000 live births and the under 5 mortality rate decreased from 196 to 103 per1000 live births
    b. Home-based management of fever (HBM) went from not being offered at all to being offered in 5 districts
    c. The number of children under 12 months of age receiving DPT3 increased by 15%.
    d. All 12 Twubakane-supported districts had trained and validated hospital training teams in Essential Obstetric and Newborn Care (EONC).
    e. 75% of health centers were actively implementing clinical Integrated Management of Childhood Illness (IMCI).
3. Community Engagement and Oversight
    a. CHWS began offering Child Survival/Malaria/Nutrition services in 5 focus districts
    b. 84% of health centers had a PAQ team working to improve health services
    c. The Community-based Health Information System was tested in 2 districts and was later merged into the national community-PBF system

Health governance outcomes were also achieved. A 2009 health governance study led by RTI evaluated Rwanda's progress in terms of 1) responsiveness, 2) leadership, 3) voice, 4) accountability, 5) transparency, 6) evidence-based decisions, and 7) efficiency & efficacy. These were assessed on a Likert scale. The evaluation found that the largest impact on health governance outcomes came from increased efficiency and effectiveness (USAID 2009:30). One of the respondents was actively involved in the health governance study. They shared their own perspective on the study results:

> *"What we concluded is that the biggest impact on health governance fell into the category of increasing efficiency and effectiveness … helping district mayors to be better at fulfilling their responsibilities, helping people to meet requirements for funding and reporting. A lot of the interviewees cited things like increased service utilization rates, higher immunization rates, better health insurance coverage; that was the link to the health outcomes.…Then the second largest category was on the accountability. Here it had to do with the accountability open house days…the training of auditors that essentially had to do with financial accountability and the DIF. Those funds essentially forced the local governments to specify how they were going to use the money, what the purposes were. It increased the accountability of planning and budgeting more than had been there before. Then I guess in terms of the other areas, we noted some increases in responsiveness around contributing to the enabling conditions of the health system so management training, better facilities. The SWOT [strengths-weaknesses-opportunities-threats] analysis helped people determine where they needed to make improvements."* (Rwanda 11, Implementer)

Other study respondents felt differently. They felt Twubakane's greatest impact on health governance was increased citizen voice. They felt that "accountability days", PAQs, mutuelles, etc. ensured that health and government officials took citizens' voices more seriously. As a result, citizens were more empowered to contribute to health governance activities.

3.1.5 Project Design

As previously mentioned, Twubakane was a unique and creative project. One implementer asserted that the project design was risky for USAID because it was innovative. According to the implementer, *"as far as I know it was one of the first projects in which that much money, 6 million dollars, was set aside for district grants*" (Rwanda 02, Implementer).

The project design was responsive to the needs of the GOR. Respondents from the Prime had the impression that USAID worked closely with representatives of the GOR to draft the cooperative agreements' RFA (Rwanda 04, Implementer). The implementers refined the project design in response to the RFA and during post-award and ongoing meetings with both the GOR and USAID. From large-scale changes such as the actual project intervention zones, to adapting health facility training manuals to local contexts (USAID 2010), interventions were modified and adapted as needed. Most stakeholders from the district to the national level, USAID, and civil society organizations, were engaged in the project design process (USAID 2010).

3.2 Pre-implementation

3.2.1 Implementation groundwork

The implementation groundwork was influenced by the characteristics of the implementing organizations and project planning. Twubakane was IntraHealth's first bilateral project. While many respondents appreciated the sense of "family" and collaboration the prime created, several respondents recognized how much IntraHealth learned from RTI. This was made possible especially due to the close collaboration between the IntraHealth COP and the RTI senior staff member on the project team (Rwanda 09, Implementer).

> "*I think we were all learning also as an organization, that being our first bilateral that we were really leading and responsible for, drawing on the lessons that we learned from being a sub on other bilaterals in terms of the partnership and how we engaged partners and counterparts at the district and central level and what then were going to be the activities that were really going to move us farther along." (Rwanda 09, Implementer)*

Not only the project design (see section 3.1.5), but also the structure, was unique for a USAID project. It appears no one was hired as DCOP, though one respondent did mention RTI's "acting COP" (Rwanda 05, Implementer). Further, there were only two expats on the RTI team; the American lead and a Senegalese expert on health facility management (Rwanda 01, Implementer). One respondent felt the structure was a key to success that should be replicated.

> *"I really liked this project and I think about it when I am writing proposals and designing projects. I liked that there was a COP and then there were these 5 team leads. There wasn't an actual DCOP. I really liked that structure. I think we had weekly or bi-weekly senior team meetings with the COP and us 5 team leads. That got the 6 of us on the same page. I really liked that and I think USAID always requires this COP and a DCOP and no one knows where to put the M&E team and nobody knows how finance*

fits in or finance is sort of pushed to the side and it's vertical, so I really liked that structure with these 5 senior team leaders." (Rwanda 05, Implementer)

Planning was done as a larger project team, including MOH. The parliamentary liaison shared that the MOH was the final step in approving Twubakane workplans, *"because most the activities were implemented supposedly with MOH so there would be a consultation about those activities"* (Rwanda 08, Implementer).

"Team spirit" was cultivated and valued, from the annual work planning process down to individual project activities. This facilitated the visibility and impact of the project.

> *"At one point we had more than 70 staff members and innovative things we did was once a month we had an all staff meeting and that meant all staff including the drivers and the accountants…I remember because the first time we had the all staff meeting all the drivers were in the parking lot and all the accountants were back in their offices. It was just the technical team and I thought, 'is this everyone?' They were like, 'no they are not'. They wanted the whole team and wanted the drivers to understand the project. It was great because the drivers became so engaged that they asked for additional work. For example we gave them all training in photography so that when they went out instead of sitting in their car when we were in the health center, they could walk around and take pictures. I mean, not that they were great pictures, but they felt like they were more engaged in the project and the goal was kind of too, that everyone who worked there was an ambassador and spokesperson for the project and should at least be able to describe to their friends, family, and neighbors what the project was all about. They probably thought were really weird at first (laughs), you know what I mean because we tried to make it less hierarchical than maybe Rwandan culture was used to, but in the end I think it really sort of pulled the team together." (Rwanda 04, Implementer)*

One consistent perspective across respondents and project documents is the challenging environment resulting from rapid decentralization efforts in 2005-2006. But Twubakane's ability to implement the project regardless, with only some delays to start-up of planned activities like the DIF, are what respondents felt made it so successful.

3.3 Implementation

As indicated in section 3.1.4, IntraHealth was the prime, heading up the three components related to health and performance improvement. RTI was the primary subcontractor, responsible for the three components related to governance. They also conducted an evaluation of Twubakane's health governance outcomes in 2009 (Rwanda 11, Implementer). Tulane and EngenderHealth were also engaged, though project documents and respondents did not elaborate much on their role. Our research indicates that many additional local implementers were involved, but it was not possible to gain a clear picture of every organization's role and responsibilities. A clear theme across implementers was strong collaboration with Rwandan counterparts and the ability to adapt and be flexible as the political climate and GOR expectations changed.

Note, we interviewed staff who worked for the prime (IntraHealth), the sub (RTI) and the Ministry of Health. We mostly learned about implementation of the decentralization process, and less about the implementation of technical assistance and more targeted capacity-building activities.

3.3.1 Execution process

For most respondents, the theme of collaboration with both GOR and district officials was part and parcel of each phase of implementation. In fact, a key strategy was that the project integrated its activities into existing health system programs, as required by the government.

"The Twubakane activities had to be integrated into the country's plan. We could not propose new activities, but rather we integrated the activities into existing health system programs, those of the local administration, and those of civil society. There was something that all implementers at the district level had to do; something we call the 'action plan' or the 'district development plan'. Using the district development plan, we would integrate our activities into existing programs to further reinforce them." (Rwanda 03, Implementer)

According to one respondent, start-up involved implementing innovative training approaches as soon as possible and relaunching some family planning policies which had not been updated since 1994 (Rwanda 04, Implementer). Twubakane staff did so by participated in government workgroups like the Health Sector Cluster Group and Decentralization Sector Cluster Group (USAID 2010). They also developed a Joint Health Sector Operating Plan together with other donors and partners (Rwanda 04, Implementer). With the workgroups, Twubakane staff worked to ensure the project supported and aligned with existing Rwandan policies like the Economic Development and Poverty Reduction Strategy, Vision 2020, Health Sector Policy and Strategic Plans (2005-2009) and the Decentralization Strategy (2004–2008). Part of this work was also informed by the Twubakane Program Steering Committee (USAID 2008b).

"The dialogue between the Twubakane project team and the counterparts at the central and local level, for me was important. The management of the project was discussing the counterpart's view on the priorities…the government was separated and I was looking [at] how the project was in the national plan and having a valid plan, some common agreement for [an] acceptable plan." (Rwanda 06, MOH)

At the local level, Twubakane staff worked hand-in-hand with district officials from planning to execution of capacity-building activities to ensure ownership and sustainability of the work.

"We met once a month for just a debriefing about what is going on as the routine staff meeting, but they [Twubakane staff] are fully there in case they need a technical representative from the program level. So the opportunity was there, but there was technical support who was on a daily basis assisting and identifying the key challenges in the districts to make sure that that issue, or planning at the district level [was implemented] from [the] bottom up instead of what was used from the Ministry to the districts." (Rwanda 08, Implementer)

Similarly, the Partenariat pour l'Amélioration de la Qualité (PAQ) (an IntraHealth addition to the proposal, not specified in the RFA), or community-provider partnerships approach, was particularly valued by project implementers. This initiative engaged community stakeholders (i.e., teams of health center managers, providers, and community representatives associated with community health centers) to meet regularly to discuss solutions to gaps in their health care service delivery (USAID 2009a:3). One respondent complimented the project explaining, "*Twubakane used a bottom [up] approach to plan its interventions, taking into account the real needs of end users*" (Rwanda 10, Implementer).

"It did have a strong community component – there was the whole PAQ component that was very critical in the whole design as well in terms of community engagement on the governance piece, but why weren't people accessing services if they were there? Well, they were treated poorly or the health center was a mess…starting to have much more of that dialogue between community leaders. I know they put in place those community groups that had teachers and religious leaders and strong women's groups that could then dialogue more with the health sector." (Rwanda 09, Implementer)

While critical to project success and a buttress for the "bottom-up approach", the numerous work plans required of the district officials and the Twubakane project overall were a source of frustration for many respondents. Not only were they numerous, but the requirements changed over time. Twubakane had to report progress towards multiple operating plans for the MOH, while USAID PEPFAR and PMI had completely different formats and expectations for their work plans. Further, few if any of the work

plan timelines aligned. Because many district officials were responsible for these work plans, they did not always have time to fully engage in Twubakane's capacity-building activities.

> *"At the national level there were always discussions. I don't know if they were always before the work planning or after the retreat and before submission there were discussions, but Rwanda had its own work planning process and joint action work plan. One of my complaints is that there were too many work plans. There was a work plan for the malaria unit and a work plan for the reproductive health unit, and they needed all of our work to go in there, but that was usually after USAID needed to see a version of a work plan." (Rwanda 05, Implementer)*

Feedback and refinement was highly valued by the project. Built into the RFA were not only participatory SWOT and situation analyses used throughout the course of the project to align local needs with national strategy resource allocation (USAID 2010), but also regular project activity evaluations. Assessments of the PAQ approach and DIF were conducted. A final rapid facilities assessment in all health centers and hospitals in the program's partner districts were also conducted at the project end (USAID 2010). An assessment of the financial viability of mutuelles resulted in a nationwide audit by the Government of Rwanda of all mutuelles (USAID 2010). Furthermore, once the rapid decentralization process had concluded, the project proposed to, and was approved by USAID, to conduct an evaluation of its governance work. One respondent elaborated that the governance evaluations' respondents may not have been as honest as possible, given the culture of compliance.

> *"The issues around voice and transparency; because of Rwanda's history, the citizen engagement is very much structured by the state. If you want to talk about service delivery that's ok, but anything that veers into anything related to politics is kind of a no-no and as you're probably aware, there's a law that makes any comments about genocide and all that against the law, so you can't bring up any sort of that stuff." (Rwanda 11, Implementer)*

Regular District-level capacity assessments were also conducted. The project responded to the identified needs on multiple occasions. At times, this meant moving resources from a higher-performing district to one with significant capacity-building needs, or obtaining the additional Packard funds to study the family planning context (Rwanda 04, Implementer) and engage parliamentarians and mayors in the family planning work (Rwanda 08, Implementer). Twubakane capitalized on close collaboration with all stakeholders and sharing and dissemination of project documents so that those districts the project was unable to reach with human resources were still able to benefit (Rwanda 01, Implementer).

3.3.2 Changes

Most respondents felt the project was executed as planned, with the exception of the change in implementation zones due to decentralization. Two respondents mentioned project innovations that may not have been part of the RFA; creating secondary posts to increase access to family planning services and training district accountants.

According to a parliamentarian, "*in Rwanda, 44% of health activities are owned by religious leaders who don't accept some contraceptive methods*" (Rwanda 08, Implementer). To increase access to contraceptives, Twubakane worked out an agreement with religious leaders where patients from religiously-funded clinics would be referred to secondary posts when they needed contraceptive services (USAID 2010). At one point, at the request of the MOH and USAID, Twubakane began training providers on a new type of implant for female contraceptives and introduced non-scalpel vasectomies (Rwanda 05, Implementer). The respondent seemed to think these were not outlined in the RFA or proposal.

One unanticipated need that arose was financial training for district accountants. As previously mentioned, GOR was not entirely comfortable with the amount of money offered to the districts

through the DIF. Thus, MINILOC instituted a "fiscal decentralization" and Twubakane assigned district accountants from the Ministry of Finance to, "understand how to finance the technical work at the decentralized level" (Rwanda 03). In the beginning, it seemed accountants were almost afraid to spend the DIF (Rwanda 04, Implementer), possibly due to fear of the zero tolerance policy towards corruption. The project then identified a need to build their capacity for budget management and resource allocation.

> *"Training accountants, we didn't plan on it in the beginning, but we ended up training all of the district accountants on how to do their whole budget because they didn't have the skills necessary, so hopefully that capacity remained. When we first gave the district grants the first year, every district didn't know what to do with $100,000, so they all wanted to do things like build latrines, which there's nothing wrong with that, but they gradually over the life of the project started putting that $100,000 into things like training CHWs or things that had maybe more of a public health impact and not sort of just building things." (Rwanda 04, Implementer)*

One respondent mentioned that trainings were conducted with police officers (Rwanda 05, Implementer) and health center managers in Kigali to encourage police officers to collaborate with health workers to raise awareness of and better respond to gender-based violence. This initiative, not in the original RFA or proposal, was funded through PEPFAR funding awarded to the project in later years.

3.3.3 Actor engagement/dynamics

Overall, the project was collaborative and full of team spirit. "Mutual respect" and "understanding" were frequently used to describe actor dynamics, especially in reference to IntraHealth and RTI. Only two respondents described the dynamics with local partners in-depth. Both respondents agree that these were strong partners, but the development partners' competing agendas and funding often impacted local partners' commitment to Twubakane.

> *"In terms of local partners, RALGA at first was a very good partner, but they had a change in director and some staffing and it became a little more difficult to work with them. It became a little sort of distracted by other partners that they were working with like the Canadians, the Swedes were giving RALGA certain directives in terms of their support and so we felt that RALGA kind of got distracted towards the end of the project..." (Rwanda 02, Implementer)*

> *"I would say locally it was challenging. We had two main local partners that actually had budgets. One of them was called Pro-Femmes, which was sort of a women's leadership organization and then the other one is called RALGA an acronym for Rwanda Association of Local Governing Authorities…Pro-Femmes was good at doing some community mobilization, but they were challenging to work with. I think it's always a struggle when a local organization sees that you are a 30-million dollar project and they want more money and they want more resources, they think they should get them. RALGA was challenging in its own way, although I think it was very creative and important to have that local association of mayors as being on the project team, so with them we were able to do a lot of creative work around sort of anti-corruption campaigns or training district mayors and their teams and planning, budgeting, etc." (Rwanda 04, Implementer)*

That said, there was a sense of ownership of project tasks, especially for implementers involved in the training and capacity-building of the districts. One implementer felt, "that this design of the project and funds went into the districts and the districts were really accountable for them and had a lot of authority around what those funds would be spent on" (Rwanda 09, Implementer). This ownership was partially built through strong project communication. All but one respondent agreed that the prime did an

excellent job communicating. A respondent from the finance team working across all aspects of the project felt that both communication and integration were lacking.

> *"An F&A team is often not well-integrated, so that was part of what I did, was hold these coordination meetings every other Friday. I guess as far as implementation goes, part of the problem was that when they brought me in, all of the different teams were doing all of the things in the work plan, but no one was communicating about if the malaria team was in this region training people and the FP team is in this region and the community health team goes out, you sort of inundate an area all at the same time because people were not really coordinating…So one of the things I did was make everyone come back from wherever they were in the field every other Thursday so that we could have a Friday meeting with all of the team leads." (Rwanda 05, Implementer)*

Work plans, meetings, and annual retreats were used extensively to manage the project and facilitate communication. One respondent felt planning meetings with central and decentralized-level representatives effectively built capacity, especially for district-level administrators (Rwanda 02, Implementer). Eventually, the time spent in meetings became burdensome for everyone involved in the project, from implementers to the target populations. MINECOFIN tried to address this by issuing a directive to all development partners that local counterparts should not be expected to participate as frequently in meetings as it was limiting their availability for actual work (Rwanda 02, Implementer). Similarly, the project Steering Committee[3] had trouble finding times that aligned with everyone's schedules and thus did not meet as frequently as anticipated (IntraHealth2007:32).

Respondents overwhelmingly reported GOR support of the project; several named Jean-Damascène Ntawukuriryayo[4] a champion of the family planning work. However, like many countries, changes in GOR leadership impacted GOR priorities. Twubakane was able to successfully navigate these shifts by staying neutral and engaging all ministries to the extent possible.

> *"We tried to bring MINALOC and MINISANTE together for joint planning at meetings, but it never went above a certain level of government…At the senior level they only wanted individual meetings; they refused to go each other's Ministry. That's just the way it was…I think it was prestige, like "who owns this meeting?" it was about ownership and who had to go where – MINISANTE has to go to MINALOC or MINALOC has to go to MINISANTE, no neutral ground…There were political sensitivities between the Ministries, that's for sure. The MOH itself was trying to figure out what it's role was because suddenly [due to rapid decentralization and empowerment of the districts] it was no longer 'in charge' of a health system, it was pretty drastic as I recall at the time and things were in turmoil in the government because of this new drastic conceptualization. So we had to play it carefully and play a neutral role." (Rwanda 01, Implementer)*

3.4 Maintenance and evolution

3.4.1 Sustaining implementation

An important element of Twubakane was to ensure that eventually, the GOR would be able to sustain the gains made by the project. To ensure this, Twubakane staff 1) aligned project activities with

[3] The Twubakane Steering Committee was comprised of the MINALOC and MINISANTE permanent secretaries, provincial representatives and USAID (IntraHealth, 2007).

[4] Jean-Damascène Ntawukuriryayo preceded Agnes Binagwaho as Minister of Health. He was elected to parliament during the course of the project.

government priorities and 2) planned for effective stakeholder engagement at all levels during the design phase. Several interventions are still in place today, even though the project was only awarded for five years. What may have contributed to these lasting effects is the fact that projects with similar objectives were awarded to Rwandan development partners during Twubakane's project period. Multiple respondents mentioned the Maternal and Child Health Integrated Program (MCHIP) which began in 2008[5]. Respondents suggested that MCHIP's activities overlapped with Twubakane's. Some respondents worked on both projects, because they were hired by MCHIP when Twubakane ended, and had trouble distinguishing project activities and outcomes between the two.

At the end of the project in 2010, over 70 local staff reintegrated back into either MINISANTE or local government jobs and about half got absorbed into other donor projects or USAID programs (Rwanda 02, Implementer). Most local Twubakane staff still work for NGOs today, evidence of the lasting effects of collaborative project management. While it is common for local staff to continue working with NGOs after a large donor project ends, respondents reflected that activities related to community engagement and policy and management have had a unique and lasting impact. Mutelles and PAQ (Rwanda 06, MOH) remain intact today. PAQ was adopted in Senegal and Nigeria (Rwanda 03, Implementer) and was declared a best practice by MINISANTE in 2006 (USAID 2010). Twubakane was an early adopter of HRIS which several respondents felt was innovative and groundbreaking. Since Twubakane, the number of HRIS users continues to increase (Rwanda 06, Implementer).

One respondent believes Twubakane's district-level work has been leveraged by other projects since Twubakane ended, but did not specify which activities (Rwanda 04, Implementer). USAID's Democracy, Human Rights and Governance (DRG Center) included Twubakane in a study on integrating governance into sectoral projects (Rwanda 11, Implementer) and has since mentioned Twubakane to other missions, "as a model to sort of emulate for the sort of integrated approach" (Rwanda 11, Implementer). Maybe most importantly, health indicators continued to improve after the project ended (Rwanda 04, Implementer).

The primary risk to sustaining impact was the lack of a follow-on award. The 1) desire by GOR that international NGO-led projects be limited, 2) growing suspicion of NGOs (Rwanda 04, Implementer) and 3) shift in USAID funding priorities from decentralization to HIV prevented a follow-on award (Rwanda 05, Implementer). Further, the nascent nature of district-level governance and their frequent staff turnover meant that there was limited staff and institutional capacity to continue activities. One responded learned that since the project end there, "was a scandal around the community based health insurance, that there had been a lot of local level embezzlement and all and I think partly that was a function of having pushed through so fast, spreading things out soon without really without putting in place controls and all…" (Rwanda 11, Implementer).

The regular celebration of successes and collaborative identification of challenges and room for growth is evidence of the project's emphasis on documentation (Rwanda 11, Implementer) and dissemination to ensure sustainability. Engaging "the right ministries, including parliament" (Rwanda 07, MOH) was also important, as was seeking regular feedback on process indicators and other outcomes and adapting activities as needed. The number of system-wide evaluations conducted by the project is evidence of this (Rwanda 02, Implementer).

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[5] "MCHIP supports programming in maternal, newborn and child health, immunization, family planning, nutrition, malaria and HIV/AIDS, and encourages opportunities for integration of programs and services when feasible." USAID, http://www.mchip.net/node/1

3.5 Challenges

The wider environment of decentralization was by far the most significant challenge cited by the eleven respondents. Resulting shifts in the implementation zones and the ever-evolving GOR expectations due to staff changes required flexibility and adaptability from the project team. GORs' misunderstanding of Twubakane funding structures, especially the why the DIF were so well-financed, created some tensions in the beginning, but these appear to have subsided over time.

> *"Yes, we had challenges. The first was adapting to this new program that was unique to Rwanda where everyone wanted to claim their stake and we had to clarify, 'no, I'm the one managing this', 'no, I'm the one …' I would explain to the government that this is the American system. We cannot add these funds to our national budget. Initially, this was a challenge. The second challenge was at the decentralized level, how to – we had to- how can I describe this? We owed $500,000 to each district. They were each responsible for the use of these funds, but they also had to show us their spending plan based on the district needs and performance. What ended up happening, however, was that in some districts we were unable to confirm their performance during that period of time. Instead of returning that money to USAID, we gave those districts' funds to the highest-performing districts." (Rwanda 03, Implementer)*

GOR work plan expectations, especially the numerous indicators both Twubakane staff and local government officials had to report on, cut into time that could have been spent on trainings and other project activities. In terms of training, one respondent suggested lack of capacity to be the greatest challenge the project addressed (Rwanda 07, MOH). Similarly, another responded felt the delay in DHS data collection was one of the greater challenges in determining project success.

> *"What's really working from an evidence service output/service quality was a challenge for the project. You always monitoring data and things like that, but I remember waiting for the DHS to really know, had modern contraceptive prevalence had gone up? And what was happening with home-based management of fever and rolling out new protocols, because I think they were doing presumptive treatment of malaria with the babies and the children and then the new protocol came out and it wasn't presumed, you had to validate, so you needed the RDTs. So I think some of the challenges are just the right clinical advancements and rolling them out, but I think the project actually responded quite well too many of them." (Rwanda 09, Implementer)*

Finally, Twubakane's visibility contributed to GOR-Twubakane tensions, as did the government's distrust of NGOs towards the end of the project (Rwanda 04). As previously mentioned, these were also contributing factors to Twubakane's failure to be re-awarded.

3.6 Success Factors

As introduced above, respondents reported several success factors around collaboration, communication, engagement, and implementation:

Collaboration, communication, and leadership:

- Strong, collaborative project leadership which was open to learning as it was their (IntraHealth International's) first major bilateral project as the prime.
- Excellent communication with "really high-functioning, high-performing teams and team leaders" (Rwanda 09, Implementer).
- Mutually respectful team-building approach integrated across project activities, from proposal-writing to project implementation and closeout. This required flexibility and adaptability.
- Effectively communicating the importance of capacity-building activities to district-level officials.

Project planning and implementation:

- Twubakane's bottom-up approach to project planning and implementation.
- Aligning the RFA with existing GOR initiatives and incorporating activities to engage consistently in GOR policy development and implementation.
- Integrated health and governance approach; "health systems strengthening".
- Allowing for innovation and at times, piloting activities at the encouragement of USAID, largely due to the fact that this was a cooperative agreement (as opposed to a contract).
- Ability to seek out and secure additional funding from the Hewlett Foundation, the Packard Foundation, and others.
- Integration of regular monitoring and evaluation, documentation, and dissemination.

Engagement:

- Successful engagement of key stakeholders, especially the highest levels of government, the most local staff, including project drivers, and USAID.
- Identifying and supporting project champions at the all levels; from President Kagame to journalists asked to engage in a photography contest to promote family planning activities (Rwanda 04, Implementer). Mayors were especially important for DIF and family planning activities.

3.7 Dissemination

The prime discussed Twubakane's branding and dissemination at length with GOR in order to promote government ownership of the policies and programs that facilitated positive changes. The project put significant effort into documenting and distributing important project information to hand over not only to USAID but also those reached by Twubakane. As noted earlier, USAID is said to have touted the project as an example of health systems strengthening but none of the respondents named specific USAID-funded projects that had emulated Twubakane. But at least one respondent has taken lessons learned about building financial capacity and the "power of the cross-sectoral programming" through DIF to other countries moving from a centralized to a decentralized model (Rwanda 09, Implementer).

To ensure Twubakane successes were recognized on a larger scale, the project held a close-of-project presentation for the USAID mission and delivered multiple presentations to the Global Health Bureau in Washington, DC (Rwanda11, Implementer). Finally, there was an End-of-Project (EOP) Ceremony with nearly 200 participants, during which lessons learned were discussed. Participants included the Minister of Health, the US Ambassador, and the USAID Mission Director, as well as the MOH's Permanent Secretary, the governor of the southern province, mayors, hospital directors, other representatives from all 12 of the Twubakane-supported districts, and a variety of partner organizations (USAID 2010).

3.8 Lessons learned

Many respondents seemed to walk away with a better sense of how to implement health systems strengthening (HSS). Though few used the term HSS, several mentioned "integration of health and governance" and a recognition that the six WHO Health Systems Framework Building Blocks are "necessarily intertwined" (Rwanda 04, Implementer). Yet another respondent came away realizing that it was not only important to *partner* with GOR, but rather to *follow and support the GOR's goals*.

"I do think that the biggest challenge was this, and I don't want to over play it, is this project versus the government's program. That I think in some ways was a little bit painful for us afterwards, that we really had to- maybe that was like the hardest lesson to learn, that the emphasis was that we were really accompanying the government and partnering with government, but it's really about the government's program and their goals." (Rwanda 09, Implementer)

Some additional lessons learned that respondents reported include the value in:

- Regular communication between team members and stakeholders.
- Building highly effective teams through regular communication and in-person retreats. Most respondents mentioned the positive impact retreats had on the team dynamic.
- Stakeholder engagement, from GOR officials to local community members, in the planning and implementation process.
- Convincing the target population of the importance of the activity. Twubakane was able to improve district-level financial planning and administrative capacity because district officials understood and agreed that these were important. One respondent applied his experience from Twubakane to his work creating Water User Associations in Senegal (Rwanda 02, Implementer).

4. DISCUSSION AND SYNTHESIS

In this section we discuss our results and synthesize the key factors that led to the successful implementation of the project.

4.1 Synthesis

Here we discuss both facilitators and barriers to the success of Twubakane's implementation. The facilitators build on the integrated, system-level, bottom-up, adaptable, mutually respectful project approach described in earlier sections.

4.1.1 Facilitators

Engagement of MINECOFIN (Ministry of Finance) in health issues. Family planning is often a very political issue, thus requiring more stakeholder buy-in than other project activities. Twubakane's engagement of MINECOFIN in these issues not only increased their awareness, buy-in, and financial support of family planning activities, but was also an innovative and unique approach.

> *"I think this integration, I mean you don't see it that often, that a project is doing this decentralization, that's what we call it but a lot of it is health systems and health management capacity strengthening with the health services all the way from hospitals to the CHWs. It was a big project, but I think that integration made people have dialogues that we wouldn't normally and I would say in most projects I've ever worked on, you work with the MOH and I've not since or ever before engaged with the Ministry of Finance; it's not in my job description. But I think [with this] project you had to, there was engagement with MINECOFIN, which means we had a better understanding of some of the issues between MINECOFIN and the MOH and some of those higher levels systems that I personally have not been privy to." (Rwanda 05, Implementer)*

District-level capacity building. Twubakane's cross-sectoral design and bottom-up approach was especially useful at the district level. Using its cross-sectoral design, Twubakane's district health teams were able to work with their counterparts in other agencies to "really advance the particular challenges of the district" (Rwanda 09, Implementer). To achieve district buy-in, Joint Action Work Plans were described as time-consuming, but also required in order to be "truly meaningful to local actors and to have any chance of actually being implemented" (USAID 2010).

Highly capable local staff. Many local project staff received either graduate-level education in Rwanda or education abroad as refugees of the 1994 genocide. This enabled them to effectively implement Twubakane activities (Rwanda11, Implementer).

4.1.2 Barriers

Reluctance to implement pilot projects. At some point, one respondent felt that it was unwritten GOR policy that interventions were only allowed to be tested and implemented if they were evidence-based [and could be scaled nationwide] (Rwanda 05, Implementer). Although Twubakane, with the buy-in of the GOR, was able to introduce several innovations, the GOR's reluctance to fully support pilot

activities did limit the level of innovation the project could introduce, despite the encouragement of USAID to experiment pilot activities.

Substantial reporting requirements. Some respondents implied that they were not always able to spend as much time implementing as they would have liked due to the extensive amount of time necessary to write the reports required by USAID due, in large part, to the integrated nature of the project and change in USAID/Rwanda staff throughout the five-year project.

The project's introduction of best practices like PAQ, which were adopted and incorporated into GOR quality assurance guidelines, reinforced Twubakane's commitment to both influencing and aligning with GOR policies and initiatives. This remained a strong facilitator for the projects' success throughout its duration. Stakeholder engagement from the RFA development through the end of the implementation phase was critical to sustaining the projects' gains once it ended. Not only were stakeholders engaged, but they actively participated, communicated, and shared lessons learned. This created a family-like team dynamic where leadership was respected, but everyone was valued. Over the course of the project, roles and responsibilities became more defined. This further strengthened both project- and health system-level capacity.

4.2 Limitations

This report is based upon the views of eleven respondents. Among these, most were implementers who worked for either the prime or the sub-contractor during Twubakane's implementation. The others worked for MOH at the time. None of the district-level staff, health care providers, or community leaders' views are represented. Furthermore, there is a risk of recall bias. Interviews were conducted in 2016, but the project ended in early 2010.

4.3 Conclusion

The Twubakane project helped successfully decentralize the Rwandan health service delivery system and subsequently strengthen district-level health service delivery capacity, resulting in improved health outcomes.

By aligning early and often with GOR priorities, the project ensured sustainability. Using an informed and respectful approach to the country's unique history and cultural context, project staff were able to collaborate closely with stakeholders at all levels. Twubakane's commitment to ensuring staff understood their roles and responsibilities allowed the project to implement with excellence.

In this way, the project helped create a more transparent and responsive health governance process to ensure that women and children especially, are better served by a quality health care system.

ANNEX A: COMBINED IMPLEMENTATION FRAMEWORK

Phase	Domain	Factor	Description	Unit of analysis
I Pre-condition	Enabling environment	Wider environment	Economic, political, social, and health system context within which intervention[6] is implemented	National/regional context
		External policies and incentives	Strategies to spread intervention – policy, regulations (not directly implemented by project but (pre)existing) Policies that constrained implementation Other donor led initiatives that complement intervention	National/regional context
	Implementation setting	Characteristics of organization	Structural characteristics of organization such as social architecture, age, maturity, and size of organization Culture of organization such as norms, values, basic assumptions of organization	Change target/larger host organization[7] (identify for each case; e.g. MOH)
		Implementation climate	Climate within organization, including relative priority of project, readiness for implementation, learning climate, and policies, procedures, and reward systems that inhibit or facilitate implementation	Change target/larger host organization (identify for each case; e.g. MOH)
	Project design	Intervention source	Stakeholder perception if intervention internally or externally developed	As applicable for each case (e.g. MOH, local partners, change target)
		Identification of effective intervention	Process for deciding intervention approach and activities Stakeholder perception of quality and validity of evidence that intervention will have desired effects Perceived relative advantage and complexity/perceived difficulty of	As applicable for each case (e.g. MOH, local partners, change target)

[6] The total package of activities that is implemented by the project.
[7] Institution within which activities are being implemented; may be MOH or other local organization (will focus on larger organization like MOH rather than individual hospitals); depending on the case this organization may be more or less involved in the actual implementation.

			intervention	
		Adaptability	Degree to which intervention was adapted to local needs, including degree to which beneficiaries' needs were understood and design was adapted to meet their needs	Project implementers[8] (e.g. prime + subs)
		Draft package	Perceived quality of how intervention is presented	As applicable for each case (e.g. MOH, local partners, change target)
2 Pre-implementation	Implementation groundwork	Structural characteristics of implementing organization	Structural characteristics of implementing organization such as social architecture, age, maturity, and size of organization; culture of organization such as norms, values, basic assumptions of organization	Project implementers (e.g. prime + subs)
		Implementation climate	Climate within project including relative priority of project, readiness for implementation, learning climate, and policies, procedures, and reward systems that inhibit or facilitate implementation	Project implementers (e.g. prime + subs)
		Planning	Degree to which intervention is planned in advanced, quality of methods; refinement of draft package based on pilot testing, stakeholder feedback	Project activities
		Orientation and logistics	Quality of initial planning and execution of the project, including needs assessment, pilot testing, leadership engagement	Project activities[9]
3 Implementation	Implementation	Executing	Fidelity of implementation	Project activities
		Engaging	How the project attracted and involved appropriate individuals throughout project: opinion leaders, formally-appointed internal implementation leaders, champions, external change agents	Project activities
		Feedback and refinement	Qualitative and quantitative feedback about progress and quality of implementation Refinement of activities based on feedback	Project activities

[8] Prime contractor and sub-contractors (may include local subs) who implement the project. This does not include the change target organization.

[9] Specific activities directly implemented by the project implementers. These may or may not align with other activities in the change target organizations. These individual activities make up the intervention as a whole.

		Cost	Costs of total intervention - planned and actual	Intervention
4 Maintenance and evolution	Sustaining implementation	Organizational, financial changes	Changes made to sustain the intervention	Project implementers (e.g. prime + subs); Project activities
		Re-customize delivery as need arises	Adapting the intervention delivery as circumstances change	Project implementers (e.g. prime + subs)
	Dissemination	National dissemination	Preparing refined package, training, and TA program for national dissemination; was project nationally disseminated	Project implementers (e.g. prime + subs); Change target

ANNEX B: KEY INFORMANT INTERVIEW GUIDE

Instructions

First complete informed consent to conduct interview and ask permission to record.

Ask as many of the primary questions as is feasible given the time constraints and as are appropriate for the respondent given their role in the project. Ask probe questions as applicable. Prioritize the most important questions if you do not have sufficient time to ask all applicable questions.

Respondent's role

1. Can you tell me about your involvement with (PROJECT)?

    a. When were you involved with (PROJECT)?

2. Who were you working for during that time? (e.g. Implementing partner (specify); USAID Mission; USAID HQ; government counterpart; other—specify)

    a. What was your position or title with (PROJECT)?

    b. Did you change organizations or positions during your time on (PROJECT)?

Pre-condition

3. What problem(s) was the (PROJECT) trying to solve?

    a. Who felt this was an issue of concern? (e.g., MOH, US Mission, other stakeholders?)

    b. Why did they see it as a concern?

        PROBE: What evidence was this based on?

    c. Was there a country/government initiative or reform targeting this issue that the (PROJECT) was intended to support? Please describe briefly.

4. How did USAID decide to fund a project to address this problem? Who was involved in the decision?

    a. What evidence was used to understand the issue?

        PROBE: Evidence used by respondent or respondent's organization, other partners, local stakeholders, USG?

    b. What approaches or activities did USAID specify in the RFA/RFP? (*Skip if can answer from documentation*)

        PROBE: Did other stakeholders contribute to what was specified in the RFA/RFP?

    c. How did USAID decide what to include in the RFA/RFP? Did other stakeholders contribute?

5. How was this (PROJECT) selected to address (ISSUE)?

a. Who was involved in the selection?

6. Can you briefly describe the (PROJECT's) approach and activities?

    a. Which do you think were the most important activities?

7. During the work planning process, how were the specific activities used in (PROJECT) selected?

    a. Who contributed to these decisions?

        PROBE: Prime or subcontractors, US Mission, MOH, hospitals, (PROJECT) participants, beneficiaries

    b. What other information influenced the selection of the (PROJECT) interventions? (e.g. government priorities, new USAID/USG initiative, existing policies/regulations, new financing, etc.)

    c. Were other interventions considered but not selected?

    d. How much consensus was there between stakeholders about the design of the interventions?

8. How were the intervention sites identified? (e.g. hospital, school of nursing, etc.)

    a. Who contributed to these decisions?

9. How were the activities designed to be appropriate for the local health system context?

    a. How were planned activities piloted?

    b. How were planned activities adapted to existing conditions during the (PROJECT)?

Pre-implementation

10. Were there any individuals or organizations who provided strong support for the (PROJECT)?

    a. How did they promote (PROJECT) implementation?

        PROBE: Did they promote implementation at individual sites or for particular activities?

    b. What are the reasons they supported the (PROJECT)? (e.g. specific to (PROJECT) or supportive to larger country initiative?)

11. Were there any individuals or organizations who delayed or impeded implementation of (PROJECT)?

    a. How did they impede (PROJECT) implementation?

    b. What are the main reasons they impeded it?

12. Can you tell me about the dynamics of the individuals and organizations working on (PROJECT)?

    a. How did these evolve over time?

Implementation

13. How were (PROJECT) activities implemented?

    a. Were all the activities implemented in all of the project sites? (*Skip if can answer from documentation*)

    b. Were activities implemented in phases? (*If yes*) What were the phases? (*Skip if can answer from documentation*)

    c. Did the (PROJECT) activities change over time? (*If yes*) Why? (*Skip if can answer from documentation*)

    d. Were changes documented? (*If yes*) How? (*Skip if can answer from documentation*)

    e. How did contextual factors affect implementation? (e.g. social, economic, political, technological, etc.)

14. Was there consensus among different partners and stakeholders about how the (PROJECT) was implemented?

15. Where did the resources for (PROJECT) implementation come from? (e.g. (PROJECT)/(PARTNER), USG, government, others) (*Skip if can answer from documentation*)

    a. Was there enough funding and other resources to support (PROJECT) implementation?

        PROBE: financial, technical, human, technological.

    b. (*If there was a shortage of resources*) How was the shortage addressed?

16. What challenges were faced during day-to-day (PROJECT) implementation?

    a. Were there any issues with policies or regulations?

    b. How did (PROJECT) address these challenges?

17. How were (PROJECT) activities monitored and/or evaluated? (*Skip if can answer from documentation*)

    a. Who was responsible for monitoring implementation progress? Was this part of standard implementing practices?

    b. Was an evaluation conducted? By whom? Who requested it? Who paid for it?

    c. How were findings from M&E incorporated into implementation?

    d. What was the response to M&E findings?

18. What dissemination activities were undertaken during (PROJECT)? (e.g. small-scale meetings at (PROJECT) sites, national workshops presenting findings, feedback sessions to USG, etc.) (*Skip if can answer from documentation*)

    a. How was feedback disseminated throughout (PROJECT)? (e.g. (PROJECT) participants, end-of-the-line beneficiaries and policymakers)

Maintenance and evolution

19. What was done during (PROJECT) to support continuation of activities after (PROJECT) ended?

a. What role did (PARTNER) or others have in helping to sustain the activities?

b. What role did others play in sustaining the activities? (e.g. US Mission, MOH, intervention sites, communities)

20. What is the current status of activities included in (PROJECT)?

    a. Who has taken responsibility for sustaining the interventions? (e.g. financial, organizational, technical responsibility)

    b. What are the long-term prospects of the interventions?

    c. What, if any, are the plans to scale-up/expand the interventions from (PROJECT)? (e.g. same country, other settings)

Reflections

21. What do you think were the impacts of (PROJECT)? (e.g. changes in health status, improved service delivery, increased quality of services.)

22. Were there any consequences from (PROJECT) that were unintended or unexpected?

23. What were some challenges to the overall implementation of (PROJECT)?

    a. How could have these been addressed during the implementation period?

    b. Do these challenges remain an issue today? Why?

24. What were the key factors that led to the success of (PROJECT)?

25. What are some lessons learned from implementing this intervention that you would take forward on other projects of this nature?

26. Is there anything else we have not discussed that you would like to share about the implementation of (PROJECT)?

27. Do you have any questions for us?

ANNEX C: DETAILED ACTIVITY TABLE

Intervention Area	Components	No. of sub-activities
Family Planning	1. Revising policy 2. Increasing Access to and Use of Quality FP Services 3. On-the-Job Training for Family Planning 4. Introduction of Permanent Methods—non-scalpel vasectomy 5. Creation of "secondary posts" near Catholic-run facilities 6. Integration of FP and HIV services 7. Improving quality of and access to safe motherhood services 8. Improving Gender-Based Violence Prevention and Response 9. Partnership with Pro-Femmes Twese Hamwe	9
Child survival, malaria and nutrition	1. Prevention and Control of Malaria 2. Integrated Management of Childhood Illness (IMCI) 3. Increasing awareness and number of immunizations for vitamins	3
Decentralization Planning, Policy, and Management	1. Collaborate and support policy planning for MINALOC, MINISANTE and RALGA 2. Health Sector Costing and Good Governance and Health Studies 3. NHA 4. Health Management Information System	4
District planning, budgeting and management	1. DIF Grants 2. JADF 3. District Auditors' Training and Orientation 4. Participatory Assessments of Districts' SWOT	4
Health facilities management	1. Revision of Health Care Policies, Norms and Standards 2. Strengthen Health Care Financing via Mutuelles 3. Capacity building of health Facilities Management	3
Community access to, participation in, and ownership of health services	1. Technical assistance for development of new national Community Health Strategy 2. Community Health Worker Capacity Building 3. Community-Provider Partnerships (PAQ) 4. CHIS	3

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