

CATALYTIC GRANTS FOR EXPANDING FISCAL AUTONOMY AND DRIVING HEALTH CARE PERFORMANCE

Lessons Learned from the Primary Health Care Performance Management Activity

Catalytic Grants: At a Glance

This brief summarizes end-of-project learning from the catalytic grant component of the Primary Health Care Performance Management (PHC-PM) Activity in Ghana and Rwanda, drawing on qualitative evidence from district stakeholders to examine how flexible financing shapes local decision-making and performance. Catalytic grants are time-bound funds provided to District Health Management Teams (DHMTs) to implement action plans and strengthen PHC performance. In both countries, they complemented the PHC Leadership Development Program (PHC-LDP) by helping DHMTs translate plans into action in contexts of uncertain or centralized funding. Beyond financing action plans, these modest, flexible grants temporarily expand fiscal autonomy and decision space within otherwise constrained public health systems. By giving local teams autonomy over approved activities, they enable timely, data-driven responses to identified bottlenecks.



Data sources: Key informant interviews (KIs) and focus group discussions (FGDs) were conducted with DHMTs, facility leads, and health workers as well as users of health services funded by catalytic grants.

Key Questions	Key Lessons	Recommendations
How did catalytic grants influence DHMT decision-making and governance?	<ul style="list-style-type: none"> Grants expanded DHMT decision space by providing predictable, flexible resources tied to action plans. DHMTs shifted from aspirational planning to implementable governance, with stronger prioritization, follow-through, and results orientation. 	<ul style="list-style-type: none"> Maintain predictable and flexible funding aligned with district priorities. Strengthen linkages among action plans, budgets, and measurable results.
How were catalytic grants prioritized and used alongside existing funding?	<ul style="list-style-type: none"> Grants were used to address operational and service delivery bottlenecks that routine funding could not cover (e.g., equipment, outreach, supervision). Catalytic funding complemented - not replaced - routine financing and helped identify priority activities for sustained investment. Catalytic grants helped advance desired measurable results (DMRs) focused on priority PHC outcomes, including anemia management, dental and eye care, antenatal care, and skilled delivery. 	<ul style="list-style-type: none"> Align catalytic grants with existing financial systems and budget cycles to improve coordination and reduce friction. Strengthen prioritization of high-impact, measurable activities aligned with DMRs. Provide early clarity on funding rules, disbursement timelines, and reporting requirements.
How did catalytic grants affect resource mobilization, planning, and accountability?	<ul style="list-style-type: none"> Grants strengthened planning discipline, documentation, and accountability by linking expenditures to results. Districts adopted more intentional, data-driven prioritization and improved monitoring and follow-through. Catalytic grants revealed opportunities to strengthen integration with routine funding sources (e.g., internally generated funds [IGF]), particularly for sustaining priority activities. 	<ul style="list-style-type: none"> Embed value for money and transition planning in action plans from the outset. Strengthen integration of catalytic and routine funding sources (e.g., IGF) to support sustainability. Use catalytic funding to reinforce core DHMT functions (planning, supervision, data use).
What unintended effects and sustainability pathways emerged?	<ul style="list-style-type: none"> Catalytic grants revealed underlying structural constraints, including staffing gaps, procurement bottlenecks, and reliance on operational inputs (e.g., fuel, per diems). Some activities (e.g., equipment maintenance, outreach, supervision) may be absorbable into routine budgets, while others pose sustainability risks. 	<ul style="list-style-type: none"> Prioritize investments that can transition into routine financing. Plan early for integration into government budgets and IGF streams. Consider partial decentralization of funding to health facilities to improve responsiveness.

INTRODUCTION

Through the Gates-funded PHC-PM Activity, DHMTs in Ghana and Rwanda sought to improve PHC performance while confronting longstanding structural constraints, including limited fiscal autonomy, restricted decision space, and insufficient district financing. Although DHMTs could diagnose performance gaps and identify solutions, they often lacked discretionary authority and assured resources to implement them. Through the PHC-LDP, DHMTs in Akwapim South and North Tongu (Ghana) and Bugesera and Gicumbi (Rwanda) reviewed their data, conducted root cause analyses, set priorities, and designed interventions through structured improvement cycles lasting approximately six months each.

Across both Rwanda and Ghana, baseline findings suggest that the primary constraint at the district level was not the ability to diagnose problems or to design improvement plans. It was the lack of discretionary authority to finance and implement them.

In this context, catalytic grants functioned as temporary expansions of functional decision space. Though modest in size, the grants altered the conditions under which DHMTs made decisions. By introducing predictable, flexible resources tied to action plans, DHMTs shifted from aspirational planning toward implementable governance. The result was not only improved service delivery, but measurable changes in prioritization, accountability, and follow-through – core behaviors underpinning effective performance management.

What are catalytic grants?

Catalytic grants were deployed to finance action plans developed through these performance improvement cycles, providing districts with discretionary funding aligned with locally identified priorities that routine government or donor financing mechanisms could not reliably support. Each district received a base amount of \$10,000 per cycle, with additional funding based on population size.¹ Funds flowed through existing government financial systems and were governed by clear

parameters: expenditures had to align with action plans, and subsequent disbursements depended on documented progress rather than performance targets achieved. The amounts were intentionally sized to address operational bottlenecks while remaining at a level that governments could realistically sustain in the future.

This expansion of fiscal autonomy was designed to respond directly to structural constraints in financial decision space within each country. In Rwanda, strong central oversight and compliance requirements linked to Imihigo targets (national guidelines for improving health outcomes) shaped district-level prioritization and resource allocation. In Ghana, inconsistent central funding for annual health plans left DHMTs reliant on IGF and donor financing, both of which were unpredictable.

Given the flexible and supplementary nature of the grants, it was critical to examine not only *how* the grants were used, but *why* certain activities were prioritized over others, particularly when DHMT action plans were financed through a mix of catalytic and routine funding sources. Endline qualitative research, including KIIs and FGDs, explored how catalytic funds addressed identified PHC gaps, influenced planning and resource mobilization practices, and generated unintended effects such as dependency risks or displacement of existing funds. The research also assessed which activities could realistically be absorbed into routine district budgets and whether catalytic financing functioned as essential gap-filling or merely supplementary support, providing insight into the strategic value of catalytic grants in strengthening district-level governance and future implementation.

¹ In practice, smaller districts like North Tongu, Ghana (about 115,000 people) received roughly \$30,000 per cycle, while

larger districts such as Gicumbi in Rwanda (serving more than 450,000 people) received closer to \$40,000 per cycle.

ASSESSMENT OVERVIEW

Data collection and analysis was led by Three Stones International in Rwanda and Ubora Institute in Ghana with support from Management Sciences for Health (MSH). In Rwanda, KIIs were conducted with stakeholders to capture an accurate understanding of the decision-making behind the use of the grants. Details are presented in Table I. In Ghana, FGDs were conducted separately for two categories of stakeholders to elicit divergent views regarding use of catalytic grants. Emerging themes were identified using thematic coding analysis and validated by the group at the end of the sessions to ensure clarity and accuracy.

Table I. Summary of KIIs and FGDs by Stakeholder Level and Selection Approach

Stakeholder Level	Data Collection Method and Participants	Selection Procedures
Rwanda²		
DHMT Members	<p>Bugesera (KIIs, N=7): Director of finance, Director of health, DHMT focal person, Director of nursing, CHW supervisor, CHW representative</p> <p>Gicumbi (KIIs, N=4): Director of finance, health center representative, DHMT focal person, CHW representative</p>	Selection focused on formal DHMT members actively involved in PHC-PM activities including workshops, meetings, trainings, and implementation. In Gicumbi, some respondents could not be reached due to limited availability.
Health Center Staff	<p>Bugesera (KIIs; N=3): 3 Heads of Health Center</p> <p>Gicumbi (KIIs; N=2): 2 Heads of Health Center</p>	Health centers were selected in collaboration with the district focal person, prioritizing facilities with staff who worked closely with the DHMT, participated in project implementation activities, and had received training. Purposive sampling was used to select participants directly involved in PHC-PM implementation with sufficient experience.
Ghana³		
DHMTs	<p>North Tongu (FGDs; N=8): District director, accountant, health information officers, disease control officers, public health nurses</p> <p>Akwapim South (FGDs; N=9): District director, accountant, health information officers, disease control officers, public health nurses</p>	Selection of at least 5 DHMT members prioritized those who actively participated in the PHC-PM Activity carrying out leadership roles. This includes the District Director of Health Services (leading the PHC vision), accountants involved in receiving and allocation of resources, and those monitoring and supervising.
Participants	North Tongu (FGDs; N=5), Akwapim South (FGDs; N=5): 2 CHMC members, 1 chief, 1 assemblyman, 1 volunteer per district	Opinion leaders were selected based on their participation in community-level project activities, such as community mobilization, durbars (traditional assemblies), outreach sessions, and other activities or received services through the Activity.

² Three Stones International undertook an internal validation process: two coders undertook the coding process, meeting on several occasions to discuss and agree on key themes and sub-themes. High level findings were validated internally by project team members and were shared with MSH and Ubora for feedback.

³ Prior to the FGD, DHMT facilitated an interpreter for the opinion leaders' group since most could not express themselves clearly in English. A note taker was selected for both FGDs. A plenary involving all four stakeholder groups (DHMT, facility leads, opinion leaders, and health services users) validated the results to complete the session.

What were district experiences with catalytic grants?

Across all four districts, catalytic grants were perceived not simply as additional funding, but as reliable and discretionary resources that altered the conditions under which DHMTs made decisions.

In contexts where routine government financing was uncertain, delayed, or centrally constrained, the assurance of catalytic funds enabled DHMTs to act on clearly identified PHC gaps rather than produce unfunded plans.

Catalytic grants were viewed as strategic enablers rather than substitutes for routine funding. In Akwapim South, the grants were described as flexible resources that allowed the district to address longstanding operational and system challenges. Unlike IGF, which are often uncertain, delayed, or earmarked for specific activities, catalytic grants represented assurance of funding that enabled DHMTs to adhere to and execute planning processes more effectively. Respondents contrasted this with routine annual plans that are prepared “because it is required” but are rarely fully funded or implemented:

“Honestly, sometimes we just pick the old plan... because even if you plan, you won’t get the money. So why will you waste your time?” (KII, DHMT member, Akwapim South)

Similarly, in North Tongu, catalytic grants were viewed as practical and flexible resources that enabled the DHMT to close critical PHC gaps that routine funding could not address. In the absence of catalytic grants, government funding would have been insufficient to close gaps in equipment, capacity, and outreach.

DHMTs applied catalytic funds across a range of interventions, including procurement and maintenance of equipment, training and supportive supervision, and expanded community engagement.

In North Tongu, access to ultrasounds financed through catalytic grants has brought services closer to pregnant women, enabling providers to identify and manage danger signs earlier in pregnancy, saving time, money, and in some cases, the life of the baby. Previously, some women did not receive ultrasounds at all, or only once during pregnancy, against a recommended standard of three. Accessing scans required long-distance travel and out-of-

pocket payments that represented a substantial share of household income for many families. By reducing both distance and costs, the intervention made scans more affordable and improved adherence to recommended antenatal care schedules.

“Before, we had to go to Juapong (town) from Volo (town) for the scan. The scan alone was about 120 cedis (\$11) and the transport was around 80 cedis (\$7) for in and out [rounded trip], so before you finish it is more than 200 (\$18) cedis just for one scan... Travelling to the other center was far—almost 30 kilometers—and you pay motor twice. With the service here, we don’t need to travel again... Now that the scan is closer to us, we pay about 40 to 50 cedis (~\$4-5) in total. Even if you don’t have all the money at once, you can save small and still do it the next month.” (KII, health services client, North Tongu)

In the absence of catalytic grants, government funding would have been insufficient to close gaps in equipment, capacity, and outreach. Pregnant women would have continued to travel longer distances at higher cost, limiting access to essential services.

In Rwanda, districts utilized the catalytic grants to introduce activities that were instrumental in addressing priorities identified within the PHC-LDP process. One key example was the delivery of dental and eye care services through health center outreach activities, which would not have been feasible without catalytic funding. Stakeholders highlighted the need for catalytic grants to fill gaps in PHC financing where no dedicated budget lines existed.

“There simply wasn’t a dedicated budget line to cover these activities. The availability of catalytic funds allowed us to act quickly, support health centers, and ensure that services reached the community.” (KII, Health center coordinator, Gicumbi)

The DHMT also used catalytic grants to fill critical primary care service delivery gaps that had remained unfunded. Grants were essential in procuring equipment (e.g., Doppler machines), training health center staff, and intensifying and diversifying community outreach activities such as involving local leaders. Respondents in Bugesera reported that catalytic grants had clear, demonstrated effects: “These grants have supported us in addressing key health challenges, and we are very thankful for them. Many health centers benefited from catalytic funds, and

we have observed significant improvements across multiple health indicators in all districts” (KII, Director of Nursing, Bugesera).

How did districts use catalytic grants alongside existing funding?

Grants were used to address operational and service delivery bottlenecks that routine budgets could not absorb — including essential equipment, minor infrastructure improvements, training and supportive supervision, and expanded community outreach.

Respondents consistently reported that, without catalytic financing, critical purchases, supervision activities, and key PHC-LDP interventions would not have been feasible.

In Akwapim South, grants supported capital-intensive expenditures such as tricycles, laptops, desktops, photocopiers, and test kits, as well as infrastructure and logistics improvements that directly affected skilled delivery, National Health Insurance Authority (NHIA) claims processing, and outreach coverage. These investments were complemented by recurrent spending on transport, fuel, and supervision, which enabled outreach and routine monitoring activities. Respondents noted that without catalytic grants there would have been little incentive to rigorously prioritize PHC-LDP action plans; investments such as infrastructure upgrades, tricycles, and improved NHIA claims processing would not have been prioritized. The DHMT also noted that some grant-supported activities were expected to be absorbed into routine operations through increased IGF from improved NHIS claims processing, suggesting that the catalytic grants helped surface activities that districts determined should remain priorities.

In North Tongu, grants supported the procurement of motorbikes, ultrasound scanners, service registers, and emergency packs for midwives, along with training sessions for service providers. Additional investments in hemoglobin testing equipment and outreach logistics (e.g., fuel and transport) supported service delivery in hard-to-reach areas.

In Gicumbi, catalytic grants strengthened both the reach and quality of service delivery through a combination of training, supervision, and targeted outreach. Funds supported training of health workers on antenatal care,

nutrition, and health management information system reporting, alongside ongoing mentorship and supervision



Figure 1. Distribution of cookware for nutrition demonstrations in North Tongu, Ghana. (courtesy of Ubora Institute)

to reinforce skills. The grants also enabled expanded outreach services, including nutrition screening and dental care, as well as more integrated approaches such as joint home visits by CHWs and facility staff to identify and manage malnutrition. At the same time, investments in maintaining diagnostic equipment, including hemoglobin testing devices, helped sustain service quality at health centers.



Figure 2. Receipt of live-saving tools in Akwapim South, Ghana (courtesy of Ubora Institute)

In Bugesera, equipment shortages had impeded service delivery quality: “Previously, certain activities were carried out, such as distributing ambulances and providing some equipment, but there were items we could not afford to purchase. Major activities could not be implemented fully. While supervision and advocacy could take place, procuring essential equipment was not feasible” (Director of Finance, Bugesera). Catalytic grants helped address these gaps through procurement of maternal and neonatal equipment (e.g., oxygen systems, patient monitors, CPAP devices) and support to anemia detection and management, complemented by training and mentorship of health workers.



Figure 3. Distribution of medical equipment in Bugesera, Rwanda (courtesy of Building Systems for Health)

Catalytic grants also strengthened planning discipline and motivation. By providing assured resources tied to action plans, catalytic grants strengthened planning discipline, implementation follow-through, and team motivation.

In Akwapim South, respondents emphasized that catalytic funding shifted how planning and implementation were approached, strengthening adherence to agreed priorities and improving follow-through on action plans.

In Gicumbi, grants enabled more integrated service delivery, including joint home visits by CHWs and facility staff to provide nutrition education and screen children for malnutrition, described as more effective and comprehensive than prior approaches. Respondents also emphasized that the grants improved DHMT motivation, which had been inconsistent.

In Bugesera, respondents highlighted improved coordination and meeting frequency: “There were many sessions beyond the usual quarterly meetings; for example, while we normally met once per quarter, this project allowed us to hold additional sessions to coordinate activities, address emerging challenges, and ensure that implementation was uniform and agreed upon by all team members” (DHMT member, Bugesera). In practice, catalytic grants also supported routine meeting costs (e.g., refreshments, meals, and limited per diems), which helped facilitate more regular participation and engagement of DHMT members. However, despite positive effects such as revenue generation from claims processing improvements, some respondents raised concerns related to the end of catalytic funding, including sustaining refresher trainings (e.g., ultrasound training for midwives) amid high staff turnover, potential declines in DHMT motivation, reduced frequency and effectiveness of DHMT meetings, and challenges motivating technical staff to attend meetings given limited transport budgets.

Did the use of catalytic grants influence how stakeholders approached resource mobilization?

Catalytic grants strengthened district budgeting and resource mobilization by reducing uncertainty, improving documentation and accountability, and motivating teams to plan more intentionally around clearly defined gaps. With assured funding, DHMTs prioritized high-impact activities and shifted to more results-oriented planning.

In North Tongu, linking expenditures to DMRs led to planning and budgeting to become more intentional and results-oriented. Grant flexibility expanded the scope of budgeting and enabled the DHMT to consider interventions that had been viewed as unaffordable. The grants supported more equitable resource allocation, particularly to facilities generating little or no revenue.

In Gicumbi, respondents described more deliberate prioritization of cost-effective activities:

“As the coordinator of heads of health centers, I was very involved in the meetings where we decided how to use catalytic funds. We would sit together, look at the data from the district, and discuss where the gaps were... So, we had to prioritize activities that would have the biggest impact and that could be measured” (Health center coordinator, Gicumbi).

Were there any unintended consequences of using catalytic grants?

Across countries and districts, catalytic grants strengthened accountability and monitoring and revealed priorities and sustainability pathways.

In Akwapim South, accountability requirements strengthened expenditure tracking and monitoring quality. Assured funding reduced uncertainty in planning and budgeting, enabling more realistic implementation. In Gicumbi, stronger monitoring and evaluation practices emerged alongside funding decisions: *“Tracking these results was very important, and that’s one of the biggest lessons we learned”* (Head of health center, Gicumbi). In Bugesera, catalytic grants supported more systematic follow-up through supervision visits: *“During these sessions, we identified activities needed to improve specific indicators or to procure essential equipment. We also followed up on these activities as, without follow-up, some items might not be delivered, even if they were included in the budget”* (DHMT member, Bugesera).

Across districts, catalytic grants surfaced activities that DHMTs considered essential but previously unaffordable. Several grant-supported activities — including equipment maintenance, outreach costs, supervision fuel, and community engagement — were identified as potentially absorbable into routine budgets over time. In Akwapim South and North Tongu, some activities were expected to be sustained through improved IGF generated by strengthened claims processing and service delivery investments.

While not explicitly raised by respondents, several unintended consequences appear to have arisen from the catalytic grant mechanism, reflected in how district teams described changes in planning, implementation, and coordination. On the positive side, catalytic grants appear to have strengthened planning discipline, follow-through, and prioritization by linking expenditures to DMRs and enabling more structured, results-oriented planning. At the same time, the Activity introduced potential sustainability challenges, as many activities (e.g., trainings, increased supervision, and higher participation at DHMT meetings) relied on operational inputs like transport, fuel, and per diems that are not consistently covered by routine budgets. In addition, catalytic grants

helped surface activities that districts came to view as essential but had been unaffordable, highlighting gaps between district priorities and available routine financing.

Together, these findings suggest that catalytic grants did more than fill financing gaps. They reshaped how districts prioritized, allocated, and monitored resources, reinforcing core governance behaviors underpinning PHC performance management.

RECOMMENDATIONS

Financing Pathways and Sustainability

Together, findings from both Ghana and Rwanda reflect the utility of catalytic grants in closing critical PHC gaps at the district level while also improving resource allocation and prioritization practices.

In Rwanda, both districts recommended several improvements to strengthen the effectiveness and sustainability of catalytic grants. First, Bugesera and Gicumbi emphasized that, if future catalytic grant funding were available, disbursements should be aligned with existing government financial management systems and hospital budget cycles to ensure smoother integration, reduce administrative friction, and better coordinate district and facility budgets.

They also underscored the importance of embedding sustainability and value-for-money considerations into the action-planning cycle from the outset, requiring teams to assess long-term feasibility—not just immediate needs—when selecting activities. This includes understanding available budgets prior to planning, ensuring that catalytic grants supplement rather than substitute existing resources, and allowing for better prioritization of activities that can be sustained over time.

Another recommendation was to decentralize a portion of funds directly to health centers, increasing autonomy and responsiveness to local priorities. Finally, districts encouraged partners to identify pathways for gradually integrating key activities into routine health budgets. Respondents expressed confidence that equipment maintenance, staff training, and routine supervision could transition to government funding streams over time, if sufficient resources were available.

Operational and Implementation Design

In addition to financing pathways, respondents highlighted several operational design considerations to improve the effectiveness of catalytic grants.

In Ghana, respondents recommended prioritizing investments with longer-term benefits—such as equipment and laptops—over short-term, one-off activities. They also emphasized the importance of providing clear guidance on permissible expenditures early in implementation, building on the initial orientation, to support more efficient and consistent use of funds.

Districts further suggested including an advance disbursement of approximately 20 percent at the start of each performance improvement cycle to enable timely implementation of planned activities. Finally, they noted that reporting templates should be shared early to streamline documentation requirements and support smoother execution.

CONCLUSION

Ultimately, catalytic grants enabled DHMTs to carry out essential management functions that had previously been constrained by limited discretionary funding, including supportive supervision, follow-up visits, and regular data review meetings without delays related to fuel, transport, or approvals. These routines, which are central to effective performance management, became more consistent and structured across districts.

These experiences suggest that modest, flexible financing can address both immediate service delivery constraints while also strengthening governance practices over time. The central lesson is not simply that catalytic grants can fund activities, but that aligning authority, accountability, data, and resources at the district level improves how performance management functions in practice.

When intentionally designed as time-bound expansions of fiscal autonomy, catalytic grants can activate governance capacity that already exists but is constrained by financing structures, offering a replicable model for district-level performance management reform.



ABOUT THE ACTIVITY

PHC is the foundation of resilient and equitable health systems. Strong local leadership is essential to ensuring accessible, high-quality care that responds to community needs. In Ghana and Rwanda, national and district health authorities are strengthening health system performance through the PHC-PM Activity, an initiative led by government partners and implemented with local institutions, with support from the Gates Foundation and technical partners including MSH. At the heart of the model are four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement:

1. Leadership development
2. Operational data & integrated dashboards
3. Ongoing monitoring, evaluation, and learning
4. Catalytic grant funding

Through adaptive performance management cycles, district health authorities continuously analyze, monitor, learn, and adapt—maturing over time into effective stewards of district health systems. The PHC-PM Activity is a collaboration between MSH, Uhora Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.

This brief is based on research and project implementation experience across four districts in Ghana and Rwanda, funded by (or in part by) Gates Foundation. The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of Gates Foundation. They are intended to inform learning and are not designed for generalization or extrapolation beyond the project context.