
COLLEGE OF ARTS AND SOCIAL SCIENCES

MASTER'S OF ARTS IN DEVELIOPMENT STUDIES

# The decentralization of health services in Rwanda: Challenges and Strategies.

## KIREHE District Case study

## 2000-2015

A thesis submitted in partial fulfilment for the requirement of master's degree of arts in development studies

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Huye, June 2016

## DECLARATION

**I, IRAGABA Felix**, hereby declare that the work contained in this thesis is my own original work and that I have not previously, in its entirety or in part submitted it at any University for a degree.

Date: ……..

Signature: ……

IRAGABA Felix

## CERTIFICATION

I Certify that Mr. IRAGABA Felix has successfully done and completed his research project in the department of Political and administrative sciences in the Masters of arts in the development studies.

Signature ……

Supervisor :Dr. Innocent NDAHIRIWE

Date ……2016

## DEDICATION

This thesis is dedicated to:

- My dear wife, Esperance Zahabu, and to our lovely chidren: Lydie Bamurange,Umutesi Ingride,Manzi Masezerano Arsene and Asifiwe Gasaro Ester.
- My parents Madabagizi Niyonkuru Ananie and Nyiramajana Lydie
- My regret father- in-law Gatambara Sadock and my mother-in-law Nyiramberwa Dorcas
- My brothers and sisters

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## LIST OF ABBREVIATIONS

CHUB: Butare University Hospital

CHUK: Kigali University Hospital

DDH: District Directorate of Health

DHO: District Health Office

DIP: Decentralization Implementation Plan

DUH : District Health Unity

DPR: Disaster Preparedness and Response

ESV: Enquête sur les conditions de vie

EDPRS: Economic Development for Poverty Reduction Strategy

FAO: Food Alimentary Organization

GOH: Government of Rwanda

GAHFs: Government-assisted health facilities

HIV: Human Immunodeficiency

IDSD: Infectious Diseases Surveillance and Research

IEC: Information, Education, and Communication

KFH: King Faisal Hospital

LG: Local Government

MDGs: Millennium Development Goals

MOH: Ministry of Health

NGOs: Nongovernmental Organization

NIS: National Institute of Statistics

OPC: Out Patient Consultation

ONAPO: Office National de la Population

PIH :Partners in Health

PSC:  Program Steering Committee

RBC: Rwanda Biomedical Center

SWOT: Strengh, Weakness, Opportunity and Threat

UNDP: United Nations Development Program

VCT: Voluntary counseling and Testing

WHO: World Health Organization

## ABSTRACT

Iragaba Felix, (2016), **The decentralization of health services in Rwanda: Challenges and Strategies, Case of Kirehe District**. Masters' Thesis of the University of Rwanda,College of Arts and social sciences.

The Rwandan government has made a significant improvement in decentralizing local institutions. Health sector is among has been also decentralized, from 2000, steps have been taken toward restructuring and decentralizing management. The district health offices have operated as autonomous entities, providing services to well-defined populations in either urban or rural zones. The district health offices are responsible for the health needs of the population in that zone and for the health facilities and services.

However, there is still some gaps or persistent problems to enable local government be more effective in fulfilling their duties in: involving community in the management and running of the health services, providing technical assistance, Planning, The gap of autonomy in financial air management,….

The aim of this Thesis is to analyze some of the challenges of decentralization and specifically in relation to the provision of health services. Apart from these challenges, this thesis identifies the strategies that are necessary in order to overcome these challenges. Studying the challenges and strategies that have come with the decentralization of health services, one needs to understand them from the following research questions: What challenges are being faced by Kirehe District in relation to the decentralization of health services? And what strategies have been put in place in relation to overcoming these challenges? While studying decentralization it necessitates that we understand decentralization as the legal transfer of administrative, political and economic responsibilities from the central government to the local authorities. This is based on the logic that the local authorities have the authority to make decisions and also manage public functions. This is meant to ultimately empower the local people, assist them to run their daily affairs with the support of their local governments. Hence with proper implementation of the decentralization policy, there will be a reciprocal relationship between the citizens and the state, leading to positive state society relations.

In terms of methodology, this Thesis is an exploratory study that tries to understand the implementation process, in terms of challenges and strategies that are in place for successful delivery of services.

The study's findings showed that districts were no longer passive recipients in the planning process, and financing of local government projects, while being actively involved in assessing the needs, allocation of resources and the implementation of activities. The study noted that Community participation is taking place through the elected health committees. However, other members of the communities had a passive responsibility in planning, and budgeting for health related activities. Other findings indicate that local-level participation in health service provision is extremely weak, as local people are not totally involved in the process.

In terms of scientific contribution to knowledge, this Thesis contributes to the pool of knowledge on decentralization, and specifically in relation to the decentralization of health services.

Key: **Decentralization, Health service provision, local government, implementation theory.**

# CHAPTER ONE: GENERAL INTRODUCTION

Many developing countries have decentralized the public health care system in the last twenty years, but little empirical research has been conducted on the effects of these fiscal changes in the health sector (Guilkey and Racelis, 2002). Robalino, Picazo and Voetberg (2001) developed one of the few existing cross-country evaluations of this relationship. This study focuses on the impact of fiscal decentralization on infant mortality rates. This study finds that countries where local governments manage a higher share of public expenditures tend to have lower mortality rates. Additionally, the authors argue that in their sample of countries, the share of public expenditures managed by local governments was correlated with their level of administrative capacity.

Most countries in Africa inherited health systems from colonial government with management practices and administrative structures that were highly centralized, both geographically and hierarchically (World Bank, Better:86).

In Rwanda, the Ministry of Health had the responsibility of health services throughout the country, from the central to district levels. However this situation changed in 2000 when the government adopted the policy of decentralization which involved transfer of significant powers and functions to district offices. The MOH was responsible for providing policy directives and planning guidelines within which these bodies were required to make their decisions. However, this policy faces some problems in its implementation.

This study seeks to discuss on decentralization policy of health services in Rwanda towards increasing local participation of citizens in health services.

This chapter entails the background of the study, historical context of decentralization in Rwanda, Problem statement, Objectives of the study, Research questions, Research hypothesis, Scope of the study, Structure of the study and lastly talk about the contribution to scientific knowledge.

## 1.1 Background of the study

Decentralization policies are part of vigorous initiatives to support rural development. In its most basic definition, decentralization is the transfer of part of the powers of the central government to regional or local authorities. Centralization is in response to the need for national unity, whereas decentralization is in response to demands for diversity. Both forms of administration coexist in different political systems. There seems to be a consensus since the 1980s that too much centralization or absolute local autonomy are both harmful and that it is necessary to put in place a better system of collaboration between the national, regional and local centers of decision-making.

The provision of health services has become an important issue in many developing countries today. The availability of health services, its quality, accessibility, efficiency and community participation are among factors of priority to any government which is committed to providing adequate and efficient health services to its citizen. This move was endorsed by the World Heath summit respectively whereby health was declared as: The Millennium Development Goals (MDGs) which have eight international development goals that were established following the millennium summit of the United Nations in 2000.Among these goals are three related to health: To reduce child mortality, to improve maternal life, to combat HIV/AIDS, malaria and other diseases. These were universal human right and that governments should pursue from 2000. (http://www.ciesin.org/decentralization/English/Issues/CSR.html 15th august 2015.

In Rwanda, the district health systems function under the GOR decentralization policy and frame work.

## 1.2. Historical context of decentralization in Rwanda

Decentralization has been a key policy of the Government of Rwanda (GoR) since 2000 when the National Decentralization Policy was adopted. The main thrust of the policy was, and is, to ensure equitable political, economic, and social development throughout the country, and to be a cornerstone of the fight against poverty and health mediocrity by increasing people's participation in the planning and management of the development process. Since inception of the policy the GoR decided that the

implementation of the strategy should be carried out in phases. The first phase (2001 to 2005) established the primary a community democratic structures and reinforce the core local government body of local government. It aimed at establishing democratic and community development structures at the District level and was accompanied by a number of legal, institutional and policy reforms, as well as democratic elections for local leaders established the primary an community democratic structures and reinforce the core local government body of local government . The second phase (2006 to 2010) was conceived after a territorial restructuring in 2005, which considerably reduced the number of administrative entities (from 11 to 4 provinces, 106 to 30 districts, 1545 to 416 sectors, and 9165 to 2148 cells).This phase focused on enhancing system of effectiveness by making the sector a center for service delivery. . The 2nd phase of decentralization also focused on trying to build capacities (human and financial) at local levels, and to boost local development((Decentralization implementation plan 2011-2015,Kigali,2011:3)

The third begin in 2011 and aimed at consolidating progress on national priorities, such as Vision 2020, and deepen the decentralization process by enhancing effectiveness in service delivery to communities. Enhanced upward accountability, particularly after introduction of the process of performance contracts-"Imihigo", has led to significant achievements in terms of governance, social and economic development, and has reinforced synergies, coordination and harmonization of interventions in local governments. But the next phase needs to improve on the key downward accountability linkages between local government leadership and citizens. This phase focused on additional tasks that has been decentralized to lower levels of administration with focus on the cell as the service delivery point.(MOH,The district health system re-organization guideline from a managerial perspective,2011:6).

The recent evaluation of the decentralization process and regular consultations between stakeholders has indicated a number of challenges hampering optimal functioning of the decentralization framework. These challenges evolve around:institutional and legal framework; sectoral decentralization ,ervice delivery, fiscal and financial decentralization, capacity building interventions in LG, local Economic Development; and Volunteerism, Participation, Accountability and Democratization.

The GoR remains committed to the successful implementation of decentralization, and the 3rd phase Decentralization Implementation Plan (DIP) activities, outputs and outcomes cover a wide range of development and governance areas to deal with the challenges. DIP deliverables will be monitored and evaluated primarily through semi-annual and annual reports and NDIS will be central to the implementation and monitoring of the DIP. The overall coordination of the DIP will be done through the Program Steering Committee (PSC). The PSC can conduct annual reviews if needed but a Mid Term 4 Review of the implementation of the DIP will be conducted by early 2013. The DIP monitoring and evaluation framework will be coordinated with the mechanisms for monitoring the EDPRS and partly receive information from other monitoring systems of central government ministries/agencies and by the local governments themselves where relevant. Particular attention will be paid to the different systems and mechanisms that the DIP will be supporting and is supposed to reinforce. A final evaluation will be carried out to assess if outcomes and outputs have had the intended impact and to determine to what extent the DIP outcomes have been achieved. The main outcomes of 3 rd. phase DIP are:

- Legal and Institutional Framework
- Sector Decentralization
- Service Delivery
- Fiscal Decentralization
- Capacity Building of Local Government
- Local Economic Development
- Participation, Volunteerism, Accountability and Democratization

(Decentralization implementation plan 2011-2015,Kigali,2011:8-9)

Specific emphasis in the study will be placed on whether power has actually been devolved by the central government to the local governments and to what extent this has had a positive impact on the delivery and management of health services at district level thereby leading to development.

### 1.3 Problem statement

The Rwandan government has made the development of the health sector as a major priority. The objective of decentralization was to make local institutions more effective and

accountable in their implementation of national programs and accelerate the social economic development agenda as contained in vision 2020 (MINECOFIN, Rwanda Vision 2020 revised,2012:10).

However, It was realized that the intended objectives of the policy were not achieved nor did the health situation significantly improved, there is still some gaps or persistent problems to enable local government be more effective in fulfilling their duties (Musonerwa M .R, Can Decentralization Contribute to Poverty Reduction? Some Insights from Rwanda, Master's thesis, University of Cape town 2010:76-77) in: involving community in the management and running of the health services, providing technical assistance, Planning, The gap of autonomy in financial air management,… Challenges comprise those factors, which form part of centralized political systems, and are not oriented to community participation and using a top-down development approach.( Mutagoma, Decentralization for community development – a Rwanda Case study, Thesis in University of Stellenbosch ,2006:34)some people have questioned whether the MoH has really decentralized its functions to lower levels or it has actually extended it.

These are the problems which need to be analyzed.

It is in this context that the researcher is interested in conducting a study based on analyzing the decentralization of health services in Rwanda with emphasis on the implementation challenges and strategies and having Kirehe District as a case study.

### 1.4 Objectives of the study

The research objectives have also served to provide guidance and direction to the study. The objective of the study focused on the decentralization of health services in Rwanda with focus on implementation problem the role of decentralization, Kirehe district is our case study. For better doing this research, the general and specific objectives were formulated

#### 1.4.1 General objective

The main objective of this study is to discuss the contributions of decentralization towards increasing community participation and improving local people's use of health services in Kirehe District.

#### 1.4.2 Specific objective

This study shall be guided by the following specific objectives:

- To identify the challenges faced by Kirehe district in implementation of decentralization of health services
- To assess the strategies to overcome this challenges

**1.5 Research questions**

- What are the challenges faced by Kirehe District health sector in implementation of decentralization policy?
- What are strategies to overcome these challenges?

**1.6 Research hypothesis**

According to QUIVY, R. and COMPENHOUDT (1995:150), and hypothesis is a proposal which anticipates a relation between two terms which, according to cases', can be concept or phenomena. It is thus a provisional proposal, a presumption, which requires to be checked. Consequently, a hypothesis will be confronted, in a later stage of research with data of observation.

The challenges faced by Kirehe District in health sector were observed since the MOH has not fully handed over health services to the district, many functions are still under the control of the MOH and community participation however efforts is still low, the health needs of the community is initiated by health officials particularly those at the district, district hospital and health center levels.

To overcome those challenges, strategies aimed to increase the involvement of community in health decision are needed, there is a need of reinforce a health decentralized system, insure that the MOH delegates powers, functions and authorities to specific bodies, by devolving functions to District Health Offices . This power does not only include decision making but also administration of financial resources. The DOH remained with the responsibility of standard setting and policy formulation.

**1.7 Scope of the study**

The study is limited on space, time and domain

### 1.7.1 In space

This study will be carried out in the administration of Kirehe District which is located in Eastern province because it is among the rural districts in Rwanda; secondly it is the area I work as local leader.

### 1.7.2 In time

About the time the present study covers the period of 15 years means from 2000 where decentralization policy was adopted up to 2015. The second year of 2015 indicates the time of carrying out of the present research.

### 1.7.3 In domain

This research is focusing to the decentralization policy in to health development and its implementation challenges; this topic is related to Governance as a domain**.**

## 1.8 Significance of the study.

Decentralization as a process of transferring authority and functions from the Centre to the periphery governments is intended to result in good governance. The quest for good governance in both developed and developing countries has taken Centre stage. Governments design policies, which are intended to improve people's welfare and subsequently lead to development.

The decentralization policy in Rwanda is one of such policies, which intends to encourage popular participation, accountability, and therefore enhance good governance and development in various domains including health sector.

The present research has the interest in the following ways:

### 1.8.1. Personal interest

A personal interest is developing the knowledge about decentralization in Rwanda and to know more how the decentralization has contributed to the development of health services in Rwanda especially in Kirehe District.

### 1.8.2. Scientific and academic interest

Regarding the scientific interest, many researchers look at decentralization of health system, but with this research its interest is on challenges faced by Kirehe District in the process of decentralization of Health system and strategies to overcome.

Concerning the academic interest, this study is done in order to fulfill the requirement of obtaining the master's degree.

### 1.8.3. Social interest

This study aims to assist community to understand the impact of decentralization in health services; it enables the community to know much more about strategies that can be put in advance to strengthen the implementation of decentralization on social walfare.

## 1.9 Structure of the study

This study is divided into five chapters:

- Chapter one covered the general introduction
- Chapter two deals with theoretical and conceptual frame work
- The chapter three analyze contextualization of decentralization in Rwanda
- The fourth chapter deals with research methodology
- The fifth chapter deals with data analysis and interpretation
- The sixth chapter comprised the summary of findings study, conclusion taken from the finding recommendation.

## 1.10. Contribution to scientific knowledge

Although a lot of research has been done on decentralization, not much research has been done on the decentralization of health services in particular at the local level. The literature on decentralization appears to be diverse and it has increased a lot of recent. Academic research that is targeting decentralization in Rwanda especially has been done especially by Taylor C, 2014; Scher .D (2012); Kabayiza B (2014); Mugume P.( 2015); Niamh G (2013), Mutagoma P

(2006), and Musonerwa M.R(2010). This research explains the challenges faced by Kirehe District in the process of decentralizing the health services and the strategies to overcome them. The focus of this thesis is on decentralization, specifically on the implications of the decentralization of the health sector. In addition the focus is on decentralization, and specifically the district health systems where primary health care services are delivered, this thesis is mainly addressing primary health care services.

### 1.11. Chapter summary

Chapter one is about the general introduction of the study, talks about the background of the study, Historical context of decentralization in Rwanda, Problem statement, Objectives of the study, Research questions, Research hypothesis, Scope of the study, Structure of the study and lastly talk about the contribution to scientific knowledge.

# CHAPTER TWO: THEORITICAL AND CONCEPTUAL FRAME WORK

Before entering into the practical work of the research, we need to first understand certain theoretical and conceptual aspects. In this context, this chapter will focus on decentralization as concept, how it functions, types of decentralizations.

In undertaking this study, a variety of literature will be reviewed in this chapter with the aim of analyzing the concepts related to the topic such as decentralization, health, challenges, and strategies. The sources of literature analyzed include research reports, books, newspapers, journals, electronic material, and workshop presentations, among others.

Although the amount of literature on decentralization has increased greatly over the past two decades, the debates have remained quite linear. Writings on political decentralization focus on the degree local participation plays in effective governance, fiscal decentralization literature primarily examines local or national fiscal potentialities.

This literature review aims at ascertaining what other authors and scholars have discovered in respect of similar research problems, in addition to identifying possible theoretical gaps that need to be addressed. The literature review will also provide a theoretical backdrop against which the results of the research study can be interpreted.

## 2.1. Definition of key terms

### 2.1.1 Decentralization

According to Yilmaz (2002), decentralization is the legal transfer administrative, political and economic responsibilities from the central government to the local authorities to make decision and management of public function and empowerment of the people to run their daily affairs through their local governments

HUSSEIN (2004:43) opined that the discourses in development studies show the variations in the meaning, purpose and forms attributed to the concept of decentralization.

For instance concepts such as participation , delegation, decocentration and devolution are associated with decentralization .As a process decentralization involves the transfer of authority and power to plan , make decision and manager resources , from the higher to low levels of the government, in order to facilitate efficient and effective service delivery(SMITH 1985:1)

Decentralization is the process that provides a structure arrangement for democratic and peaceful development to be planned and implemented at local community level with participation of the local people. It is an arrangement which can facilitate such activities only when it is appropriately designed and implemented and under the appropriate condition, such as, political leadership will, bureaucratic commitment, and popular craving for empowerment. Decentralization succeeds best in situation where there is a strong central government As well as an empower community level.

### 2.1.2 Centralization

The concentration of management and decision-making power at the top of an organization's hierarchy.

UNDP Report (1997:47) define centralization as just the opposite of decentralization as proposes a strong center taking away all powers from down the levels it's the tendency to restrict the delegation of decision -making usually by holding it at the nearest top of organization structure. In other words is the situation where top management is in the hand of the people who takes all the organization decision.

### 2.1.3. Local government

The term 'local government' normally refers to units of the public administration that do not depend hierarchically on the central government administration for those public functions that they have the authority to exercise in an autonomous way. Typical examples are the district, but in some countries important degrees of autonomy are granted at regional, provincial, or municipal levels as well. Municipal governments are often created only in urban areas over a certain size, whereas decentralization of responsibilities for rural areas often stops at the district level. However, some countries, for example Bolivia, Mali and Cape Verde, transfer responsibilities for rural areas also to municipal level.

The people responsible for a local government can be elected locally or appointed by the central government. However, the term 'local government' is increasingly associated with a democratic system of selection. It is important not to confuse the local units of the central administration with the local government administration. Although the two administrations operate within the same territorial boundaries, their functions generally differ. The former is accountable to the politicians responsible for the central government, the latter to the politicians responsible for the local government, and ultimately, to different constituencies of the politicians in power at the two levels. (http://www.fao.org/docrep/005/y2006e/y2006e05.htm)

### 2.1.4 Health

Most of the definitional issues raised by the authors with regards to 'Drowning' apply to the definition of 'Health'. Although concern with health and disease have been a major pre-occupation of humans since antiquity, the use of the word 'health' to describe human 'wellbeing' is relatively recent. The word 'health' was derived from the old English word 'hoelth', which meant a state of being sound, and was generally used to infer a soundness of the body (Dolfman M.1973,491-497).

Scores of definitions of 'health' are available on the Internet. The most commonly quoted definition of health is that formalized by the World Health Organization (WHO) over half a century ago; "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity." (WHO,1948).

### 2.1.5. Health Services

According to WHO(2016:1), health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services.

Health services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions.

Improving access, coverage and quality of services depends on these key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users.

According to Australia privacy law and practice (2014:1), health services are an activity performed in relation to an individual that is intended or claimed (expressly or otherwise) by the individual or the person performing it.

### 2.1.5 District health system.

District Health System consists on an administrative office, district hospital and network of health centers that are either public, government assisted not by profit or private. Its key functions are to organize the delivery the minimum and complementary sevices,manage logistics and resources as well as supervise community health workers(MOH,the District Health System re-organization guide line from a managerial perspective,2011,Kigali:p6).

### 2.1.6 The health policy

According to WHO, a national health policy is an expression of goals for improving the health situation, the priorities among those goals and the main directions for attaining them (WHO 1979:15).

The specific objectives among others are to: ensure that health services become available and accessible to all people wherever they are in the country, whether in urban or rural areas; move towards self sufficiency in manpower by training all cadres required at all levels from the village to the national level and sensitize the community on common preventable health problems; and to improve the capability at all levels of the society, assess and analyze problems and design appropriate action through genuine community involvement

### 2.1.7. Challenges

Challenges are defined as the situation of being faced with something that needs great mental or physical effort in order to be done successfully and therefore tests a person's ability(http://dictionary.cambridge.org/dictionary/english/challenge,Cambridge dictionaries on line,2016:1, 12/12/2015).

Challenge is also something that tests strength, skill, or ability, especially in a way that is interesting(Dictionary of contemporary English,Pearson,London,2012,:263)

### 2.1.8. Strategy

Is a method or plan chosen to bring about a desired future, such as achievement of a goal or solution to a problem. It is the art and science of planning and marshalling resources for their most efficient and effective use. The term is derived from the Greek word for generalship or leading an army. Strategy also is a high level plan to achieve one or more goals under conditions of uncertainty. In the sense of the "art of the general", which included several subsets of skills including "tactics", logistics etc.( http://www.businessdictionary.com/definition/strategy.html 17/04/2016)

Strategy is again an adaptation or complex of adaptations (as of behavior, metabolism, or structure) that serves or appears to serve an important function in achieving evolutionary success.( http://www.merriam-webster.com/dictionary 12 /12/2015)

## 2.2. Decentralization of health services.

Decentralization is a recurrent theme in the literature of public administration and development. Only recently it has been promoted in the health sector as a key component of the strategies aimed at reaching Health for all.

The decentralized health services as a means of achieving greater coordination and responsiveness to local needs through delegation of responsibility, authority and resources to the community and to the intermediate levels.

Anne Mills and others have identified the following expected benefits from decentralization of health services:

* a more rational and unified health service;

* greater involvement of local communities;

* containment of costs and a reduction in duplication of services;

* reduction in inequalities; 7

* integration of activities of different agencies;

* strengthening health policy and planning functions of ministries of health;

* improved implementation of health programs;

* greater community financing and control;

* greater community coordination; and

* reduced communication problems and delays (Anne Mills et al , 1990:142) .

The main argument for decentralizing health system is that greater local participation in health policy and local accountability can lead to improved quantity (including coverage) and quality of service. Moreover, DeMello (2004) stated that decentralization in the health sector tends to be more complex than in other sectors because diseconomies of scale. He argues that these diseconomies of scale tend to discourage sub-national governments in the provision of costly curative treatments and immunization. At the same time, he argues, spillover effects tend to discourage the sub-national provision of preventive health care, particularly immunization and epidemiological controls. Nevertheless, decentralization of the health sector has become appealing to many researchers, international donors, and policy makers because it raises expectations about several advantages including the following (Mills 1994:24):

• A less unified health service that is better tailored to local preferences.

• Improved success in the implementation health programs. That is, day-to-day overlooking and evaluation, which are necessary for implementation, are more likely to succeed under local accountability • Reduced inequalities between urban and rural areas and between accessible and secluded regions of the country. This is assumed to occur due to proximity and responsiveness of rural local governments and providers to the needs of rural people—typically, in poorer countries rural areas tend to be more underserved than urban areas.

• Lower costs due to better targeted programs. This argument assumes that local service providers would tend to have better information about the local population to better allocate resources to target the poorer income groups.

• Greater community involvement and higher chance of sustainability in the long run. Little concrete evidence confirms these potential benefits, however. Few developing countries have long-term experience with health sector decentralization, and its impact on the management of the sector and on the services it delivers has rarely been evaluated (DeMello 2004).

In Rwanda, decentralization of health services is expected to increase greater involvement of local communities, improved implementation of health programs and strengthening health policy and policy planning functions of the MoH.

**2.3. Theorization of decentralization:**

Scholars have tried to conceptualize decentralization and they have remarkably treated the problem of conceptualizing it. Decentralization is a transfer of decision making power and assignment of accountability and responsibility for results. It is accompanied by delegation of commensurate authority to individuals or units at all levels of an organization even those far removed from headquarters or other centers of power.
(http://www.businessdictionary.com/definition/decentralization.)

FUMIHIKO SAITO Decentralization is a process through which sub national government increasingly partakes in deciding on and administering essential public policies. Various decentralization measures are currently being implemented in many parts of the world, primary because it's hoped that decentralized state will fulfill high expectations reflecting the diverse demand of our time. Decentralization reforms have become particularly popular since the 1980s. This measure is expected to make state both democratic and developmental. As regard democratization, decentralization is intended to widen the opportunities to participate in local decision making processes. As for economic development it is anticipated that decentralized states will improve the general welfare by making public services more responsive to the different needs of people. Therefore decentralization has often been regarded almost as a" panacea" a policy that is indisputably and normatively justified , even if nobody has officially proclaimed decentralization as such.

According to Akpan H.E (decentralization and service delivery: a Framework, Nairobi, 2007),The presumption is that lower levels of government, for example, a local government, is better placed at perceiving the desires and demands of its constituents for public services than a

distant centralized government. It is for this reason that most developing economies are stressing decentralization, a process of pushing responsibilities and resources to lower levels of government.

Fadime Cinar ( Decentralization in health services and its impacts: SWOT Analysis of Current Applications in Turkey,Istambul,2013,p712) argue that The main idea of decentralization is based on the argument that smaller organizations inherently more agile and accountable than are larger organizations.

Decentralization does facilitate and encourage local Participation, then the benefits of community involvement – improved project design and implementation due to better match with beneficiary needs and better appreciation of local constraints etc. - can follow, and result in greater efficiency in government activities, especially in the long term.( Nannyonjo J and OKOT,2013.)

In the 1980s analyst tended to overlook the historical, political, and social economic contexts in which this complex reform has to take place. In 1990s more empirical investigation started to report that decentralization sometimes is implemented in a halfhearted way, and often resulted in unsatisfactory outcomes. While the good intention behind decentralization can be appreciated, the important point is to examine whether such noble intention can actually be realized in the harsh realities of today's world especially in developing countries.

According to World Bank,the term "decentralization" embraces a variety of concepts which must be carefully analyzed in any particular country before determining if projects or programs should support reorganization of financial, administrative, or service delivery systems. Decentralization -- the transfer of authority and responsibility for public functions from the central government to intermediate and local governments or quasi-independent government organizations and/or the private sector -- is a complex multifaceted concept. Different types of decentralization should be distinguished because they have different characteristics, policy implications, and conditions for success.

Rizal P. Dhurba (2001) identified the two fundamental dimensions of Decentralization as:

• Decentralization as means; where decentralization is the process of Transferring functions and power from the central government to the local Government units and organizations.

• Decentralization as a philosophy; where decentralization entails the sharing of power and functions between and among the various levels of governments And enables them to identify and respond to the local needs and priorities, Mobilize and allocate resources and deliver services. He further states the three principal objectives of decentralization as following:

• Enhance national development throughout the country especially in the under developed regions and areas.

• Enable equal sharing of development responsibilities for the central and local authorities and equal bearing of the national burden of managing and Exercising functions related to national development.

• Enlarge the government capability and capacity to deliver better services to the people and to enrich the knowledge, skill, ability and competency of the people allied with the development related public and non-public Organizations and local government institutions.

Thus, all the definition of decentralization propounded by the various scholars and writers passed on same connotation and concludes that decentralization brings government closer to the people and empowers people to participate in and influence the decision made with their close community.

### 2.3.1. Pro-decentralization argument

Among the many reasons of decentralization is at the heart of the debate between supporters and openers of decentralization policies. The efficiency of argument constitutes the core of the first generation theory of decentralization. The decentralists argued that because local government is located closely to people they are better suited than central government to identified what kind of service people need this information advantage in identifying public needs suggests that local government can produce services that are more responsible to public aspirations. In addition, public needs differ from one locality to another. Local government can provide appropriate solution in each locality whereas the central government tends to impose standardized services across the country.

Participation of citizens in local decision making is an important advantage claimed by decentralist. Participation signifies that peoples have the legitimate right to voice their concerns

in affairs which affect their lives. If and when the poor, the young, the women, ethical minorities etc… can participate in designing implementing public policies. This process it is itself empowering to the marginalized.

In addition, such consultative processes provide valuable opportunities for disseminating critical government information which was not easily accessible before. Accordingly decentralized entities reduce corruption of public funds by political representative and administrators. Furthermore if officials are elected by popular mandate relations between leaders and the population becomes more intensive which in turn contribute to more accountable between leaders and followers.

### 2.3.2. Counterarguments by critics

Critics of decentralization, measures provide Counterarguments to the entire claim made by pro- decentralist. Local people do not necessarily know local issues well. In addition if proximate is to result in knowledge attitude of government officials who tend to be authoritative have to be changed in order to facilitate interactions with people at grass roots especially the poor and the marginalized. In addition whereas local government may enjoy an information advantage, decentralized government often face an increased cost of coordination. Critics argue that precisely because many tasks are devolved from the central to different local government and even to non-government organizations, coordination becomes a critical issue that consume much more energy than centralization. Furthermore critics point out that the closeness between local government and people does not yield positive result. The newly available opportunities of local autonomy are often abused by local leaders.

It is apparent from the above literatures that the demand for decentralization had been very strong. However there are serious drawbacks and if the decentralization measures are not applied at the appropriate moments and circumstances, it may harm rather than heal the decentralization system. Thus, decentralization, although politically very fashionable nowadays all across developing and transitional countries, it does not offer all the promises it makes. Thus, it is necessary to understand the negative effects of decentralization in order to have a better understanding of its dangers and contribute to a wiser application of potentially desirable decentralization programs.

RémyPrud'homme (1995) points out the dangers of decentralization as:

• Decentralization can increase disparities: Decentralization can lead to increase in disparities. This is because the poor in well of regions do well than the poor in more deprived regions. The decentralized redistribution is self defeating. If the authority adopts an income redistribution policy in which the rich are imposed high taxes and high benefits are given to the poor, then the rich people will move to low tax bracket area and the poor will tend to move in from areas that offer lower benefits. The imposing authority will not be able to sustain its policy. Thus, it should be the central government's responsibility to redistribute the income.

• Decentralization can jeopardize stability:

A decentralized system makes macroeconomic policies more difficult to implement. Fiscal and Monetary Policy are the main instruments of macroeconomic policy. Fiscal Policy is a very powerful instrument for stabilizing the economy. It is an instrument which only the central government can manipulate and the local authorities have no incentive to undertake economic stabilization policies. The impact a particular regional government could have on national or global demand and on prices is negligible. Even if the influence of the regional government is significant, most of the impact would be outside its jurisdiction because sub national economics are much more open than national ones and sustain greater leakages to other regions as a result of over spending or under spending. Moreover, a regional government would have to pay the full political cost of an economic stabilization policy that would bring it only partial benefits. Therefore, regional and local governments can never provide enough economic stabilization and thus it is the central government who can provide it.

• Decentralization can undermine efficiency:

The existing literatures on the economies of scale in various local public services are of the view that there are few local public services for which economies of scale imply nationwide supply. The welfare losses attributable to economies of scale that would result from decentralization are probably minimal. There might exist the economies of scope and the central bureaucracies may be more efficient providers than local bureaucracies. The central bureaucracies are likely to operate closer to the technical production frontiers as the central government bureaucracies are likely to attract more qualified people as they offer better carrier.

RémyPrud'homme also holds the view that corruption is more rampant with decentralization. Corruption is more widespread at the local than at the national level and thus decentralization automatically increases the overall level of corruption. This outcome, by the way, might not be bad in terms of redistribution, because the benefits of decentralized corruption are better distributed than the benefits of centralized corruption. However it would certainly increase the costs in terms of allocative efficiency, because it leads to the supply of services for which the levels of kickbacks are higher. It is also costly in terms of production efficiency, because it leads to corruption-avoiding strategies that increase costs, favor ineffective technologies, and waste time.

### 2.3.3. Diverse issues of decentralization

Different political and economic groups support decentralization of different reasons those who emphasized economic efficiency they advocate swift marketization and increases reliance on private service providers. For those who appreciate democratization, decentralization is a promising avenue because its enlarges the scope for citizen participation.

In conclusion Decentralization is an excellent topic, since the various ensure and discussions are relevant both theoretically and practically.

Generally much of the debate related to decentralization involves significant issues in coordinating diverse stakeholders in analyzing political and economic common goods, and often at local levels.

### 2.3.4. Types of decentralization

Different form of decentralization includes political, administrative, fiscal and market decentralization. It is important to make distinction between the various types of decentralization in order to understand the dimensions to successful decentralization and to find out need for coordination among them. However it is not possible to have definite distinction between the different types of decentralization.

The different types of decentralization are the follows:

## A.Political Decentralization

Political decentralization mean different thing to different people. Political decentralization is the process of shifting from the central government to the local government and communities, the:

• Power to choose the political leadership and representatives: and

• Power and authority to make social, political and economic decisions. Rizal P. Dhurba(2001) defines political decentralization as the correlate of democracy and is based on internal party democracy as well as democratization of state, de-concentration of wealth and social power and in creation of civil society through mass mobilization and mass participation in the institution of representative bodies. He cites the objective of political decentralization as to increase the efficiency of local political unit, increase the participation of the citizen through empowerment and provide more freedom of choice in the process of electing the matter which is of their primary concern. Political decentralization can support democratization by giving citizens, or their representatives, more influence in the formulation and implementation of policies.

However, it is often associated with pluralistic politics and representative government. Thus, decentralization is conceptualized on the belief that election of the local representatives allows the citizens to have a better knowledge of their political representatives and also the elected officials to have a better knowledge of his constituent's needs and desires. Also if more people are involved in the decision making, rather than the decisions being taken by the national political authorities, the decisions will be better informed and more relevant to diverse interests in society. Political decentralization requires structural arrangement that goes beyond putting in place local governments. It requires a combination of vertical and horizontal decentralization in which the vertical decentralization transfers power and authority from central to local government and the horizontal decentralization empowers the local communities and enables them to receive and utilize the powers transferred to them. (Kauzya M. John, 2007). Political decentralization, unlike administrative decentralization is not concerned primarily with increasing efficiency, improving service delivery by the 11 government, removing bottle necks and reducing delays

and increasing the ability to recover cost, but it is concerned with the devolution of power to the grassroots and leading to the formation of local level governments. Thus, Political decentralization often requires constitutional or statutory reforms, the development of pluralistic political parties, the strengthening of legislatures, creation of local political units, and the encouragement of effective public interest groups. The belief that political decentralization is a good form of decentralization based on the following arguments, as favored by its proponents has been reshaping governments across the globe

• The decision making that is more suitably left to the regional governments is essential for promoting democracy and good governance.

The local authorities who are more aware of the local situations and hence in the better position to take judicious decision have the decision making power in their hands.

• Political decentralization ensures more efficient allocation of resources enhances the mobilization of local resources and improves local governance. These are effective strategies of poverty reduction.

• The decentralized government enables the people to participate in local development. There is greater awareness of community preference in decision making which leads to a greater people's participation in the governance system and greater sense of belongingness of their infrastructure facilities thereby contributing towards sustainability of infrastructure

. • Decision making at the lower levels implied an enormous reduction in the time taken for decision making and administrative costs.

• Since the local government comprises of local popularly elected representatives, it would enable greater participation of the marginalized communities. • Political decentralization would lead to a balanced regional development as there are inefficiencies in administering a very backward economy through a highly centralized political authority and the development of that area might often get neglected. However, the political decentralization despite a range of positive trends cannot be a panacea. It would rather be presented as solution to larger number of problems.

**B.Administrative Decentralization**

Generally, administrative decentralization is the process of transfer of planning, financing and management responsibilities and functions from the central government, regional governments and its agencies to local governments, semi-autonomous public authorities and regional or functional authorities. Administrative decentralization redistributes responsibility, authority and financial resources for providing the public services among the different levels of government. Thus, administrative decentralization divides the labor through functional differentiation and claims bureaucratic accountability to the people at the lower level than to the superiors by the structuring of rules, procedures and institutions(Worldbank,Administrative decentralization,2001, http://www1.worldbank.org/publicsector/decentralization/admin.htm 22th/03/2016)

As far as development is concerned, Administrative decentralization is the most practiced and accepted form of decentralization.Cohen, J. M., Peterson, S. B.(Administrative Decentralization: Strategies for Developing Countries, 1999) states that administrative decentralization has been used by developing countries and nations in transition as strategy for addressing critical governmental needs like more effective and efficient production, delivery of public goods and services, improved governance, increased transparency and accountability.

Administrative decentralization has three forms: de-concentration, delegation, and devolution and they have different characteristics.

a) De-concentration: De-concentration is the process of redistribution of the decision making authority, financial authority and management responsibilities among the different levels of central governments. The Decentralization Thematic Team (World Bank, 2007), states that deconcentration creates strong field administration or local administrative capacity under the supervision of central government ministries. The specific functions and tasks of the central administration staff are transferred to the staff stationed in the lower level governments within the national territory. The managers of these lower/ field level governments and agencies have authority for autonomous decision making as the staff, equipment, vehicles and budgetary resources are transferred to the regional and district offices. Thus, it enables the local and field level offices to efficiently and effectively carry out the tasks through timely decision and reasonable latitude of flexibility and discretion as per the local needs and conditions. The primary

objective of deconcentration is to improve the production efficiency of the administration with an improvement in the impact of the services delivered as second priority.

General deconcentration happens when a wide range of tasks are de-concentrated to an administrative system which is horizontally integrated. Functional de-concentration occurs when the specific tasks are de-concentrated to the field units of a particular ministry or agency.

However, the decentralization team also admits that in de-concentration, the central government agencies in the capital city simply shift their responsibilities to the regional, provincial and district offices. Despite the shift of financial and management responsibility to these offices, the appointments, salaries and assignments of the local administrative leaders were dependent on the central government. To this, Rizal P. Dhurba also affirms that de-concentration does not allow adequate freedom to the local units to take initiatives and decision without the consent of central government. The field 15 and local level agency just acts as the agents of the central government and does not have any autonomous status. Siddiqui (2005) states that de-concentration is a less desirable option as it retains central control and direction. He further states that de-concentration will trouble the activities at the local level if there is a poor quality of bureaucracy. Deconcentration is not a widespread type of administrative decentralization. However, it is commonly practiced in the developing countries.

b) Delegation: Delegation is more common form of administrative decentralization. It is through delegation that a central government transfers the decision making responsibility for public function to semi-autonomous organizations which are not fully controlled by the central government, but they are ultimately accountable to it. Thus, delegation as per World Bank, 2007 is the transfer of administrative and decision making authority for the carefully spelled out task from the government to the semi-autonomous organizations. In delegation, the functions are transferred to the functional and regional development authorities and the special project implementation units with the consideration that these units would take up their budgeting, personnel recruitment, procurement, contracting and other matters reasonably free of central government regulations. It is also done with the consideration that

these functional units would perform as the agent of the state while performing prescribed functions, with ultimate authority remaining with the central government (Siddiqui, 2005).

Delegation is a way to balance local and national government interest. As per Sylvian H. Boko, 2002, governments delegate responsibilities when they create: Public enterprises; special service districts; housing authorities; special project implementation 16 units; semi-autonomous school districts and transportation authorities. These organizations usually have high discretionary power in decision making and are often free of the limitation of regular civil service personnel and they can even collect user fees. Delegation does not restrict to the national service delivery, it can also be adopted by any level of government. However, Siddiqui (2005) also insists that delegation can be troublesome if there is no local accountability in the organization to which the delegation has been made and if the delegated organizations tend to be adherent to the higher level bureaucrats and political leaders despite their stated legal position.

c) Devolution: Boko S.H (2002) cites devolution as the transfer of responsibilities for decision making and administration of public functions to local governments who elect their own functionaries and councils and have independent authority to make investment decision. Thus, devolution creates and strengthens the government institutions at the local level by devolving powers and functions to them. In this kind of system, the local government has lawfully recognized geographical limitations within which they work out their authority and carry out public function. Rizal P. D (2001) identifies the essence of devolution process as the decentralization of power and authority of decision making to the districts, villages and towns, thus enabling the growth of autonomous units of self-governance. The UNDP, 1999, states that devolution in its purest forms has certain fundamental characteristics such as:

• The central authorities have no direct control over the local government and thus, the local governments enjoy independence and autonomy.

• There is a comprehensible and legally recognized geographical limitation for the local governments, within which they exercise authority and carry out public function; •

Local government has corporate standing and the authority to secure resources to carry out their tasks

• Local government should be an institution that provides the local citizens with the services that meets their requirements and also the local citizens should have some influential power over it.

• Devolution is a system in which there are mutually beneficial and coordinated relationships between the governments both at the local and central levels. Thus in devolution, the local governments have the responsibility to decide which services should be provided on the priority basis and to whom. Devolution sets the basis for political decentralization and it is through devolution, that the government at the central level relinquishes certain tasks or forms new government units that are outside its direct control. Devolution is inferred as one of the best forms of decentralization (World Bank, 2007). Here the local bodies have legal existence to exercise their own choices of decision-making concerning their own needs and aspirations. There is minimal or no control from the Centre. It is through devolution that the local capacities and knowledge are best used as devolution provides opportunity for the effective participation of the local people in the local decision making process through their own local government institutions elected by themselves

. Thus this ultimately leads to proper administrative, political, and economic system management. It 18 results in improved allocative efficiency as it opens the systems to the influence of the beneficiaries of the services delivered.

However, Siddiqui (2005) argues devolution to be free of problems and states that devolution is incapable of serving the underprivileged if they do not participate and if they are not empowered. Thus, he suggests certain conditions and reforms to be made for the success of the system of devolution. In support of his argument, FAO Technical Cooperation Team also states that if the accountability process which is the prerogative of the central government interferes with the local government's decision making autonomy, or if the transfer of resources is insufficient to cope with the responsibilities transferred, there is inadequate devolution. Political decentralization often fails to achieve its objectives because of the complex phenomenon involving many geographic entities like the international,

national, sub-national and local levels and the social factors like the government, the private sector and civil society. He further stated that political decentralization often fails in absence of efforts towards strengthening of accountable local government institutions and developing popular participation. It is unlikely that decentralization of the state will be accompanied by increased political power of the people if people do not exercise democratic control over the central apparatus of the state. Political decentralization can also result in loss of control over scare financial resources by the central government and loss of economies of scale. The weak administrative and technical capacities at the local and field levels may result in services being delivered less effectively and efficiently in some parts of the country. Equitable distribution of the services becomes difficult as administrative responsibilities may be transferred to the local levels without adequate financial resources. Political decentralization can be time intensive activity if it aims at strengthening democracy and empowering citizens as it has to be a process oriented 13 activities. Thus, territorial unity and a minimum level of political stability should be present for any policy of political decentralization.

**C. Fiscal decentralization**

Fiscal decentralization comprises the financial aspect of devolution and local government. It's the currently a fashionable term; alternatives descriptions central- local is used in Africa especially in Rwanda**.**

The goal of this fiscal decentralization policy is not only to pursue efficiency in the provision of services at local level but also sustainable development implies efficient management of resources and the environment economic growth process , all based upon partnership between public, private sectors and civil society . Fiscal and financial decentralization can promote efficiency innovation, human resources development, and dynamism at the local level. Indeed these are the key element of a poverty reduction policy (Bahl, R.W, and.Bird R.M.2008:1-25).

There are too many ways local authorities can be empower to do so:

- By empowering local government to collect their own revenues local from taxation , user charges and other forms of locally raised revenues
- By transferring funds as grants from centrally collected government resources including donor funds.

**2.4 . The Decentralization of Health Services.**

Decentralization is a recurrent theme in the literature of public administration and development. Only recently it has been promoted in the health sector as a key component of the strategies aimed at reaching Health for all.

The decentralized health services as a means of achieving greater coordination and responsiveness to local needs through delegation of responsibility, authority and resources to the community and to the intermediate levels.

Anne Mills and others have identified the following expected benefits from decentralization of health services:

- A more rational and unified health service;
- Greater involvement of local communities;
- Containment of costs and a reduction in duplication of services;
- Reduction in inequalities;
- Integration of activities of different agencies;
- Strengthening health policy and planning functions of ministries of health;
- Improved implementation of health programmes;
- Greater community financing and control;
- Greater community coordination; and
- Reduced communication problems and delays (Anne Mills et al , 1990:142) .

The main argument for decentralizing health system is that greater local participation in health policy and local accountability can lead to improved quantity (including coverage) and quality of service. Yet, exactly how these benefits can be realized and the impact of different kinds of reforms is not well understood (Litvack and Seddon 1999). The highly differentiated levels of health provision (i.e., primary, secondary, and tertiary) and several additional aspects of health care, such as family planning, information campaigns, and the training and supervision of

personnel, make the effects of decentralization on this service more difficult to understand, particularly when looking at final outcomes. Moreover, DeMello (2004) stated that decentralization in the health sector tends to be more complex than in other sectors because diseconomies of scale. He argues that these diseconomies of scale tend to discourage sub-national governments in the provision of costly curative treatments and immunization. At the same time, he argues, spillover effects tend to discourage the sub-national provision of preventive health care, particularly immunization and epidemiological controls. Nevertheless, decentralization of the health sector has become appealing to many researchers, international donors, and policy makers because it raises expectations about several advantages including the following (Mills 1994:24):

• A less unified health service that is better tailored to local preferences.

• Improved success in the implementation health programs. That is, day-to-day overlooking and evaluation, which are necessary for implementation, are more likely to succeed under local accountability • Reduced inequalities between urban and rural areas and between accessible and secluded regions of the country. This is assumed to occur due to proximity and responsiveness of rural local governments and providers to the needs of rural people—typically, in poorer countries rural areas tend to be more underserved than urban areas.

• Lower costs due to better targeted programs. This argument assumes that local service providers would tend to have better information about the local population to better allocate resources to target the poorer income groups.

• Greater community involvement and higher chance of sustainability in the long run. Little concrete evidence confirms these potential benefits, however. Few developing countries have long-term experience with health sector decentralization, and its impact on the management of the sector and on the services it delivers has rarely been evaluated (DeMello 2004).

In Rwanda, decentralization of health services is expected to increase greater involvement of local communities, improved implementation of health programs and strengthening health policy and policy planning functions of the MoH.

## 2.5. Theoretical orientation of implementation of decentralization

This sub chapter presents the theoretical approaches and models related to implementation of decentralization. Therefore the research has political perspectives on the role of decentralized entities in the process of implementation of decentralization of health system in Kirehe District based on the ideas of ( MASKIN E,2008)

### Implementation Theory

According to Maskin E and Sjostrom T(2008), The implementation problem is the problem of designing a mechanism whether or not a social choice rule is implementable may depend on which game-theoretic solution concept is used. The most demanding requirement is that each agent should always have a dominant strategy, but mainly negative results are obtained in this case. For them, the problem is formulated in terms of the implementation of social choice rules. A social choice rule specifies, for each possible state of the world, which outcomes would be socially optimal in that state.

According to CORCHÓN L.C ( 2007), Implementation theory studies which social objectives (i.e. Social Choice Rules) are compatible with the incentives of the agents (i.e. are implementable). In other words it is the systematic study of the social goals that can be achieved when agents behave strategically.

Our finds are linked to this theory as follow:

-The social choice in this thesis is the adoption of decentralization policy by the Rwandan government. As mentioned in implementation theory, this choice can obtain negative results. Our research revealed that Decentralization has reached a significant height in Kirehe District health sector. However, it is still confronted with challenges considered as negative results, thereby deteriorating the effort to the concerted and systematic approach towards decentralization .The challenges find are located in Community Participation, gap of autonomy and Planning.

-In order to implement decentralization of health services in Kirehe District,the dominant strategies mentioned in this theory are those strategies find as solutions to overcome challenges of decentralization of health services: reduce the gap of autonomy in financial management, involving community in health decision,…

## 2.6 Contextualization of Decentralization in Rwanda.

### 2.6.1. The decentralization of Health services in Rwanda.

The decentralization of health services has drawn advocacy from various international organizations among which is the World Health Organization (WHO), requiring that certain health system functions be transferred to the local levels in order to meet the health needs of the people. A study of decentralization in Uganda by Hutchinson et al. (1999) showed that public sector decentralization paved the way for the health sector decentralization. According to Mills et al. (1990), health sector decentralization in developing countries have been central government initiatives with local areas playing a supportive role by providing village level health services.

According to MOH,(overview of the health system in Rwanda,2013),Following the 35th session of the African Regional Committee of the World Health Organization held at Lusaka in 1985, Rwanda adopted a health development strategy based on decentralized management and district-level care. The decentralization process began with the development of provincial-level health offices for health system management. Progress was made toward decentralizing management to the province and, ultimately, to the district level. The development of the health system was completely disrupted at the time of the 1994 genocide. Much of the infrastructure, equipment, personnel, and the health system itself was destroyed. With the advent of peace, the government has been working to rebuild the health system. In February 1995, the government issued a new policy to guide the reconstruction of the health system.

Since 2000, steps have been taken toward restructuring and decentralizing management. The district health offices have operated as autonomous entities, providing services to well-defined populations in either urban or rural zones. The district health offices are responsible for the health needs of the population in that zone and for the health facilities and services, whether provided through the governmental or private sector. Decentralization of financial and logistic resource management has been implemented universally. However, there remain specific health programs that were initiated as vertical programs and that continue under a vertical management structure.

**Proposed District health system management structure**

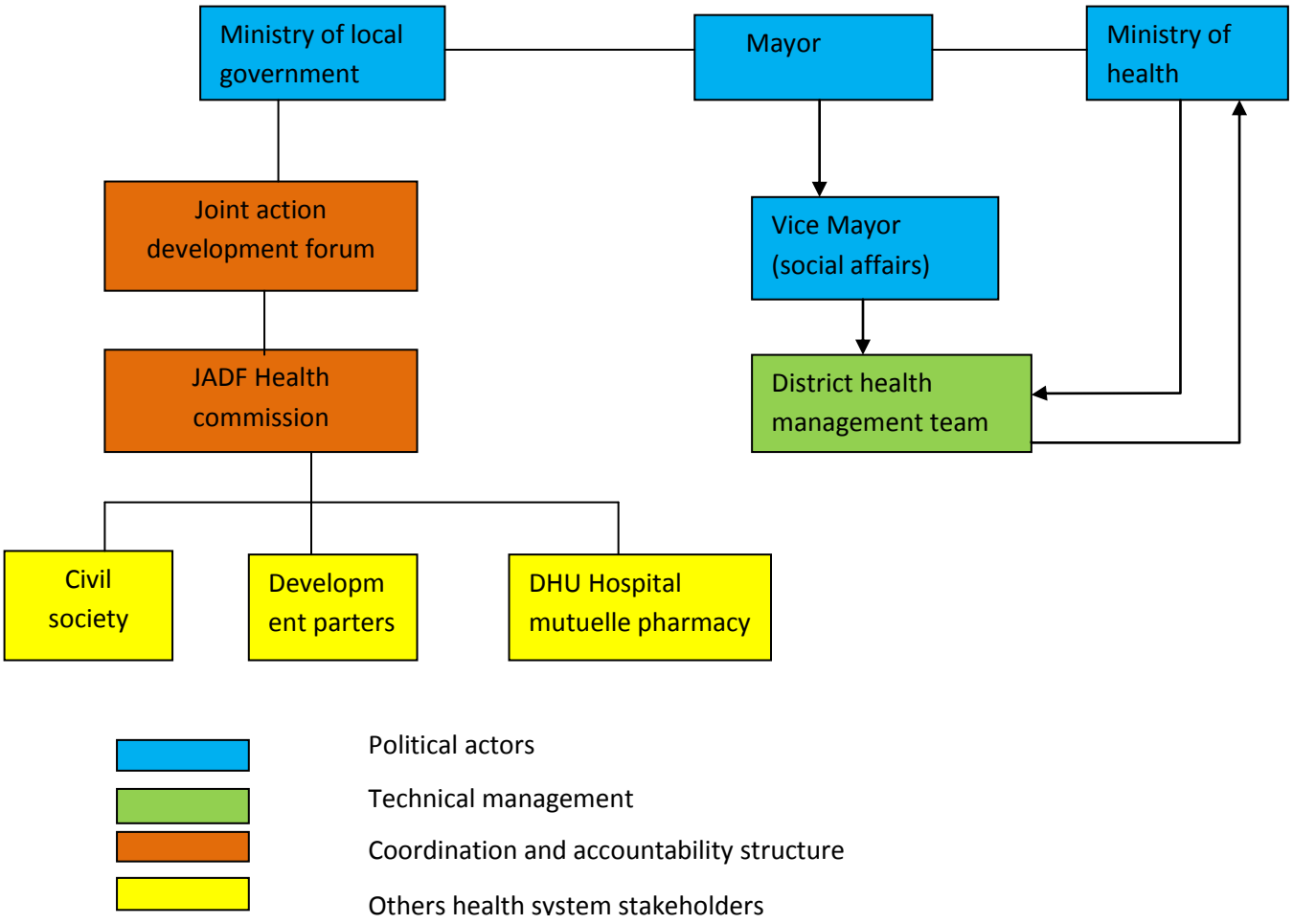



**Figure 1: figure of district system health management structure**

Decentralization within the health system of Rwanda seems unique from when the MOH the District Health System Guideline for the re organization of the district health system from a managerial perspective.

Decentralization in the health sector has taken place within the framework of the overall decentralization of the public sector. The planning and management of primary health sector takes place at the district and lower levels with the "involvement of the communities". The ministry of health was restructured to assume reduced roles of health policy formulation, standard setting, technical support, regulation, supervision and inspection. On the other hand the district health system was restructured to enable it to take on enhanced roles.

District hospital has mission of inpatient/outpatient services, surgery, laboratory, gynecology, obstetrics, andradiology.

Health centers have the mission of prevention activities ,primary health care, inpatient, referral, maternity health posts have mission of outreach activities(i.eimmunization, family planning, child growth monitoring )

Overview of Operating Authorities for Health Services Health services in Rwanda are provided through the public sector, government-assisted health facilities (GAHFs), private health facilities, and traditional healers.

### 2.6.2 Public Sector

The public sector is organized into three levels, with each level having a defined technical and administrative platform called a minimum package of activities. Each level coordinates with each other, to prevent overlap and to improve use of resources and services.

1. The central level, based in the capital, is primarily responsible for developing health policy and the overall strategic and technical framework within which health services are provided. The central level is also responsible for monitoring and evaluating operational programs and for managing the national referral facilities (the Butare Teaching Hospital and the teaching hospital in Kigali).

2. The intermediate level consists of 11 provincial health offices managed under health, gender, and social affairs guidelines. The Public Health Department of Kigali City also is in the intermediate level.

3. The peripheral level consists of district health offices. Each district has an administrative office, a district hospital, and primary health care facilities (health centers). The district administrative offices are responsible for planning, managing, coordinating, and evaluating, on a daily basis, the activities occurring in the health district. This administrative unit (work group) is made up of a basic management team of health professionals and managers, representatives of program managers active at the community level, community leaders, and directors of nursing schools.

At the end of 2001, there were 39 functional health districts, each with a district management team. Only 33 of these, however, had a functioning hospital. The main function of district

Hospitals are to care for patients referred by a primary-level facility. Although curative and rehabilitative cares are the principal functions of the hospital, the hospitals are also responsible for supporting preventive and promotional activities within the catchment area. Hospital management participates in the planning of district activities and training and supervision of district personnel. Although the mean hospital capacity of one bed per 1,000 people is not unreasonable, it masks substantial variation among districts and provinces.

There were 365 peripheral health facilities at the end of 2001; 252 were health centers while 113 were health posts and dispensaries. Health centers are responsible for providing basic primary health care, which includes a complete and integrated array of curative, preventive, promotional, and rehabilitation services. Health posts, set up to take care of transitional situations, such as the flow of refugees or the existence of an epidemic, are not intended to remain a permanent part of the health system and will gradually be phased out. There is a nationwide lack of physicians, nurses, and managers with sufficient experience to respond to the needs of both administrative structures and health facilities. This problem is more acute at the periphery, where operational management and delivery of health services occur.

### 2.6.3 Government-assisted Health Facilities

The conventional nonprofit sector is made up of health facilities run by various religious groups and nonprofit associations. In 2001, 40 percent of primary and secondary health facilities were in this category. Government-assisted health facilities (GAHFs) called agree facilities in Rwanda are completely integrated into the public health system, and are included in the RSPA. The government provides services to both public and conventional nonprofit facilities, irrespective of their resources (human, equipment, or operating budget). GAHF staff and government staff are equally eligible for government-sponsored in-service education. GHAF representatives participate integrally in the work group (district management team) of each district and have a formal agreement to follow the policies of the MoH.

### 2.6.4 Private Sector

Since 1995, the private medical sector in Rwanda has grown considerably and continues to grow. In 1999, there were 69 private physicians either with private practices or working as employees of NGOs, commercial establishments, private insurance companies, or mutual societies. The number of private pharmacies throughout the country increased from 300 in 1999 to 405 in 2001.

As of 1999 there were 329 private health facilities in Rwanda, with more than 50 percent located in or near Kigali. Among these facilities, 63 were headed by physicians, 242 were headed by nurses, and 14 were headed by persons who were not medically trained. These private facilities have hospitalization capacity and some have very specialized services, such as gastrology, ophthalmology, and physiotherapy. They are often staffed with trained paramedical staff.

## 2.7 Geographic Distribution and Populations Served by Health Facilities

To ensure the most efficient health care coverage possible, given limited availability of resources, norms were established in 1997. These norms include an average coverage of 200,000 people per district, with one hospital per district and 20,000 people per health center. The geographic area covered by an administrative unit or health care facility is the catchment area, or "zone de rayonnement." Originally, under the restructuring of the health system, administrative units for the health system were formed primarily base on geographic accessibility, regardless of the availability of infrastructure or existing civil administrative boundaries. As a result, it is not uncommon to find health centers or managers responsible for populations that cross several administrative boundaries. Over time, the boundaries for the administrative units for the health system have been adapted, taking into account the size and boundaries of civil administrative units, while still considering geographic accessibility. At present, a population is defined as having access to health care if the service can be reached by foot in one and a half hours. Considering the current distribution of facilities, about 85 percent of the population lives within one and a half hours of a primary care health unit. Geographic distance and mountainous terrain, however, continue to constrain access to health care. To improve geographic accessibility, a referral system combining access to ambulance services and a telephone network for district-level facilities is gradually being developed. This system will solve the problem of geographic

accessibility between primary care health centers and hospitals, but not the problem of transporting patients to health centers, which still depends largely on traditional means of transportation. District health offices in Rwanda are characterized by great variability in size and demographic coverage. The population covered by a district facility varies from 70,000 to 480,000 people. The national average is around 200,000, which approximates the national norm.

## 2.8 Package of Health Services

Most common illnesses in Rwanda are transmissible diseases that are preventable through improved hygienic measures and changes in individual health behavior. The ten most important causes of morbidity and mortality fall into this category. Nine in ten health consultations at primary care facilities in Rwanda are for infectious diseases, such as malaria, respiratory infections, diarrhea, parasites, skin diseases, HIV/AIDS, tuberculosis, typhus, cholera, and meningitis. A package of activities directed toward these, as well as common preventive interventions, has been defined for each level of the health system.

### Minimum Package of Activities for the Peripheral Level

At the health center level, the minimum package of activities (MPA) includes:

1. Promotional activities, including information, education, and communication (IEC); psychosocial support; nutritional activities related to small farming and food preparation; community participation; management and financing of health services; home visits; and hygiene and sanitation in the catchment area around the health center. Rwanda has a large population that has not completed primary education (over 60 percent of men and women over age 15), with many having no formal education (ONAPO, 2001). Fifteen percent of men and women age 15-24 (with larger percentages at older ages) reported having no education. Thus, visual aids for promoting health education messages are important. The MoH has indicated that the availability and use of visual materials for providing information, education, and communication (IEC) for health education is a concern, and in fact, during June 2002 a national seminar was held specifically to review the use of IEC materials related to reproductive health and to discuss ways to improve the situation.

2. Preventive activities in areas such as premarital consultation, postpartum care for the mother and child, family planning counseling and services, school health, and epidemiologic surveillance activities.

3. Curative activities, including consultations, management of chronically ill patients, nutritional rehabilitation, curative care, observation before hospitalization, normal deliveries, minor surgical interventions, and laboratory testing. Each health center is responsible for managing personnel, supplies, and financial resources and for training staff. The health center oversees general health-related activities that include development of health promoters and intersectoral collaboration with other departments (e.g., social welfare and agriculture) when appropriate. Health centers are the focal point for the development of community participation. (MOH,Overview of the Health System in Rwanda,2013:1-2)

### 2.9 Health policy, its objectives and priorities in Rwanda

According to MOH(Health sector policy,2014),Rwanda's Health Sector Policy translates the Government's overall vision of development in the health sector, as set out in Vision 2020 and the Economic Development and Poverty Reduction Strategy(EDPRSII 2013-2018).

The Health Sector policy gives general orientations for the sector which are further developed in the various sub-sector policies guiding key health programs and departments. All health sub-sector policies will be updated in line with this new policy. The Health Sector Policy is the basis of national health planning and the first point of reference for all actors working in the health sector. The overall aim of this policy is to ensure universal accessibility (in geographical and financial terms) of equitable and affordable quality health services (preventative, curative, rehabilitative and promotional services) for all Rwandans.

**General policy objectives**

- **Health programs**

Improve demand, access and quality of essential health services: maternal, neonatal and child health; family planning and reproductive health; nutrition services; communicable diseases, infectious diseases surveillance and research (idsr) and disaster preparedness and response (dp&r); non communicable diseases; health promotion.

This objective is centered on the reduction of burden of disease of the most important health problems in Rwanda, i.e. Maternal and child health problems, infectious diseases and non communicable diseases through access to primary health care. Both prevention and treatment and care services are included in these programs, as well as interventions aiming at improving

important health determining factors, such as behavior change communication, promotion of adequate nutrition, environmental health and sanitation and access to safe water.

- **Health support systems**

Strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs.

Health system strengthening is centered on six building blocks to ensure availability of necessary resources and management mechanisms for an appropriate functioning of the key health programs described under objective.

These building blocks are human resources for health, medical products management, health service delivery (infrastructures and equipment), health financing, leadership and governance and health information system.

- **Health service delivery**

Strengthen policies, resources and management mechanisms of health services delivery Systems to ensure optimal performance of the health programs. This objective aims at the effective organization and management at the different levels of the health service delivery system, from the community to health centers and district hospitals and to referral hospitals, and also including the emergency medicine and pre-hospitalizations.

**2.10 Policy directions (objectives)**

- To reduce mortality and morbidity linked to malnutrition
- To reduce mental health morbidity and other psychosocial conditions

- To address the growing burden of disease related to non-communicable diseases among which the most common are cancers, diabetes and arterial hypertension.

-Health products (medicines, vaccines, lab commodities, derived blood products and consumables): the aim of this program is to ensure universal accessibility and availability (in geographical and financial terms) of quality health products for all Rwandans.

**Community Health Program: Community** health interventions are implemented by Community Health Workers and by Community-based organizations.

**Collaboration and coordinatio**n between these two key groups is important to strengthen linkages between the health care delivery system and the community.

-Human resources: The policy objective of this program is to improve the availability of well-qualified health professionals throughout the country, particularly in rural and other poorly served areas.

-**District Health Care System: Each** administrative district has one or two district hospitals supervising all health facilities

**Organization of Health care delivery system:** The health system has a pyramidal structure, consisting of three levels: central, intermediary and peripheral.

- The central level includes the Ministry of Health, Rwanda Biomedical Center (RBC) and the national referral hospitals. The central level elaborates policies and strategies, ensure monitoring and evaluation, capacity building and resource mobilization.

Relative to health care delivery, the central level has five national referral hospitals whose mission is to provide tertiary care to the population: King Faisal Hospital (KFH), Rwanda Military Hospital, Kigali University Hospital (CHUK), Butare University Hospital (CHUB) and Ndera Hospital for psychiatric care. The King Faysal hospital was created to provide a higher level of technical expertise than that available in the national referral hospitals to both the private and public sector; its role is also to ensure that there is a reduction in the number of transfers abroad.

- An intermediary level of health facility will be established with one provincial hospital in each province, with the objective of creating an intermediate level of referral hospitals to decrease the demand of services in the national referral hospitals.
- The peripheral level is represented by the health district and consists of an administrative office, a district hospital and a network of health centers that are either public, government assisted faith based, or private. An intermediate level of health pots between the community and health center is promoted by the Ministry of Health in a model of Public-Private-Community Partnership to bridge the gap of geographic.

- Accessibility. The health district deals with the health problems of its target population. The functions of the health district include: (i) the organization of

health services in health centers and the district hospital in terms of the minimum and complementary package of activities

### 2.11. Description of the study area

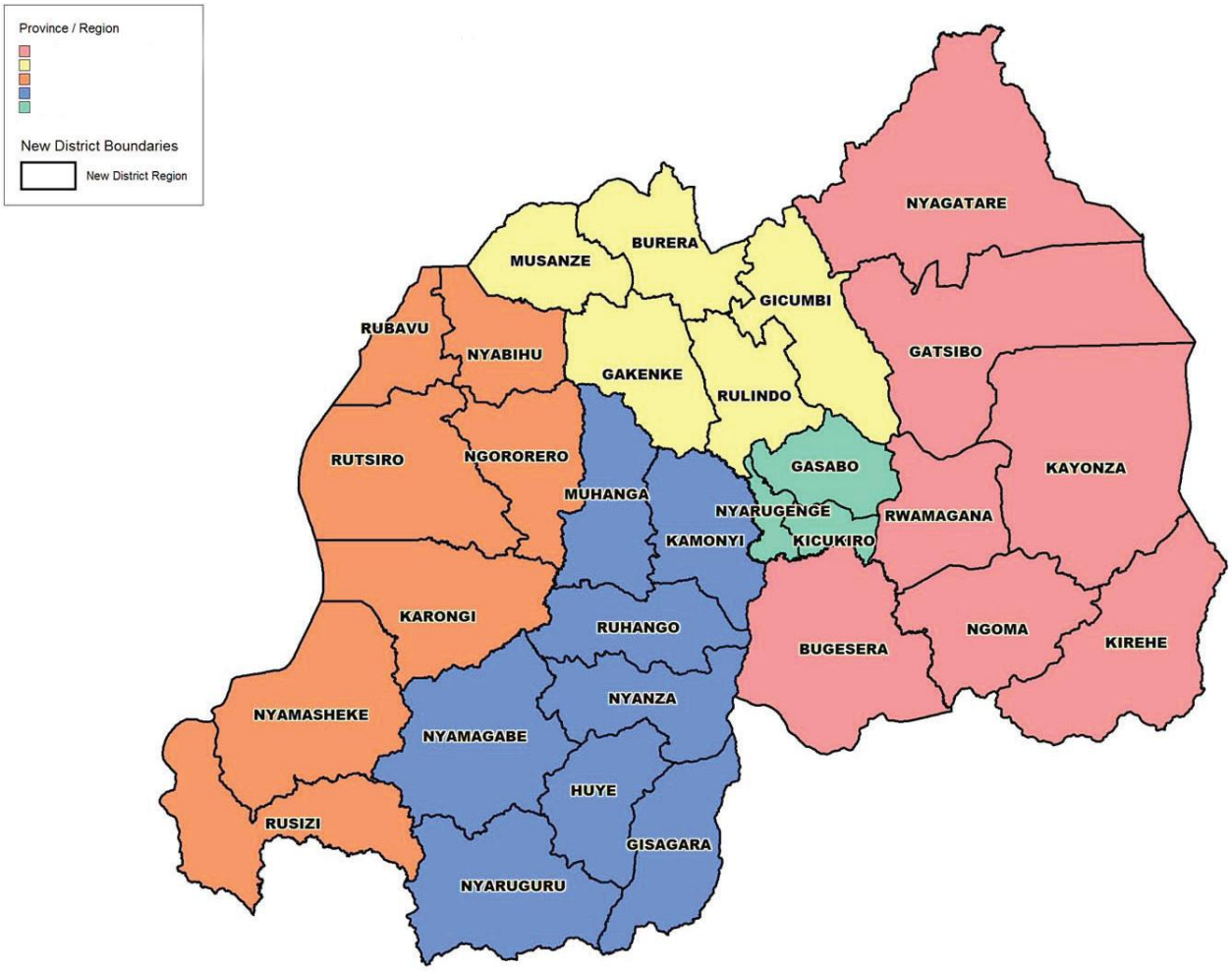



**Figure 2: Administrative Map of all Districts of Rwanda**

#### 2.11.1. Main biophysical characteristics

The district of Kirehe, which has a surface area of 1225, 4 km2, is located at the south-east of the Republic of Rwanda at 133 km from Kigali capital. It shares with Tanzania, the eastern border of Rwanda. The Akagera River constitutes the natural limit between the District

and Tanzania. In the south, Kirehe District also borders with Republic of Burundi and Tanzania. In the west the District shares border with Ngoma District and Kayonza District in north, as shown in the above administrative Map. Kirehe District has 12 administrative sectors, divided in 60 Cells.

**Figure 3: Kirehe District Administrative Map**


In general the relief of Kirehe District is that of the areas of the low plates. However, there is a mountain chain which divides the area into two geographical entities, characterized by a plain of low altitude of more or less than 1350m of altitude, punctuated by insulated hills and those of the hills and mountains with plates at the tops (Mahama Mount and a mountain chain

of Imigongo).The average altitude of Kirehe District is 1500m. Concerning hydrograph, fauna and flora, the main river of the District is the Akagera river which surrounds in south-east of the District and continue to be thrown in Lake Victoria. Fauna is very dense and very varied. The vegetation of the Kirehe District is of the savannas type apart from natural timbering which tends to disappear completely. In the agro-climatic field, Kirehe District has a climatic rhythm in 4 times making it possible to make 2 harvests per annum on the same land. Agriculture is strongly dependent on the climatic risks, like everywhere in the country, the rain primarily. The tropical soils are more widespread in Kirehe District. It is about Kaolisoils, the xérokaolisoils and the grounds of the valleys especially the vertisoils and the histsooils. Combined at a lenient time, all these soils can be exploited and give a satisfactory production. Concurrently to these soils, considered good for the culture, there are also sandy soils favourable to construction, found in the area of Bukora, of Nyamugari Sector (District Development Plan of Kirehe 2008-2012:6).

According to ESV3(NIS 3-8) the population of Kirehe district is 329,000, of which about 83% are under 40 years old. Kirehe has the lowest average household size among eastern province districts (4.6).

Kirehe is ranked second in the eastern province by percentage of extreme-poor and the first by percentage of poor: about 52% of the population is identified as non-poor, 22.3% as poor (excluding extreme-poor) and25.6% as extreme-poor.in terms of the water and sanitation sector, 61.5% of households use an improved drinking water source.24.3% of households are within 15 minutes' walking distance of an improved water source. the mean time to an improved water source is 26 minutes and 75.2% of households have access to improved sanitation facilities.

among eastern province districts, Kirehe is ranked last by the proportion of households with a cement floor(the figure is 5.3%); the district is also ranked last by the proportion of households using electricity as the main source of lighting (1.6% of households).

the percentages of households owning a mobile phone and radio are 42.7% and 63.3% respectively in terms of the mean walking distance to primary school, Kirehe is ranked third country-wide with 34.6 minutes while the mean walking distance to a health centre is 92.4 minutes. Only 22.1% of households walk for under an hour on average to reach a health centre. 29.4% of households have at least one saving account and Kirehe is ranked third lowest country-wide on this indicator, above only Nyabihu and Gisagara districts (both 27.2%).

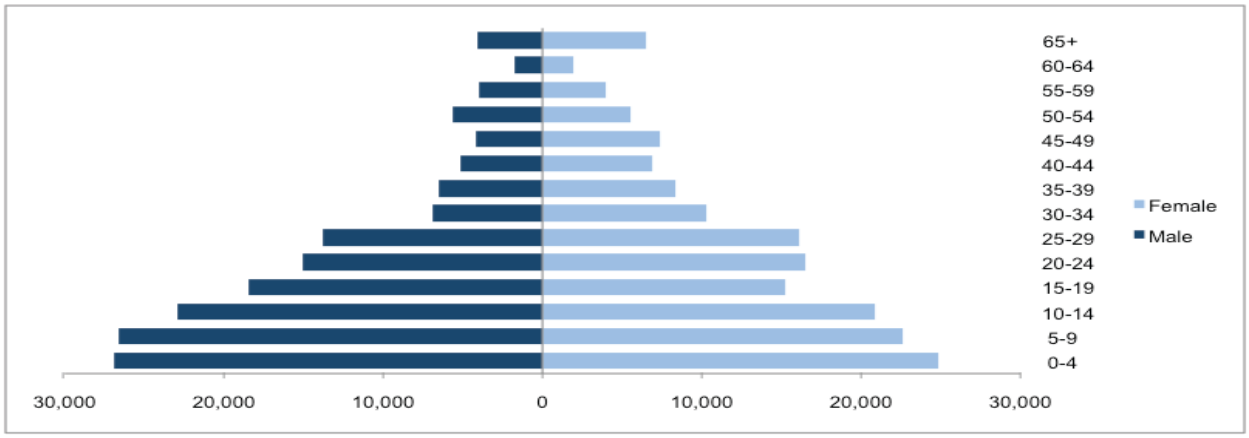
In Kirehe district, agriculture is the main industry for 88.3% of the working population aged 16 and above, followed by trade (4.9%), manufacturing (1.8%), and 0.7% for both transport and communication and other services (including utilities and financial services).

The mean size of land cultivated per household is 0.73 ha; only 24.2% of households have under 0.3 ha and around 79.2% of land has been reported as protected against soil erosion. Over the last 12 months, 70.3% of all households raised some type of livestock.

The nar is 86.7% in primary school and 13.9% in secondary school. Moreover, only 1.4% of the population aged six and above has used a computer before and would feel confident using one again. Kirehe has 3.8% of people with a major disability. Among the population aged 0–20, 2.3% are orphans with both parents deceased and 14.3% are orphans with one parent deceased. 28% of households in Kirehe district are headed by females and 5% are de facto female-headed households. The majority of females in Kirehe district are small-scale farmer workers (84.2%); 9% are wage farm workers and 2.6% are independent non-farm workers. males also mostly work in small-scale farming (68.7%), with12.8% being wage non-farm workers.

2. Overview of the demographic situation of the district number of the population the table below shows the structure of the population by age and sex.

**Figure 4: Distribution of population in Kirehe district by age groups and sex**



### 2.11.2. Priorities set by Kirehe district in health system

.a) Health increase the rate of adhesion to the mutual insurance health from 58% to 100%;

b) Reduce to the average of 4 km the way carried out by the population to reach the medical centre. Reduce the rate of malnutrition of the children up to 1%;

c) Reduce the rate of contamination of hive from 10% to 4%; reduce the rate of infection of the palladium from 90% to 50%;

d) Increase the rate of antenatal consultation check and childbirth in Centres of health from 10% to 80%; f) Reduce the demographic growth rate of 6 births per family to 3 births;

g) Reduce the diseases due to the lack of hygiene of 100% to 50% Reduce the average of the children by family of 6 children to 3 children**.**

### 2.11.3. Vision, mission and objectives of development of the district

The vision of the District within five years is a response to the main concerns of the local population as regards to welfare. This is why, this vision will have to take as a starting point the various problems identified by the population and to be in bond with the vision of the country at the national level (Vision 2020) and some of the objectives at the international level (Objective of the millennium in particular) Let us reconsider initially the problems such as they were identified by the population and their hierarchization on the level of the District.

### 2.11.4. Sructure of Kirehe health (Tableau)

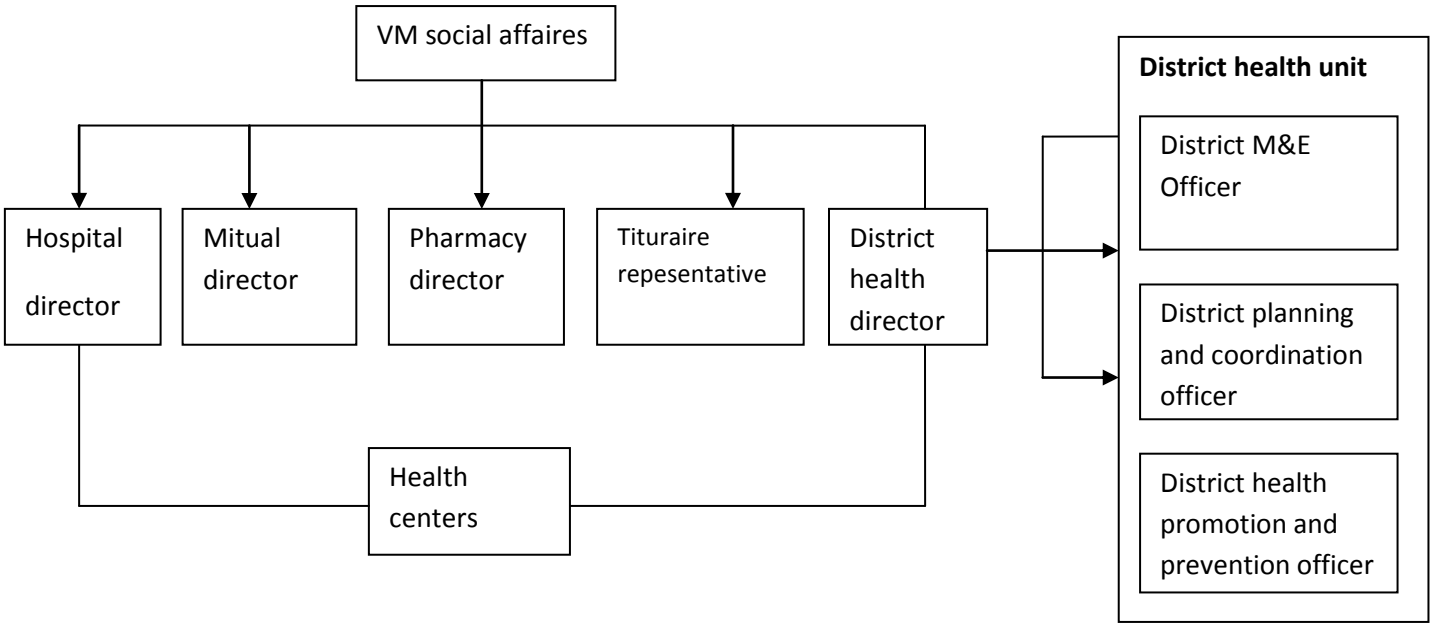



**Figure 5: Structure of Kirehe health Sector**

### 2.11.5. Achievement of Decentralization of health services in Kirehe District.

Through decentralization, Kirehe district has chalked some success in the general health outcome of the people.

Informants from both communities admitted that the decentralized system had created the opportunity for the local people to live in close proximity with health services and personnel, and has contributed largely to the control of epidemics particularly the guinea worm disease. Even though the district has no good source of drinking water, the presence of hospital, health centers and the personnel has contributed in terms of resources such as water filters and information on water hygiene which led to the eradication of the disease in the community.

There is also the improvement in health outcomes. With the creations of health groups such as the mother-to-mother support groups, mortality of mothers and children have been brought under control as mentioned by the health director. This success chalked is attributed to the creation of awareness on maternal mortality through durbars and the provision of anti- snake venom. It is realized that antenatal services were absent for pregnant women with no health personnel to assist in deliveries were not available. Delivery complications and maternal deaths

were common, but the introduction of decentralization coupled with the free deliveries policies saw the deployment of health personnel to rural areas, where pregnant women and nursing mother can afford to enjoy free and accessible health services. This has contributed to saving the lives of women and children.

Furthermore the

In this context, decentralization developed health sector in Kirehe District as follow:

**A) Role of local population in development of health sector.**

The study noted that the formal arrangement at the health centers in Kirehe District is such that each health centre has a management committee through which elected and appointed members of the communities participate.

> *It is a requirement for each health center or hospital to have the committee ... the roles of these committee members mostly they are involved in the management and running of the health unit ... they make budget estimates, plan and identify major requirements of the unit which are forwarded to the district ... These units are fundamental to the running of the units ... I think the idea is to let the community members do things their way. (Personal interview with the person in charge Kirehe Health center25/04/216*

**B) Role of district council**

According to Macchiato H R (2016:11), An important indicator of local representativeness relates to how the councils were constituted and the extent to which the local population they are deemed to represent took part in this process.

In Kirehe District, the district council play a crucial role in making decision especially in health sector, five health centers and a District Hospital were constructed by decision taken by the district council. From 2006, The District investment in construction of health facilities has been remarkable. As matter of facts, 1 District Hospital, 8 health centers, 11 health posts were constructed.

NB: Kirehe District Hospital was constructed from 2010 (Phase 1), and the phase 2 in 2012 where as phase 3 was in 2013-14 phase. 8 health centers were also constructed; a VCT and Maternity at Kirehe health center were also built.

### 2.11.5.1. Construction of a district hospital

Kirehe District Hospital is public District Hospital of Kirehe District in Eastern Province and opened in October 2008.This development is considered as the result of decentralization policy, before the implementation of this policy, the single hospital was located at Kibungo, head coater of former province which was located very far from Kirehe District office.

Kirehe Hospital is located in Kirehe District in the Eastern Province just at 42km from KIBUNGO town and 100m from the main road Kigali – Rusumo.

It was constructed by the District in collaboration with Ministry of Health and Partners In Health (PIH). In its construction plan, it is planned to be constructed in 3 phases and presently it is working in the first finished phase which is composed of Maternity, Internal medicine and consultation rooms. Presently, due to lack of enough hospital rooms, some services which were not planned to be offered in the 1st constructed phase building are being offered in the same rooms and other services are provided in the nearby borrowed Health Center rooms.

Kirehe Hospital covers 13 health Centers with a population totaling to 292 215. The services offered by the hospital are : Out Patient Consultation (OPC), hospitalization (Internal Medicine and Pediatric), Maternity, Anti-Retrovirus Treatment (ARVs Program), Ophthalmology and Dentist services. The hospital has workers totaling to 115 in which 8 is Medical Doctors/General Practitioner, 4 are A0 in administration, 9 are A1 Nurses, 68 are A2 Nurses, 15 are Para medicals and 11 are support staff.
The hospital receives an average number of 700 patients in a month, presently; the hospital has a total number of 80 beds, the bed occupation rate is 63%. The main causes of hospitalization are severe Malaria, respiratory diseases, chronic diseases and opportunist infection /HIV/AIDS. In the 1st semester, 27 patients died and the major cause is severe Malaria which represents 27%. This is due to culture in this region where a big number of the population believes in poisoning where once they are attacked by malaria or other diseases they spend much time in traditional

hearers and later get to the hospital very late to be healed.
On the 24 April 2009 the President of the Republic of Rwanda paid visit to Kirehe District, for this occasion the President Paul Kagame met with malnutrition as a serious problem in this District; children even mature people suffer from malnutrition. Mature people suffer from malnutrition and claim they have been bewitched; how can the Kirehe district have such preventable illness today? Why these illnesses still devastate this District? Some reason is that the East lies in area that often experiences drought most of the year; but is not true there have not been serious cases of famine many years ago.
After the journey of the president, many solutions have been taken by both central government, Kirehe District and Kirehe Hospital.

(http://Kirehehospital.com/spip.php?rubrique1,p1. Consulted 12/08/2015)

#### 2.11.5.2. Construction of health centers

Within the periode where decentralization policy were adopted,Kirehe District has done a lot of realization in terms of health centers construction, eight centers were constructed since 2006.

The construction of health centers reduced the walking distance to a health centre. The mean walking distance to a health centre in Kirehe district is 92.4 minutes and just 22.1% of households walk for under than an hour on average to reach a health centre.

#### 2.11.5.3. Decentralization and the quality of primary care in Kirehe District

These approaches are made on the understanding that changes in health system organizational structure directly or indirectly affect the delivery of health services.

This corroborated earlier qualitative study that had noted that there was increased individual purchases of drugs in Rwanda, which they attributed to reduced or absence of medicine in health facilities.

### 2.11.5.4. Capacity building of health staff

Building capacity for health sector in terms of both human resources and infrastructure is crucial to having vibrant activities in Kirehe District. Improving human resource capacity requires attracting, training.(Ministry of Health, 2012:10).

Technical staffs have noted improvement in the capacity of the district, sector and health facility staff and officials to lead and direct their own budget and planning exercises. District authorities also wish that some partners facilitated capacity-building activities and fostered greater sustainability through decentralization guidelines, they support in the form of coaching.

### 2.11.5.5 Decentralization of Mutual Health Insurance

Heath insurance is officials formally hold a fund that consists of payments by insured participants and use resultant resource pools to finance all parts of members' healthcare costs. In African countries that have schemes for the informal sector, most plans fall into the first three of the following four models, where the officials are members of an identifiable group whose contributions make up the pools, and are responsible for management activities such as determining benefits and contributions, the model is a mutual benefit society model. In a variant of these mutual and provider model, the officials are responsible for managing the insurance product and providing healthcare and are drawn from members of mutual society as well as a healthcare provider organization, (Arhin and Carrin G, 2003:43).

It does so by pooling the risks of each individual across an entire group of individuals who by paying to be covered. Thus, an insurer of a particular financial risk faced by an individual was offer to «cover» that risk in return for payment of a premium. This premium is determined by averaging the expected losses (during the time period covered) for the whole group of individuals buying the coverage, and adding a charge for the administrative and other expenses of the insurer (Jutting, J, 2003:132).

The Mutuelle de Santé scheme, as known in its current form, was formally launched in 2005.4 since then the enrolment into the scheme has also gradually increased (Ministry of Health, 2010).

In Kirehe District, all activities concerning mutual health insurance are decentralized. The organizational Structure is that the organizational structure of the Mutuelle is closely aligned to the decentralized administrative structure of the country. The Mutuelle system is uniform, meaning that the administrative structure, premium payments and services covered by the mutual insurance are the same across all sectors in Kirehe District, this remain the same in all districts of the country. At the sector level, each health centre has a Mutuelle section staffed with an administrator and an accountant. These sections are also the first point of contact for the population and responsible for the enrolment of members. Following the decentralized structure, the Mutuelle scheme is coordinated and managed at the district level with each of the 30 districts in the country holding a mutual insurance fund ("Fonds Mutuelle de Santé"). Each Mutuelle office at the district level is staffed with a director, in charge of the management of the Mutuelle and an auditor to oversee and control the billing process at the district hospitals. At the national level, the services offered at the reference hospitals are paid for by the National Risk Pool.

Because of the decentralization of mutual insurance, there are positive outcomes in terms of access to health services, health insurance coverage or enrolment and this pushes the well-being of population.

There are linkages from Health Insurance Coverage to Health Outcomes. We are assuming that there are two main channels linking insurance coverage to final health outcomes. The first and probably clearest link between health insurance enrolment and child health runs through improved access and utilization of medical care. More specifically insurance enrolment reduces the cost of health care. By lifting the financial constraint, access to both regular preventative check-ups but particularly also treatment should be increased. This latter aspect, however, is of course conditional on the supply of health care facilities and the quality of treatment received. If we take quality of care as a given for now we would expect a direct positive influence of health insurance enrolment on the health status of children though improved access to preventative and curative medical care. A second potential channel through which health insurance enrolment could affect child health outcomes could be trough changes in health behaviors. With this we mean the multitude of preventative or precautionary measures to limit disease and infection at the household level. Here, the link could actually go into two directions. In the insurance literature, a phenomenon that is commonly mentioned is the issue of moral

hazard. In case of health insurance this would be presented as case where households would reduce preventative measures (ex-ante moral hazard) as health insurance makes it easier to seek health care when sick (ex-post moral hazard) and thus limits the motivation to undergo preventative actions. If this proposition holds we would consequently see a reduction in the precautionary measures taken to prevent illnesses but then again an increase in the utilization of care when sick. Therefore, in terms of final health outcomes, it might actually be a zero-sum-game as reduced prevention would be compensated by increased care. From a societal perspective moral hazard might be quite costly due to an increased use of medical care at an inefficiently high level.

In order to limit moral hazard, the Ministry of Health does run regular (at least bi-annual) sensitization campaigns by community health workers discussing and informing the community on inter alia on prophylactic health care measures. Concerning child health in particular topics covered include, pre- and post-natal care, nutrition, sanitation and hygiene, and disease prevention e.g. by reducing the risk of Malaria infections through the use of long lasting insecticide treated bed nets. If the advice from sensitization would be followed child illness could be reduced which in consequence would also imply a reduced need for medical treatment. Concerning the flow of information apart from running directly through sensitisation campaigns there could also be a direct interaction between prophylactic measures and health centre visits. On the one hand we assume that more and regular precautionary measures would reduce health centre visits while on the other hand these might actually also provide a potential source of information on prophylactic measures to be taken as part of the consultancies delivered there. While in terms of information there might be a potentially ambiguous effect between medical visits and preventative measures it cannot be established if the link on health insurance to prophylactic behaviours is a positive or a negative one as it depends on the relative strengths of moral hazard vis-a-vis the effectiveness of the sensitization delivered. While the linkages between insurance coverage and access to 10 medical care and changes in health care behaviours might be more short-term and repetitive, changes in the child's health might only be detectable after some time thus there might also a timing issue (lag) to be consider ( Binagwaho A, Hartwig R, Ingeri D and Makaka A,2012:8-10 ).

Among the health insurances that we have available in Rwanda, the mutuelle are the only one that pay in a timely manner, which allows health staff in hospital and health centers to cover their expenses.it is because the mutuelle are decentralized, and so it's the local district that pays directly.

Decentralization increased:

- Health committees effectively functioning to strengthen health facility management
- Increased rate of membership in mutuelle
- Capacity of mutuelle to manage and ensure quality of services strengthened
- Participation of mutuelle in the prevention and promotion increased

**2.11.5.6 Health Facilities Management**

Through its management support to hospitals and health centers, MOH has supported the increased capacity of health facilities to better manage their resources and to provide high-

Quality health services. The MOH, district and partners collaborated closely on health facility strengthening initiatives, and worked together to develop health facility management.

Situation analyses at the facilities identified priority areas for strategic planning, including quality of care, human resource management, overall equipment needs, improvements in infrastructure, hygiene, general communication about services and community outreach.

**2.11.5.7. Increase Health care indicators**

- ✓ People have been trained in Maternal/Newborn Health: people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal and/or newborn health and nutrition care.
- ✓ Integrate management of childhood illness
- ✓ Nutrition
- ✓ 90% have medical insurance cover under mutuelles des santé in 2013,
- ✓ Under five year mortality rate is at 126 per 1000 born.

- ✓ Family planning is at 42.8%, the use of modern family planning methods have increased to 37%;
- ✓ Fertility rate at 4.7%, acute malnutrition currently is at 1%,
- ✓ The population is served by a hospital (Kirehe Hospital),
- ✓ 15 health centers and 12 viable maternity wards in each health posts of Bukora, Nasho, Kabuye, Musaza, Gahara, Gashongora, underweight children that are under 5 years has been reduced to 90%.

(District Development Plan of Kirehe 2013-2018:11).

## 2.12 Chapter summary

This chapter has spelt out the various priorities, advantages, disadvantages, strategies, target, resource and resource allocation criteria for the decentralization. The decentralization of health services in Rwanda remain a framework of the country where is geared towards addressing the major challenges associated with health care. These include access and equity to health service, and ensuring that health services contribute largely to reducing poverty in the country. Its policy areas include the promotion of primary and emergency services through the tackling of geographical access by placing Health Points with community health officer in remote rural areas.

# CHAPTER THREE: RESEARCH METHODOLOGY

## 3.0. Introduction

Carrying out any scientific research needs the utilization of different methods and techniques. (Grawtz1987, p 42)

According to BAILEY, (1982:42) Methodology includes the assumption and values that serves as ration for research and the criteria researcher uses to interpret data and reaching conclusion**.**

The analysis of every topic during a research requires taking into account the clarity and modality of a research so that the results provided by that study reflect the reality.

Therefore, methodology is an important tool that allows confirming, nuancing or rejecting ideas obtained from data collected through different techniques. In order to arrive on this, different methods and techniques are used**.**

The purpose of this chapter is to provide guidelines about the researcher achieve his /her research intentions. Technically, this chapter describes the methods and techniques to this research paper.

The chapter also present also in précis manner the technics of data processing and an analysis.

Finally the chapter puts forward problems that were uncounted in this research and provide the background against which the findings and conclusions of the study was examined and appreciate regarding reliability and validity

Again, this chapter explains the methodology for this research, including the rationale for the selected methodology, the construction of research framework and the strategy to respond to the research questions and achieve research objectives, and the process of data collection and analysis.

Restating the introduction chapter in this research, the main objective of this research is to analyze the impact of mining industry to the local development and how decentralization has

changed the prevailing socio-economic situation and condition that significantly affects the expectation placed upon the incumbent mining corporation. Careful observation to the research objective is central to the selection of methodology in answering the research question

Having selected qualitative and quantitative methodologies for this research, the next step is to formulate the structure of such methodology to fit with the fundamental philosophy that forms the background and eventually the objective of this research. The key aspects of this research are decentralization impact and local development. Decentralization plays a role as an exogenous factor that brings about changes to the 19 prevailing socio-economic situation and condition in the research area with respect to the mining impact and local development. In measuring the impact of decentralization, this research should therefore focus on the changes that take place before and after decentralization. The prevailing socioeconomic situation and condition that changes as a consequence to decentralization.

### 3.1 METHODS.

Researcher has used analytical, structural and historical methods.

#### 3.1.1. Analytical method.

Analytical method was used in the sense that researcher analyzed different data that he used in the research.

#### 3.1.2. Structural method.

The structural method was used in the sense of considering the structure organizational chart of Kirehe district.

#### 3.1.3. Historical method

The historical method is a guideline by which I used the argument to the best explanation of back ground of decentralization in Rwanda, especially in Kirehe District

### 3.2. Techniques

This is clearly defined procedure which has been tried, tested and accepted as at least partially successful in solving problem.

The techniques can be defined as the compilation of knowledge in order to produce means of effective action.

Generally a technique is a series of ways and processes that help the researcher to put together data .They can also be defined as a tool arranged for the research and organized by the method that aims at reinforcing the stages of limited operations. It relies to concentrates practices adopted to defines aims.

### 3.2.1. Documentary techniques

According to BAILEY, D.K (1978:226), Documentation study is the analysis of document. The document include any written materials that contain information about their intended research: the researcher asked text books report pamphlets, as well as electronic mails. This means any written materials that contain information about the phenomena we wish to study. This technique will help me to consult different document concerning my topic where I will be able to collect relevant data.

We shall try to review a number of literature sources on decentralization that exist in the field of public administration and will help in exploring decentralization within the context of the health system. I will do that because this will help me to critically review the efforts of the government in the field of transferring power to lower levels.

### 3.2.2. Interview techniques

For the sake of consistency and objectivity, different sets of questions has been prepared as interview frameworks for individuals based on whether they are the key informants among those working in Kirehe District, Kirehe District Hospital and three health centers(Kirehe,Rusumo and Mahama).

## 3.3. Data processing and analysis

Data processing is a link between data collection and data analysis. It involves the information of observation from the field into the systems of categories and into coding. The data collected has beeen transformed into meaningful information foe easy interpreting and understanding. Therefore data processing involves editing, coding and finally data analysis (MACHIMIAS D. and MACHIMIAS C 1976:52).

### 3.3.1. Editing

GIRBERT and Churchill (1992:51) defined editing as the inspection and collection, if necessary of each question or observation from interview.

Editing will be necessary to ensure completeness, accuracy and eligibility of the data.

### 3.3.2. Coding

GILBERT and CHURCHILL (1992:51) defining coding as technique procedure by which data is categorized: it involves specifying alternatives categories on classes into which the responding are to be placed and assigned code number on the class. Coding in this study was used to summarized data by classifying different responses which were collected into categories for easy manipulation

### 3.3.3. Tabulation

GIRBERT and Churchill (1992:51) defined tabulation as orderly arrangement of data in table or other summary format achieved by counting the frequency of respondent to each question. In this study tabulation involves putting data into statistical tables such as percentages and frequency tables to show the number of respondent to particular question.

## 3.5. Study sites and participants

### 3.5.1.Study sites

Two key units of study and analysis 'social unit' and 'space' -were chosen.
Health centres and District Hospital are common places where the government put more effort to decentralize. Thus,Kirehe District Hospital,Kirehe Health center, Rusumo Health Center and Mahama Health Center were respectively the centre for observation and those who were interviewed were mostly located in these local health institutions. All of these health centers and District Hospital are rural based.

Kirehe district was chosen because of its social economic dynamics. Firstly,it is among the rural districts in Rwanda; secondly it is the area I Work the district as local leader. Besides this is a place in which I know that making contacts would not be a problem because the majority of the people know me and would make the quality of interviews better. This reassure the

respondents that there is no secret behind the research, although care was made so as to retain my neutrality, since if not well addressed this can cause contamination.

### 3.5.2. Study participants

**Table 1. List of informants.**

| Informant | Number |
|---|---|
| District Director of Health | 1 |
| District Health Budget Officer | 1 |
| In charge of health insurance | 1 |
| In charge of health and teachers salary | 1 |
| Director of District Hospital | 1 |
| Administrator of District Hospital | 1 |
| Head of health centers | 3 |
| Health workers | 15 |
| Community informants | 20 |
| Total | 44 |

Source: Field study

## 3.6. Methodological problems and Limitations

There were a number of limitations and problems that I encountered during the study. These included study sites, participants, permission and ethical issues. Although these problems did not hold back my research schedule, it is possible that the time framework for the study could have been shorter had I been problem free.

A number of respondents therefore were suspicious of the intentions of the study and feared they might be stigmatized or even lose their jobs, although later these fears were overcome.

The women were often more willing to talk in the absence of their husbands. This could be because of the oppression that women still experience in Rwanda.

There was a problem where some were not able to articulate issues because they did not understand the question.

There are always ethical problems of conducting research on politically related subjects. But these did not so much feature because I had got permission from higher levels of government from the very start and did not identify myself with any political group to ensure neutrality.

But i think the biggest difficulty was what constituted reasonable private space for interaction with the patients. An attempt to conduct the interview within the hospital vicinities made some patients very apprehensive. There was that look of maybe the health staff is seeing and hearing what we are talking'. The interview was always conducted either under the tree or within 44

The provided room within the health facilities. The officials at the Ministry of Health (MOH) were more relaxed and I did not sense any tension during the Interviews. On the other hand too, health staffs of lower cadres felt less relaxed due to the feeling that their superiors may be hearing what we were talking.

Another practical difficulty was the need to translate the interview questions into a national language (kinyarwanda) for the participants to be able to understand as well as translating the responses back to English. This is a universal problem confronting researchers in Uganda but it assumes greater significance if the participants are in rural communities. The questions in this

Case had to be reduced to the lowest level. This was condescension towards the ability of each respondent, because it was essential that they understood the questions in order to generate best responses.

### 3.7. Chapter summary

This chapter has looked at the methodological approaches that were employed in gathering and analyzing the data. It is realized that a combination of various methods such as individual and group interviews, and self administered questions served as the means of obtaining the primary data needed. This chapter also looked at the strategies that were adopted to enhance the validity and reliability of the research

# CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

## 4.1. Introduction

The research carried out under the topic "The Decentralization of Health system in Rwanda. Challenges and strategies." presents the overview of Impacts of Decentralization on development of health sector in Rwanda. Findings concern the respondents views related to achievements made in health sector since the policy of decentralization was introduced in Rwanda, challenges faced by Kirehe District in decentralization of health system. Specifically these findings focus on the strategies to overcome them in order to promote a better service delivery.It look at findings from the analysis made from the the interview of the staff involved in health sector , focus group discussion and key informant interview of Kirehe Distric,Kirehe District Hospital and three health centers(Rusumo,Kirehe and Mahama).

The chapter is divided into four sections: section one presents marital status and age of the household is presented in section two. In section three, the human capital: education, family size and family labor of the households are presented. In section four, natural capital: livestock ownership and land financial capitals are presented.

## 4.2. Demographic characteristics of respondents

Findings present in this chapter were generated from 44community informant, health workers, Kirehe District staff, head of health centers and district Hospital composed of both men and women at the proportionate number. Data were collected through the use of questionnaire and focus group discussion among others. Both qualitative and quantitative data were analyzed and interpreted to answer the research questions and respond to research objectives presented in the chapter one (General introduction). Therefore the subchapter demographic characteristics of respondents present the gender distribution, age group of respondents, and education level and profession of respondents.

### 4.2.1. Gender distribution of respondents

The table below presents the gender status of informants contacted in the selected case study of Kirehe District, Kirehe District staff, three health centers( selected for different reasons: big number of population covered and the head of these health center are more experienced in health sector),heath works and community informants.

**Table 1: Sex of the respondent**

| | Frequency | Percent |
|---|---|---|
| Male | 24 | 54.5 |
| Female | 20 | 45.4 |
| Total | 44 | 100.0 |

Source: Primary data, December, 2015

Te table shows that a big number of responds were male  than female.

### 4.2.2. Age group of the respondent

Age group of respondents plays an important role in social economic analysis of phenomenon because it helps assess the validity, accuracy and reliability of data. Thus the table below contains the age group of heads of households contacted in Gasabo District.

**Table 2: Distribution of respondents by age**

| | Frequency | Percent |
|---|---|---|
| Under 21 | 3 | 6.8 |
| Between 22 and 35 years | 11 | 25 |
| Between 36 and 55 years | 18 | 40.9 |
| Beyond 55 | 12 | 27.2 |
| Total | 44 | 100.0 |

Source: Primary data, December, 2015

Depicted from the table above, findings show that among 44 informants(selected among health workers, community informants, head of health centers and others involved in health sector in Kirehe District such us DDH,had of district Hospital,administrator of district hospital, budget officer and in charges of health insurance, health and teachers salary) contacted only 3% of heads of were under admitted age of marriage.

Portrayed in the table above findings in relation to the age of respondents, a high number of respondents lie between 36 and 55, that is %; nearly lies 81.8% of respondents between 22 and 50%; while 27.2% of respondents were more than 55 years. Even though the research could not find a great number of respondents aged beyond 55 who could provide comparative testimonies because they should have lived the society that has faced both the period of the absence of decentralization policy.

### 4.2.3. Education level of respondents

The level of education of respondents when looked at beyond its conventional boundaries forms the very essence of all actions and arguments. Thus the research respondents' level of education offers the reliability of the variety of information acquired from the informants and respondents on decentralization of health system in Kirehe District. The table below presents the respondents' level of education with consideration of primary, secondary, university levels as well as the no schooling status.

**Table 3: Education level**

| | Frequency | Percent |
|---|---|---|
| Primary level | 28 | 63.6 |
| Secondary level | 7 | 15.9 |
| Diploma level | 3 | 6.8 |
| Bachelor's level | 5 | 11.3 |
| Master's level | 1 | 2,2 |
| Total | 44 | 100.0 |

Source: Primary data,december 2016

Education is the most powerful weapon at any kind of situation. The direction in which education starts a man will determine his future in life, it not only sharpening the brain but also, it sharpen the habits as well. Education breeds confidence, confidence breeds hope and hope breeds peace. So education is the root of the life(Gov.UK,school:departemental advice,London,2016:2)

### 4.2.4. Profession of research respondents

The profession of community members helps to manage social and economic change and challenges they face in their everyday lives. The Researcher state that the predicted future of the community is today's reality and commitment to development. Thus the table below presents the profession of respondents contacted in Kirehe District.

**Table 4: Profession of respondents**

| | Frequency | Percent |
|---|---|---|
| Farmers | 23 | 52.2 |
| Public servant | 7 | 15.9 |
| Unemployed | 2 | 4.5 |
| Self employed | 12 | 27.2 |
| Total | 44 | 100.0 |

Source: Primary data, December, 2015.

Regarding the profession of respondents in Kirehe District, a number of 4.5% of respondents are unemployed; a number of 52.2% of respondents are farmers; a number of 15.9% are public servants working in local administration level and health institutions in Kirehe District; while a number of 27.2% run their own business.

## 4.3. RESEARCH FINDINGS

The following sub-chapters provide with data findings on the topic under study.

### 4.3.1. Challenges in implementation of decentralization policy of health system in kirehe district

Health development in decentralized system is not only ambitious, and may be unrealistic, but it invites a number of methodological challenges (Naustadalislid 1992:27).

This section presents the key challenges find in our research that impacts implementation of the decentralization system in Kirehe District in health sector. Decentralization has reached a significant height in Kirehehe District health sector. However, it is still confronted with challenges, thereby deteriorating the effort to the concerted and systematic approach towards decentralization. The challenges listed here are focused on the following ten key areas.

1. Technical capacity and staffing
2. Financial capacity: The gap of autonomy
3. Planning
4. Lack of facilitating health infrastructures
5. Coordination problems among various actors and stakeholders
6. Poor referral system of patient in Kirehe District Hospital.
7. Inadequate office and staff accommodation
8. Water and sanitation
9. Community Participation
10. Job security

#### 4.3.1.1 Technical capacity and staffing

The decentralization process in Kirehe District in health sector entailed a major shift in the roles of the government at all levels. This is expected as decentralization creates more opportunities for local autonomy and responsiveness to more specialized constituencies.

The decentralization process in Kirehe District shifted the existing role of the government to that of proactive and engaging local communities, assisting and enabling communities to identify priorities and to allocate and utilize resources efficiently to health priorities. However one major factor that has beset decentralization system in Kirehe District in health sector has been the capacity problem, especially at the local level, district staff who are dealing with health and even the nurses suffers some height of capacity constraint.

One of the key elements in any decentralization reform is the development of the administrative capacity at all levels of the government. The capacity development goes beyond training, although training of politicians and staff should be an integrated part of the reform. In order for the decentralization system to be a success, there should be a sufficient implementation capacity at the local level to carry out the development activities delegated to them (Chodden :77). In Kirehe District, though there has been an increase in the overall staff working at the local level that has health in their responsibility; the staff strength working at the local governments is comparatively lower than those in the central government which impedes the local governments in carrying out their delegated activities effectively. There is also lack of doctors and nurses who are daily working on health care. As a result of the ongoing decentralization is not totally achieved. Thus, there is a clear need for additional capacity support at block level.

The district is among the last districts to have an hospital in the country with low infrastructure development. The district is also noted for lacking a lot of amenities and services which deter many personnel from accepting postings to this area despite it strategic location. It is therefore common to see most of health staff working the district but residing in Ngoma District, the nearest metropolis. Poor local management therefore affects the use of local resources and the meeting of health targets, and the overall health outcomes of the district.

Staffing with regards to deployment of health personnel in the district is a challenge. According to Murindwa G, Kirunga Tashobya C, Kyabaggu J, Rutebemberwa E and Nabyonga J(Meeting the challenges of decentralized health service delivery in uganda as a component of Broader health sector reforms, Health Systems Reforms in Uganda: Processes and Outputs, 2006,pp98),there remains a critical problem of variability in human resource availability across districts. The capacity to recruit qualified health workers varies from district to district with some

districts able to attract a higher number of qualified health workers than others. Considering the poor nature of the district and the absence of some social services and facilities such as accommodation, educational and recreational facilities, some health personnel refuse postings to the district. It is therefore not surprising that users complain of non availability of health personnel at the various health facilities particularly during weekends as these personnel tend to enjoy their weekends at their various homes outside the district.

- **Lack of medical doctor in health center**.

The category of health personnel in Kirehe district includes nurses, in charge of community health and auxiliary staffs. There is no single medical doctor in health center which serve an average of 25,000 of population who are far from the district hospital where medical doctors are based and this has implications for the general health situation of the people surrounding this health center.

The decentralization system aims to increase workload to the local employee and also demanded for good service delivery, transparency, efficiency and accountability especially in health sector.

#### 4.3.1.2. Financial capacity: The gap of autonomy

It is realized that the financial policies allocated to the health sector are budgeted by the MOH located at Kigali, with major decisions regarding funding being centralized. However with the numerous tasks before the central government coupled with other factors that need to be considered, there is sometimes the delay in the disbursement of funds to the local health structures and this has the tendency of affecting the decentralized activities.

*In Kirehe District, the tax base of the blocks is so small that they cannot fund their development plans on their own revenues. The process of decentralization has given autonomy to the blocks to propose the activities they need the most. This was a very excellent move in addressing the local needs but it results in a mere cataloguing of the wish list, rather than 84 a realistic plan. The local governments hugely depend on the resources from the state government to carry out the development activities. The lack of proper coordination and indicative outlay between the central government responsible for mobilization of the finances for development*

*plans and the blocks, results in widening gap between what people actually wants and what the available resources of the government can fund* (*personal communication with the District budget officer,Kirehe,20/01/2016)*

In Kirehe District, the tax base of the blocks is so small that they cannot fund their development plans on their own. The process of decentralization has given autonomy to the blocks to propose the activities they need the most. This was a very excellent move in addressing the local needs but it results in a mere cataloguing of the wish list. The local governments hugely depend on the resources from the state government to carry out the development activities. The lack of proper coordination and indicative outlay between the central government responsible for mobilization of the finances for development plans and the blocks, results in widening gap between what people actually wants and what the available resources of the government can fund.

In fact from the data, it is visible that districts remain dependent on external sources (central government and donnors) of funding for the majority of their programs; sources which according to the study places a significant restriction on how funds may be used:

> *Most funds distributed to the districts have been earmarked by the MOH and for specific uses ... the district authorities have to use the funds as directed and we are not allowed to deploy them or divert them even when the need arises. In fact we have had a situation where we needed money to construct safe water springs but even when there was some money, it was not meant for that and we have been trying to get permission from the central ministry but it is not some thing Very easy (Personal communication with the director of health, Kirehe. 20//01/2016).*

The perception of the present status of the district control over resources suggests that in many cases the flexibility apparent in policy documents is not present in reality. On the other hand, the perception for resource autonomy and flexibility is concerned, therefore shows that even with decentralization, the decisions on the use of a large share of funding for primary health care in Kirehe District are still outside the districts' control.

To emphasise the lack of autonomy and flexibility, the District Director of Health noted that:

> *When the funds come in from the Ministry of Finance, the district can only allocate the unconditional grant for the needed activities the centrally allocated government funds, certainly no one can alter anything and you must seek approval from above if any diversion is to be made ... certainly this causes delays here and there. (Personal interview with the District Director of*
>
> *Health se, 23/01/2016).*

What is clear is that the sources of funding for primary care services for a rural district in Rwanda such as Kirehe are still outside the district control even when devolution has taken place. This lack of control and flexibility in fund allocations adds to the already chronic problems of financial deficit the district faces amidst increasing needs, coupled with untimely release of funds from the centre which restricts the primary health sector activities and affects the delivery of quality care. Some respondents saw this influence as the cause of delay of some health activities. In trying to characterize what happens as far as funding for decentralized funding is concerned, a district budget officer noted that:

> *Even when we can come up with ideas, if they are not priority areas for the MOH, even when they will appear very important, there is no way we can implement we have not achieved the level where we can do what we wish ... so we still depend on the donors and in most cases they direct our course of action the funds are not enough. (Personal interview with District Budget officer, 21 /01/2015)*

Implicit in this quote is the perception by the county chief that decentralization in fact increases dependence by poor districts such as Kirehe on the external sources of funding and reduces the choices available for them when it comes to spending on public services. The county chief noted that because of the status quo the districts are put on the receiving end, which

automatically reduces their bargaining power and choices on how to spend on priorities of the district whereas the district realizes its plans from below (bottom).

#### 4.3.1.3. Planning

In theory decentralization in Rwanda has emphasized bottom up planning, an effort that was meant to increase local contribution in the planning process of the primary health sector. Decentralization of health services suffers from the interference of, imposition, and response to externally determined programs that differ from local needs. In many decentralization programs, the service structure is influenced by donors who fund specific projects even when these may not meet the priorities of the local areas( Lutoti S, Oria H, Anguma B. and Kitutu F Institutional challenges to decentralization of health services in Uganda - a traditional review,review paper,2015)

> *The plan guidelines say the plan must start from the lower levels ... this has been well understood and encouraged. Different councils come up with their proposals, which Are sent to the district where such proposals are analyzed and form the district plan Proposals, which are sent to the headquarters in Kigali. (Personal interview with head of Kirehe District Hospital).*

This was the view of some managers who thought that the central government still plays a central role in the planning process:

> *The Ministry of Health provides guidelines for preparing the annual work plans and receipt of funding depends on the adherence to those guidelines ... These are actually instructions "soft instruction sayings please do ... from the centre in the process of Planning. (Personal interview with the District planner, Kirehe District , 2004*

The health managers recognize the lack of skilled manpower as one of the constraints of decentralization in so far as health sector planning is concerned.

> *Donors and central government still determine the extent to which some intervention can be implemented , they decide on the money and sometimes that is reflected in the work plan guidelines ... it is in most cases uniform for the whole country as if we have similar problems ... it cannot be that all the time the problems in Kirehe are same as that of other rural district. It makes it so hard for us to move resources in case of an outbreak of cholera or calamity. This happened to districts that were affected by Ebola ... by the time the ministry of health acted, many people had died.... This is the lack of flexibility we are talking about. (Personal interview with the Administritor of Kirehe Hospital).*

According to the study, there is an apparent danger in this form of plan influence in Kirehe, which promotes commoditization of primary health intervention during the planning process offering little flexibility on the part of the district managers. This limited flexibility was attributed to the central government and donor control over resources, and implementation of specific primary health interventions, such that even when a district such as Kirehe has instituted a bottom up planning approach in which the district bases its annual work plans of sub counties and health units, planning is still centrally influenced.

> *There are always conferences and workshops by donors at the districts, or regional basis in which we are told how to spend, where to spend and it is very strict. Donors indicate where their money should be spent and how it should be, and the next funding in most cases depends on how well you did in the previous year. (Personal interview with the District Budget officer, 28/03/2015).*
>
> *You cannot claim to have autonomy when you're still being told do this and the other ... the central government still tells us infact what to do ... But we are the people on the ground ... we know our problems but nobody wants to hear us and they keep saying the power is given to you this is just another way of confusing us more, because when we ask for this they instead don't give. (Personal interview with the head of Rusumo health health centre, 27/01/2016).*

Health managers such head of Rusumo Health center, sees these conferences as a way to alert the district that however good your plans and ideas are, implementation basically depends on "us" donors.

#### 4.3.1.4 Lack of facilitating infrastructures

As Kirehe District moves towards empowers people at the grass root level to make their own decisions on issues affecting their community, it still has many blocks without having sufficient health infrastructures at hospital and health center levels. The district has only one District Hospital which is still lacking basis infrastructure. There is again one sector which doesn't have a health center. The lack of these facilitating infrastructures had been a serious predicament for the effective implementation of the decentralization process in Kirehe District.

#### 4.3.1.5. Coordination problems among various actors and stakeholders

One of the major challenges faced by the decentralization system in Kirehe District is the lack of coordination between the donors, national institutions, non-governmental organizations and civil society organizations. In Kirehe District, this coordination is still low, some partners participate t them self in preparation of their budget without any participation of District leaders, the coordination become hard because administrative powers for such aspects is limited.

#### 4.3.1.6. Poor referral system of patients in Kirehe District Hospital

The main issue here is limited number of transport facilities and ambulance for transporting emergency cases are lacking .In Kirehe District in total of15 health centres, there is only 7 ambulances that serves the total population of the District. This can be solved by MOH instead of transferring budget to the local entity. The role of the district is to express the need.

#### 4.3.1.7. Lack of clarity on relationship between the DDH the District executive committee

This is one the challenges facing the district health unit in Kirehe District. The district unit has limit where the DDH is spending large proportion of time on activities not related to responsibilities as currently defined in their job description, this is appear in their office where they chair the same office with others. During the research in the district, I visited the district health unit. I was surprised to see the same room of office being used by district health

administration and other distict staff (examples :disaster manager, in charge of cooperatives,…) at the same time.

#### 4.3.1.8. Water and sanitation

The eicv3 results show that 61.5% of Kirehe district households use an improved drinking water source.

Improved drinking water sources include protected springs, public standpipes, water piped into dwellings/yards, boreholes, protected wells and rainwater collection, as defined by the world health organization on (who). Figure 4.1 shows that the majority of households use a protected spring (33.7%), followed by a public standpipe (27.2%) and 0.6% use other improved water sources.

Kirehe district has not yet achieved the EDPRS national target for the water and sanitation on sector, which is to increase access to drinking water to 85% by 2012.(NISSR,EICV3 District Profile East-Kirehe:7)

#### 4.3.1.9 Community participation.

Community participation may assume variety of forms depending on the nature of activity or intended objectives. Community participation is generally defined as: An active process by which beneficiary/client groups influence the direction and execution of a development project with a view to enhancing their well-being in terms of income, personal growth, self-reliance or other values they cherish (Paul 1988:2)

.However according to WHO and UNICEF report of 1978, community participation or involvement in health is defined as a process whereby individuals and families would come to view health not only as a right but also a responsibility. The strategy would discourage passive acceptance of government-sponsored programs, substituting active participation (or 'cooperation') at every stage.

There are two levels at which the public can participate in the health service delivery in Rwanda. It is either through the health management committees of health centers or through election of health workers at the village level, which have association with primary health service delivery.

a) **Participation trough through the health committees of health centers**

In each health centre that participated in this study, there was a Health Committee with Some committee members such as the health unit in charge noted:

> *It is a requirement for each unit to have the committee ... the roles of these committee members mostly they are involved in the management and running of the health unit ... they make budget estimates, plan and identify major requirements of the unit which are forwarded to the district ... These units are fundamental to the running of the units ... I think the idea is to let the community members do things their way. (Personal interview with the head of Rusumo health center).*

Without underestimating its value, the study shows that these committees link the communities to the service providers while at the same time also noting that the committee members are still not secure from manipulation from above:

> *The health centers management comities are very important ... they serve as a link between the communities and the primary health service providers ... the only problem that I see is that sometimes they are by passed and they are not involved in every process ... the members are still very inferior and can easily be manipulated, so I think that they could benefit from autonomy and greater sense of independence. (Personal interview with health worker at Kirehe Health Center).*

The respondent noted that in most cases they are bypassed by the bureaucrats who aim to influence everything.

a) **Participation through election of health workers at the village level**

Health workers are elected by the population living in the village in order to help them to

The study therefore noted that there were other problems such as supervision of the health sector and those who work, in it as one staff noted:

> *We used to have in charge of community health at the health center health; they could go from one village t to another. Surely that put standards in the system because they were professionals who ensured quality but under the current circumstances you cannot expect standard because they are much time in their offices (Personal interview with the health workers in Rusumo Health center).*

In most health centres visited, it was noted that health workers were not subject to supervision by professionals with knowledge and capacity to carry out that function in a way they would have considered legitimate, instead they were purportedly under the supervision of local actors with neither the capacity nor interest to perform the function nor knowledge about what to supervise nor the backup from professional cadres from the district. The inability of local actor to carry the weight of supervision on his or her own is best described by the testimony of a member of health workers:

> *Those people are so difficult. We cannot control them. Whenever we try to say anything they threaten to leave saying they are educated and can find work elsewhere. Now we simply keep quiet and let them do as they please. Many of us on the committee are uneducated; how can we question those who are educated?*

This testimony not only shows the lack of power and the inability to health workers to hold their supervisors accountable.

#### 4.3.1.10. Job security

Job security is very important in all aspects of public and civil service therefore most health workers as public servants do value job security highly. Decentralization has changed the employment status of the district health staff from being national public servants to local

employees answerable to the District administration. This change has threatened the stability and security of employment for all public servants:

> *Job protection under decentralization is tricky ... you are responsible to the local politicians you cannot be sure for how long you will keep the job ... I tell you we are living like that. Anything can happen any time ... it worries me here every day because what will I do at my age if I lose the job ... but that is very common. (Interview with the hade of Mahama health centre]*

Inherent in these quotes is the insecurity health staff has about their jobs in Kirehe District.The health staff's experience here is explicit about career uncertainty and an increased level of instability in employment under decentralization.

### 4.3.2. The strategies to overcome challenges of decentralization.

#### 4.3.2.1. ImprouveTechnical capacity and staffing

Thus, for the local governments to shoulder their new roles and responsibilities effectively and discharge their assigned critical functions ably, the existing capacities of local governments and institutions will have to be enhanced considerably. Here the immensely critical factors that will determine the success that the local government will enjoy in carrying out their function and responsibilities would be the institutional capacity building and human resources development at local levels. Thus, achieving this will require improvement in the quality and numbers of administrative and technical staff in districts and blocks (local governments). Equipment of the community leaders with technical knowledge and fluency over the general policy issues that comes with policy issues were very vital. However, in the current scenario, there is reluctance among the civil servants to serve in rural areas and also the line ministries tends to retain their most qualified personnel in the centre. Many of the local leaders are hardly literate and in many instances, the local leaders are not even in the position to distinguish between an annual plan and the five year plan documents.

**4.3.2.2. Reduce the gap of autonomy in financial management and increase the budget allocated to health sector at the district level.**

The process of decentralization has obviously increased local participation in the development planning process and has drastically enhanced their powers to prioritize and identify needs of the people, however, it has also created huge imbalance in the demand for and supply of development services. This is primarily attributed to the lack of resources both at the local and central level. The initiative of decentralization, the granting of autonomy to locally planned activities may not go in line with the resource position of the governments (both local and central). Also the lack of adequate resource base would make the bottom up approach in planning cycle merely result in huge 85 resource gap. Thus, there should strike a balance between the local demand and the provision of budgetary support from the government, eliminate what we call air marked fund because limits local leaders to go beyond.

Many stakeholders at all levels have realized that, for decentralization to be truly effective, finance must be available, with districts and other decentralized entities having the resources necessary to support their activities related to health sector.

The district should also put in place mechanisms to increase own revenues in order to finance health projects because in the current situation we realize that without grants from the central ministry, nothing can be done.

**5.3.2.3. Increase the autonomy of planning to District level**

The district must be responsible significantly to set the priorities and the content of district health plans, it generate consensus and made the public begin to understand the issues surrounding health services and eliminate the danger that what people identify the major issues are not in the end implemented.

Policy makers have to take lesson to be learnt especially those from poor districts such as Kirehe, which struggles with poverty. Such districts have continued to overcome the lack of autonomy and continue to suffer from influences outside the districts in the form of what to include in the plans, and what to spend on which affects the delivery of quality primary health services.

#### 4.3.2.4. Providing Health center and hospital infrastructures

Lack of health infrastructures is one the challenges facing Kirehe district in health.

D*istrict leaders are doing less to address this problem. Providing these infrastructures is the best solutions to solve the issue of health delivery in local communities (personal communication with the head of District Hospital, 04/08/2015)*

#### 4.3.2.5. Organize the coordination among various stake holders.

For an effective decentralization system, there is a requirement of organization of different stake holders.

*All initiatives towards fulfilling the objectives of decentralization should be carefully coordinated to avoid overlaps and duplications and gaps in health service delivery and to maximize available resources in order to ensure more systematic implementation of the decentralized activities*.(*personal communication with the administrator of District Hospital,23/02/2016).*

This will generate the achievement of greater result in Kirehe District.

#### 4.3.2.6. Organize the referral system of patients in Kirehe District Hospital

The big issue is to solve the problem of transportation of patients by increasing the number of ambulance by working with partners and advocate identifying and mobilize resources to address current and future gaps in health service delivery. *The district should work with a target to providing at least one car by health center (personal interview with the head of District Hospital,15/02/2016).*

#### 4.3.2.7. Assigning the DDH related to his responsibilities

The tasks assigned to the Direction of health at the district level *should be addressed to their job description related to play an operational role to serve the overall district health services coordinate and supervise the staff of district Hospital and health centers(personal communication with the DDH,24/01/2016).*

#### 4.3.2.8. Involving community in health decision

In order to enhance the level of community participation, the government of Rwanda should have a political commitment to public participation in decision-making, and the structures are in place to facilitate this. To a certain extent there is a growing feeling of ownership of their local health units. However, autonomy is far from being achieved both in resource, choices of projects and the decisions to implement them. The district is still dependent on external sources of funding for their health activities. There is not much indication that this is about to end since local revenue gathering capacities are likely to remain low due to low investments in the district and given the economic state of the district revenue gathering capacities are likely to remain low due to low investments in the district and given the economic state of the district.

Thus unless governments are able to provide appropriate mechanism which will lead to legitimacy and in the final analysis institutionalization of community participation, community participation will always remain to be government participation.

The various health groups in the communities sometimes my act on behalf of their community members in issues related to needs assessments.

#### 4.3.2.9. Insuring Job security

Decentralization may be seen here by the health staff to have increased the degree of their protection that they have enjoyed under centralization.

The workers organizations, and the national medical and nurses unions makes the staff very confident and to believe that they have protection against unfair treatment in case of victimization.

The national public service rule should be used by local decision makers in case of a health staff is going to be punished.

#### 4.3.2.10. Construction of water adduction and promote sanitation

In order to increase the safe life to the population of Kirehe District,the leaders have the task to promote the construction of water adduction.

## 4.4 Chapter summary:

Thus, the decentralization Kirehe District is faced with many challenges as discussed above. Challenges have been faced in the planning and implementation process. The decentralization of tasks to the blocks has called for increased capacities to discharge new roles and face new risks. Thus, incapacity at the local governments had been a concern for the moment, which has to be carefully addressed. The sustainability of the blocks is questionable, given the limited tax base. It calls for continuous and unfailing requirement for the state to provide annual subsidies and expertise for the development of the Blocks.

# CHAPTER FIVE: CONLUSION AND RECOMMANDATIONS

## 5.1. Introduction

This study provides an evaluation of the structures health system under decentralization and to a certain extent the performance of it in Kirehe District. Understanding the implementation problems in decentralization of health system in Kirehe District.This study provides a basis upon which government can reform health policy.

## 5.2. Summary of major findings

In this concluding chapter, I will provide an evaluation of the decentralization of health services in Rwanda with emphasis of Kirehe district as case study. A qualitative exploratory approach enabled the study to assess the users and providers' own experiences with the current structures of decentralization of health system and the implications for the general health of the public who use the services. The study therefore provides an intermediate evaluation of the on-going decentralization process and its impact health in one of the rural districts of Rwanda (Kirehe) The testimonies of the respondents that decentralization of health system the difficulties in health services that most people experienced under centralization. Throughout this thesis, we have seen that decentralization has altered the role of the Ministry of Health, which now focuses on developing policies and guidelines and setting standards to be followed by districts. On the other hand, the study has also showed that districts are no longer passive recipients of plans and financing and are actively involved in assessing the needs, allocating resources and implementing activities. The literature review revealed that decentralization is well accepted in Rwanda. Most of the literature on decentralization is focused on how to carry it out rather than on whether it increases social welfare. The study therefore developed a methodology in a qualitative tradition that allows the views of the users and providers to be heard as a means to understanding the impact of decentralization on the quality of primary health care. Throughout the study therefore, the users and the providers are treated as major actors and at most, best evaluators of the success and challenges of the decentralization policies based on their daily interface with health services.

District leaders noted that decentralization has a positive development impact on the structural development of health system in Kirehe District.

The study noted that throughout the district, there were various levels of health services ranging from lower levels at the village, which are the current vehicles for the delivery of primary health care. In each village, there was  health workers. Community participation is taking place through the elected health committees. The communities therefore to a certain extent have assumed their passive responsibilities in planning, budgeting for health related activities. The findings showed that local level participation in health service provision is extremely weak, as local people are not totally involved in the process.

The study showed that districts are still dependent on external sources of funds for most of their health activities. This is likely to continue into a foreseeable future since local revenue-generating capacities are likely to remain low, at least in the short term. However dependence on external financing did not appear to be an inherent problem, assuming that funding is not abruptly withdrawn and the funds are released in time to allow planning and implementation, which is still the problem. The study showed that the districts such as Kirehe are still not free to allocate resources to priority areas as per their needs because of the conditions that follow funding. The district administrators were concerned that if the donors (central government and the international donors) continue to influence budgets and plans, the district priority plans are left out.

The study noted that if local health services consist mainly of a collection of vertical programs funded by donors and central governments, local decision-making discretion remains quite low and decentralization will be limited at best to deconcentration. Delegation and/or devolution to achieve integrated service delivery need to offset the effects of these vertical lines of control to allow more community and local government roles in planning and implementation of major projects that affects the communities. The establishment of Health Unit Management Committees and the District Health Committees to carry out planning, management and financial

Oversight functions are a classic organizational response to this issue. Evidence on the effectiveness of this response is, however, mixed, given the lack of skills for various functions (the capacity gap). A classic issue that was noted at the local government however was the lack of capacity. In fact most of the health units are technically and administratively weak. It was also noted that local government level lacked the capacity to plan, and at other health units budgeting skills were not up to standard.

The study noted that the management of the health staff was like many other responsibilities devolved to the local government. The study however noted that under decentralization health complains loosing job security than when they were under centralization.

Major issues that were captured in the study relate to the social status and the self its relationship to the behaviors of the health staff and their relationship to the delivery of quality primary health care.

Experience of Kirehe District concludes that decentralization in this district had been a key result of the political will and the institutionalization of regulatory system. Its experience also shows that decentralization policy brings the government close to the people and increase quality and quantity of the service delivery and multiplication of health infractures. However the decentralization in Kirehe is fraught with challenges.

As we have seen, decentralization policy was first adopted as an overall national policy. However it was later adopted by the MOH as an effective means of implementing health policies at the local level and also as a means for community participation in health. However the study has shown that' there was no effective implementation because of a number of methodological challenges.

The findings revealed that lack of facilitating health infrastructures, Coordination problems among various actors and stakeholders, poor referral system of patient in Kirehe District Hospital, inadequate office and staff accommodation, water and sanitation have also contributed to poor implementation of the health policies.

Apart from above challenges, The study revealed some strategies to overcome challenges of decentralization among these we can mention: Improve Technical capacity and staffing, Reduce the gap of autonomy in financial management and increase the budget allocated to health sector at the district level, Providing Health center and hospital infrastructures, organize the coordination among various stake holders, increase the autonomy of planning to District level, Organize the referral system of patients in Kirehe District Hospital Assigning the DDH related to his responsibilities, involving community in health decision, Insuring Job security, Construction of water adduction and promote sanitation

Although this study does not recommend a return to centralization; it does however, points to implementation requirements that have made it less successful in Kirehe District.

## 5.3. Conclusion

The difficulties highlighted by this study also points to two particular lessons for efforts to deliver high -quality services by strengthening popular participation and decentralization. First, health workers must be paid adequately, and resources for technical supervision made available.

Secondly, efforts to improve health services quality must be made and publicized, thereby providing the foundation for public interest in exercising voice in the decision- making.

## 5.4. Recommendations.

The following provide suggestions on what can be done to improve local entities and local people in management of health services in Kirehe District. These recommendations are molded out of the challenges that the thesis identified to be impeding the full utilization of health services by the local people. The recommendations also touch on need of MOH of adopting a health decentralized system.

### 5.4.1. Recommendation to the MOH

- If the MOH wants its policy to be effectively implemented, there is a need of reinforce a health decentralized system. Whereby the MOH can delegate specific powers, functions and authorities to specific bodies, by devolving functions to District Health Offices and Municipal Health Office. These levels have powers and full autonomy in their respective levels with regard to implementation of Health policies. This power does not only include decision making but also administration of financial resources. The DOH remained with the responsibility of standard setting and policy formulation.
- "Decentralization will be successful only when local government, base, solid health agencies and hospitals have sound financial administrative efficiency" ( World Bank 1993:163) . It is important therefore while the MOH devolve some of its functions to lower levels. It has to make sure that, those levels have ability to raise revenue in order to implement local programs. If big share is to come from the central government then it would mean another way of strengthening the central government.
- The MOH should make it a policy that participation as a process will cover all the spheres of health care delivery that is from policy making down to the

implementation stage. The process should also be transparent to allow every aspect of service delivery to come under scrutiny by both community members and the health personnel. Accountability should be rendered at every stage of service planning, with a free flow of information between local people and health personnel. By this, local people will be motivated to participation and the outcomes of health programs will be ideal.

- This leads to the recommendation that the government of Rwanda and development partners should focus not only on health policies but also on monitoring the it's implementation part. This would help decentralization to reach the goal of better service delivery local communities.

### 5.4.2. Recommendation to the District

The district health unit should map out local key service providers in the various communities and integrate them into the decision making process. The health unit should partner with these people through education, training, and visits so to discuss with them ways of promoting good health practices. Since these people live much more closely to the people, it will be easier for the health unit to reach out to the local people if the modern health system is built around these local service providers.

### 5.4.3. Recommendation to the local communities

Health system leaders should be educated on the importance of involving beneficiaries in planning and managing health system. These providers can be sensitized during training, worships and seminars organized by policy makers, NGOs, and civil society groups. This is because, the health worker is the one close to the user and until he or she sees the need to encourage local level participation.

Community participation in the whole public sector should be made official or legal, parliament should enact a law on local level participation in service delivery in the country so that when beneficiaries are denied the opportunity to partake, they will have the power to challenge the operators of the given health delivery system.

The identification of these challenges should serve as the stimuli of reforms and improvements in decentralization to achieve its original aims and objectives for all service sectors including the health sector in Rwanda.

This leads to the recommendation that the government of Rwanda and development partners should focus not only on health policies but also on monitoring the it's implementation part. This would help decentralization to reach the goal of better service delivery local communities.

## BIBLIOGRAPHY

1. B**OOKS**

1.Bailey, D.K. 1978. Method of social research, Free press 866 third avenue,New York

2.Bahl, R.W, and Bird R.M .2008. Local taxes in developing countries the way forward. Public budgeting and finance ,New-York

3. Boko S.H .2002. Decentralization and Reform in Africa. Kluwer Academic Publisher. Massachusetts.

4. Baoyun Qiao (2008) Jorge Martinez-Vazquez, Yongsheng Xu, "The Tradeoff Between Growth and Equity in Decentralization Policy: China's Experience," Journal of Development Economics 86, no. 1

5. BAILAY, K.D (19982), Method of social research 4th edition, Macmillan, New York.

6.Binagwaho A, Hartwig R, Ingeri D and Makaka A, Mutual Health Insurance and the Contribution to Improvements in Child Health in Rwanda ,Kigali,2012,p8-10 .

7. Cohen, J. M., Peterson, S. B., Administrative Decentralization: Strategies for Developing Countries, Kumarian Press (published for and on behalf of the United Nations), June, 1999

7. CROOK, R.C., (1994). "Four years of the Ghana assemblies in operation, decentralization, democratization, and administrative performance", public administration and performance, vol.14.

8. Cheema, G.S., and D.A. Rondinelli (1983). Decentralization and Development: Policy Implementation in Developing Countries. Beverly Hills, California: Sage Publications.

9. Dictionary of contemporary English,Pearson,London,2012,:263)

9. District Development Plan of Kirehe 2008-2012.

10. DeMello, Luiz. 2004. Fiscal Decentralization and Sub-national Expenditure Policy. International Monetary Fund. Washington DC

11. Dolfman M (1973), the concept of health: an historic and analytic examination. Journal of School Health

12. FUMIHIKO S, decentralization (2011), the sage handbook of governance, MARK BEVIR, Los Angeles.

13.GIRBERT and CHURCHUL (1992), basic marketing research Dryden press , England

14. Gov.UK,school:departemental advice,London,(2016:2)

14.GRAWITZ, J. (1987), Science Administrative: Theorie generarale, institut administratif, LGDJ, Paris.

*15.*Jutting,J*(2001)* The Impact of Health Insurance on the Access to Healthcare and Financial Protection in Rural Developing Countries, *Fourth Edition, Washington, DC*

16.Kabayiza B(2014), Education Decentralization in Rwanda: A case study on the role of government and the Catholic Church in two secondary schools in Nyarugenge district , Scholars' Press,Kigali.

17.Kauzya M. John (2007). Political Decentralization in Africa: Experiences of Uganda, Rwanda and South Africa. Department of Economic and Social affairs, United Nations, New York.

18.Leroux (2012) French Liberalism in the 19th Century: An Anthology, Chapter 6: Maurice Block on "Decentralization", Routledge.

19. Litvack, Jennie and Jessica Seddon. 1999. Decentralization Briefing Notes. In World Bank I

20.MACHIMIAS D. and MACHIMIAS C( 1976) data processing and data analysis

21. Malaysia (1999), Rurality , educational and development, unesco Paris

22. Mankiw N.G(2003), Macroeconomics, 5th Edition, newyork,USA

23. Mills, a et-al. (1990). Health System Decentralization: Concepts, Issues and Country Experience. Geneva, World Health Organization.

24.Mills, A et-al. ( 1990). Health System Decentralization: Concepts, Issues and Country Experience. Geneva, World Health Organization

25.Mills, Anne. 1994. Decentralization and Accountability in the Health Sector from an International Perspective: What Are the Choices? Public Administration and Development 14:281–92.

26. Maskin E and Sjostrom T(2008), Implementation theory, Princeton

27.Ministry of Health, Health Sector Research Policy ,February 2012,p10

28.Ministry of Health Rwanda Community Based Health Insurance Policy (April 2010). Kigali:
29.Ministry of Health, Republic of Rwanda,2010.

30. MOH,Overview of the Health System in Rwanda,2013

31. MOH,the health sector policy,2014.

32. MOH,The Distict Health System re-organization guideline from a managerial perspective,2011
33. MINALOC, Decentralization implementation plan 2011-2015,Kigali,2011
34. MINECOFIN,Rwanda vision 2020 revised,Kigali,2012
35. NISSR,Eicv3 District Profile,East-Kirehe ,2012

36. Rizal P. Durba (2001). Bhutan: Decentralization and good governance, Adriot Publishers. Delhi.
36. Robert K. Federal ,Decentralization and development: the Indian balancing act June 2008.

37. Robalino, David; Picazo, Oscar; Voetberg Albertus( 2001). Does fiscal decentralization improve health outcomes: evidence from a cross country analysis‖. The World Bank
GUILKEY AND RECELIS, 2002

38. Sen., A. (1983 :). Development: Which Way Now? Economic Journal, Vol. 93 Issue 372.

39.Shandana M.K (2005). Representative decentralization vs Participatory Decentralization: Critical Analysis of local government plan 2000. L.C.Jain, New Delhi

40.Siddiqui, Kamal (2005). Major Governance Issues for poverty reduction in South Asia. L.C.Jain. New Delhi.

41.Shandana K.M (2005). Representative decentralization vs Participatory Decentralization: Critical Analysis of local government plan 2000. L.C.Jain, New Delhi, pp.278-280

42.Scher D(2012). The promise of imihigo:Decentralized service delivery in Rwanda, 2006-2010, Trustees of Princeton University, New Jersey

43. UNDP (1999). Decentralization: A sampling of definitions.

44.WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, 19-22 June 1946, and entered into force on 7 April 1948,Geneva.

45.WHO(2016),Health services, Geneva.

46.World Bank, Better Health in Africa(1993), Green report, Washington.

**2**. **Thesis**

1.Chodden(2009),an evaluation of decentralization system in Bhutan ,thesis submitted to kdi school of public policy and management in partial fulfillment of the requirements for the degree of master of business administration .

2. Mugume P.( 2015), Environmental Conflicts Management in Rwanda. The Role of Decentralization,Phd thesis Gothenburg University

3.Musonerwa M.R(2010), Can Decentralization Contribute to Poverty Reduction? Some Insights from Rwanda, Master's thesis, University of Cape town

4. Mutagoma P(2006), Decentralization for community development – a Rwanda Case study, Thesis in University of Stellenbosch

5.Singawinata I. (2008), Decentralization and development: the Indian balancing act, Master's thesis,Naval post graduate school,California.

**3.Electronic source**

1. http://www1.worldbank.org/publicsector/decentralization
2. http://unpan1.un.org/intradoc/groups/public/documents/UN/UNPAN028411.
3. wikipedia.org/wiki/poverty.
4. http://www.ciesin.org/decentralization/English/Issues/CSR.html

5. http://www.macmillandictionary.com/dictionary/british,/challenges

6. http://dictionary.cambridge.org/dictionary/english/challenge,Cambridge dictionaries on line

7. https://en.wikipedia.org/wiki/strategy

8. http://www.merriam-webster.com/dictionary/strategy 12 /12/2015)

9. Prud'homme R. (1995): The Dangers of Decentralization. Oxford University Press. Vol. 10, No. 2, 201-220, Retrieved 07/08/2015 http://wbro.oxfordjournals.org/cgi/content/abstract/10/O8/2015

10. Worldbank,Administrative decentralization,2001, http://www1.worldbank.org/publicsector/decentralization/admin.htm 22th/03/2016)

11. http://www.businessdictionary.com/definition/strategy.html 17/04/2016)

12.

**10.**Gasana C(2002), The Decentralisation process in Rwanda "Ensuring Improved Accountability on all levels, info.world bank.org

**4.Journals**

1. Akpan H.E (2007), decentralization and service delivery: a Framework, Nairobi.

2.Arthin and Carrin G (2003) Community-Based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives,Geneve,2003

3. Australia privacy law and practice, The Privacy Act and Health Information,ALRC 108,Cannberra,2014.

11. Corchon L.C and Sjostrom T(1997), The Theory of Implementation When the Planner Is a Player, Journal of Economic Theory,Oxford no ET972318

8. CORCHÓN L.C, The theory of implementation: what did we learn? Working Paper 08-12 Departamento de Economía ,Universidad Carlos III de Madrid,126

13. Dolfman (1973),The concept of health: an historic and analytic examination. Journal of School Health 1973; 43:491-7

14. Fadime Cinar, Decentralization in health services and its impacts: SWOT Analysis of Current Applications in Turkey,Istambul,2013

15. 10.Hutchinson, P. et al( 1999),Health care in Uganda. World Bank Discussion Paper, No. 404. The World Bank Washington, DC

4. Lutoti S, Oria H, Anguma B. and Kitutu F ,Institutional challenges to decentralization of health services in Uganda - a traditional review,review paper,2015

5. Murindwa G, Kirunga Tashobya C, Kyabaggu J, Rutebemberwa E and Nabyonga ,Meeting the challenges of decentralised health service delivery in uganda as a component of broader health sector reforms, Health Systems Reforms in Uganda:Processes and Outputs,2006

6.Maschietto H R(2016), Decentralisation and local governance in Mozambique: the challenges of promoting bottomup dynamics from the top down.

8. NANNYONJO J. and OKOT N., Decentralization, Local Government Capacity and Efficiency of Health Service Delivery in Uganda,Kampala,2013

**10.Niamh G** (2013), Decentralisation, Conflict and Peacebuilding in Rwanda,DCU,Dublin

9.Taylor C(2014), Explaining the design of the Rwandan decentralization: elite vulnerability and the territorial repartition of power, Journal of Eastern African Studies ***Volume 8***, ***Issue 2***.

# APPENDICES

**INTERVIEW GUIDE FOR INFORMATION (JANUARY 2016)**

**TOPIC: THE DECENTRALIZATION OF HEALTH SERVICES IN RWANDA: CHALLENGES AND STRATEGIES.KIREHE DISTRICT CASE STUDY.**

**UNIVERSTY OF RWANDA**
**COLLEGE OF ARTS AND SOCIAL SCIENCIES.**
**MASTERS IN DEVELOPMENT STUDIES.**

## Community members

### Community participation

1. In your opinion, what is community participation in health services?
2. What features or elements do you consider necessary as part of community participation?
3. Who identifies your health needs?
4. Who initiate the participation process?
5. What type of health groups exist in the community?
6. Do these groups play active role in health decisions concerning the community?
7. What types of resources are being provided by the community towards meeting health goals?
8. Who decides the types of resources to be provided by the community?
9. What role does the local community play in managing the health service delivery?
10. Who decides on how resources should be put to use?

**Access**

1. How many kilometers do you cover before you reach the health center?
2. What will make you patronize the health center?
3. Before decentralization (2000), describe the nature of health service provision?
4. Between decentralization and before decentralization, which one of these periods do you think health services was satisfactory?
5. In your view, what ways would you want the community to participate in health matters?
6. What other things are not mention and are worth noting as far as health service delivery is concerned?

**District Health Director**

1. In your opinion, what is decentralization about?
2. What features make the health sector decentralized?
3. What are the reasons for the setting up of the district health directorate
4. In what ways does the health unit monitor and supervise the activities of the various health centers?
5. What is the composition of the District Health Management Team?
6. What has changed in the delivery system under decentralization?
7. What are the challenges of health service delivery under the decentralized system?

**Community participation**

1. Who initiates community participation?
2. What are the ways by which community needs are assessed?
3. Who identify these needs
4. What category of health groups exist in the community?
5. What are the importance of getting these people involved in health matters?
6. What direct health services are being provided by the community to augment services provided by the modern health facilities?
7. What are the ways by which community members participate in the management of health services within the community?
8. Who are the various health facilities accountable to?
9. What platform is created to allow community members express their level of satisfaction or dissatisfaction of health services?

**The District budget budget officer**

1. What are the sources of revenue to the health unit?
2. What is required of the various health centers before money is disbursed to these areas?
3. What criteria is used to allocate funds to the various health center?

4?

5. Who approves of the budget of the unit?

**Head of District Hospital**

1. What position does the district assembly occupy in health decision making?
2. What contributes in terms of resources does the district assembly give to the health unit?
3. In what ways is the assembly involved in the health issues of the district?
4. What are the various areas of which the assembly coordinates with the health unit?
5. In what ways does the district assembly monitor the activities of the district health unit?
6. What role does the district play to improving access to health service?
7. As the political head of the district, what is done by the district assembly to ensure that local people participate in health decisions?
8. Is the district health unit adequate enough to handle health issues of the district?
9. What functions would you recommend the health unit to have?

10. Would you recommend that health service provision be a complete responsibility of the Kirehe District Assemby

**Head of health centers compound**

1. Is your number adequate enough to meet the community health needs?
2. Where do you make referral cases to?
3. Who supervises your activities?
4. What type of records do you keep regarding the functioning of the health centers?
5. How do you handle emergency cases?
6. What are the ways by which community members are involved in providing

**In charge of health insurance**

1. Who gives the mandate for the operation of the District Mutual Health Insurance Scheme?
2. What is done to ensure that there is adequacy of personnel?

**In charge of health and teachers salary**

1. Who are involved in the drawing of budget for the district health unit

**Administrator of hospital**

1. what % of the local health spending is borne by the central government.
2. Are the health services well equipped to be able to provide good health care?