REPUBLIC OF RWANDA

MINISTRY OF HEALTH
P.O.BOX 86 KIGALI

BTC RWANDA

ANNUAL REPORT 2010

INSTITUTIONAL SUPPORT TO THE MINISTRY OF HEALTH – PHASE IV
RWA 08 066 11

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1 Project form

Sector	Health – Health policy and administrative management (code CAD 12110)
Navision code BTC	RWA/08 066 11
DGD intervention number	3006009
Partner Institution	Ministry of Health
Duration of the specific convention	60 months (1st phase 48 months)
Date of onset (specific convention)	02/08/2010
Local Contribution	Availability of offices and staff required for the implementation of the project activities
Belgian Contribution	12.000.000 EUR
Management modalities (Cogestion / régie / mixte)	Mixed
Global Objective	Rwanda has put in place a health system capable to respond in an appropriate way the needs of his population
Specific Objectives	**Specific Objective 1.** the local health system is strengthened through a better functionality of his institutions and their overall interactions. **Specific Objective 2.** the central level assures quality of the health sector through better planning, coordination, management and monitoring and evaluation, based on evidences generated by research.
Expected results	**Specific Objective 1** 1. The integrated district management teams are strengthened 2. Competent and motivated human resources are available at local level 3. Equitable access to quality health services is guaranteed 4. Resources management is improved through progressive rationalisation of the internal functioning 5. Quality of care is continuously improved 6. Knowledge is systematically managed and developed **Specific Objective 2** 7. Health sector plans are developed 8. Coordination and management are global and integrated 9. Human resources are developed according to the elaborated plans 10. Financial management is assured in an efficient way according to national and international standards 11. A performant system of integrated m&e is put in place 12. Quality norms and standards are developed an implemented 13. Action research is performed and the evidences generated at local level do feed the development of policies.

2 Summary

2.1 Analysis of the intervention

The activities only covered the inception phase and set up of the project.

Activities that took place mainly concerned the introduction of the project to the partner at central and district levels as well as the stakeholders. They also included sets of meetings at both levels and visits to the districts to appreciate the current situation of the health system and identify key priorities for the project.

In the mean time, the partner assigned the Administrative and Financial Director of the Ministry to be the Director of Intervention and the coordinator of the Decentralisation Unit to be the Technical Coordinator to assist the project.

While the steering committee took place in December, two activities were funded upon the request of the partner and following the Belgian commitment made by the embassy.

TOTAL BUDGET	Planned Budget	Total year expenditure (31/12/2010)	Balance of the budget	Implementation rate
12 000 000	**714 910**	**730 243**	**11 269 757**	**102%**

2.2 Key points

The report covers the inception phase of the project. It was necessary to appreciate the evolution of the context during the one year gap between the closure of the previous project “Minisanté phase III” and the onset of “Minisanté Phase IV”: restructuration of the district health management, constitution of Technical Working Groups at central level, further implementation of the decentralization, etc. Therefore the technical and financial files were disseminated across central units and the three districts for updating and ensuring ownership.

Achievements include development and approval of district plans in the three districts and central unit plans by the steering committee. Funding for the Capacity Development Pooled Fund was provided to assist the Ministry in implementing the human resources strategic plan more efficiently. Funding for Performance Based Financing was also secured to assist the staff at central level to cover the gap until the onset of The Global Fund support. Staff was recruited and will be appointed early 2011 to assist the project in effective implementation: an accounting manager, an administrative assistant and three

drivers. The project also expects the arrival of a third technical assistant who will also be the DELCO from 1st January 2011.

One must take note that a project that aims at providing institutional support requires an adequate understanding of the context and the local health priorities. Similarly key stakeholders also require an adequate understanding of what an institutional support means at an operational level. Therefore, the steering committee acknowledged that the initial plans included funding for a number of operating costs activities. The committee also recommended that future activities be more in line with effective institutional support at district and central levels.

2.3 Lessons learned and recommendations

During this first stage and contact with the stakeholders at district and central level, the project was faced with requests around funding for operating costs. While funding for operating costs can contribute towards system strengthening, the potential impact is likely to be limited over time. However this approach aims to allow for an entry point in the system at both central and district level.

The issue of office availability within the Ministry will need to be addressed effectively because of the recruitment of project staff and the need to be in close contact with the immediate partner in the Ministry. The current offices won't accommodate all the staff. Options will be explored in the course of January to attend to the need.

Procedures will need to be identified to develop a clear view of the current situation and ensure a joint a vision of what the project aims to achieve. Past experiences with previous projects have showed the risk of the project being used as a resource for last minute or unbudgeted activities on an ongoing basis. The evolution towards "institutional support" projects is not easy to appreciate at operational level and requires change of mindset. The assistance from the "scientific support" will provide relevant support to assist in the mindset change and to identify critical and relevant priorities in a comprehensive and systemic bottom-up approach.

The move from project to programme approach will require that all BTC health sector funded projects get better coordination and efficiency. There will be need for clear understanding of the approach by the different actors with the assistance of the School of Public Health. It will be critical to identify best ways to integrate the Mental Health component (that project ends in July 2011) as an opportunity to move towards the programme approach. This move may require structural arrangements among and across the various existing projects.

3 Evolution of the context

The project specific agreement was signed on 2nd August 2010, therefore time did not allow for much context evolution during the four months of project. However, due to a number of delays prior to the signing of the project, there has been a gap between the closure of the previous phase (Minisanté Phase III) and the onset of the current project. During this gap, the Government of Rwanda further implemented the decentralization process. As a result, some of the issues described in the Technical and Financial File were outdated or needed re-actualization. These included:

- a restructuration of the district health management system with the disappearance of the "Unité Santé promotion de la Famille et Protection des Droits de l'Enfant". There is now an "In-charge of Health" at the district level who fall under the authority of the district (Minaloc) while the hospital still has links with Ministry of Health on technical issues as well as staffing. The hospital still has technical responsibilities over the health centres through regular supervision while the district has more administrative responsibilities. Coordination mechanisms exist and their extent may vary across the districts. As mentioned in the Joint Health Review, there will be more guidance from the central level to assist the districts in efficient management and provision of quality health services.

- Another significant development was the set up of Thematic Working Groups whereby Development Partners and the Ministry of Health work together to support and advise the Rwandan Ministry of Health (MoH) in the implementation of sub-sector strategies and policies. Seven groups and 27 sub-groups were identified. The Belgian Development Agency has been assigned to co-chair the Health System Strengthening working group.

- Similarly, due to the gap between Minisanté phase III and phase IV projects, the Ministry requested funding from The Global Fund to support the unit responsible for the Performance Based Financing that was initially included in the Minisanté IV DTF.

Besides the institutional developments, the onset of the project has allowed for fostering the coordination between the various health projects funded by the Belgian Development Agency. These include Mental Health, Support to the Kigali Health Strategic Plan and the Belgian budget support for health sector. This will enable the development of a shift from a "project approach to a programme approach". Opportunities abound to increase synergies between the projects and this was further developed by the partner who appointed a health sector coordinator for all BTC funded health projects. The objective is to facilitate a better coordination and increase synergy, efficiency and visibility of the various projects (Mental Health, Support to Kigali Strategic Health Plan, budget support, Minisanté Phase IV).

4 Analysis of the intervention

4.1 Institutional anchoring and implementation modalities

While efforts have taken place to ensure adequate anchoring in the Ministry of Health, it is currently premature to provide a definite appreciation of institutional anchoring. Therefore at this early stage we would score the anchorage as “appropriate” but should aim at improving the score to “very appropriate” during the coming year.

The essence of the project being institutional strengthening, anchoring has taken place at two levels: central level and districts level.

The designation of the Administrative and Financial Director of the Ministry of Health as Director of Intervention of the project has provided a key anchorage at the Ministry in a critical position. Similarly, in order to facilitate anchorage on a technical basis, the Permanent Secretary of the Ministry of Health assigned the Decentralization Unit coordinator to provide technical guidance to the project. While the project is at his early stage, it will be critical to ensure adequate anchoring in the early months of 2011 to maintain ownership of the project by the partner.

In the mean time, the Ministry of Health has provided temporary offices for the project at central level. These were given as temporary because of lack of office space at the central office. Contingency plans may be required if the temporary situation extends over time because these offices are fairly distant from the central office. There will also become too small when the additional personnel join the project in 2011.

At district level, a number of planning activities has taken place in 2010. Visits and meetings took place to ensure acknowledgement and recognition of the project as a resource for the district health plan. It is however premature to assess the anchoring at that level. It is expected that the first 6 months of 2011 will see the start of the implementation of activities and will enable the development of progressive anchoring at district level. This will involve the district office as well as the hospital.

Implementation activities are “co-management” for 80% of the budget. The first steering committee took place in December 2011 in a positive and effective manner. All central and district representatives were present. Implementation of activities will demonstrate how this will translate into practice.

The recruitment of staff (an accounting manager, an administrative assistant and three drivers) is taking place and the personnel is expected to start early 2011. A third technical assistant will join from 1st January and will take the responsibility of DELCO. The Financial and Administrative sector official is assisting part-time (shared with Kigali city project) and two international technical assistants are involved at central and district levels. Three districts are included in the project: Gakenke, Rulindo and Bugesera. Two districts have one district hospital each while Gakenke has two district hospitals.

4.2 Specific objective

4.2.1 Analysis of the intervention so far

Specific Objective 1

The local health system is strengthened through a better functionality of his institutions and their overall interactions.

Specific Objective 2

The central level assures quality of the health sector through better planning, coordination, management and monitoring and evaluation, based on evidences generated by research.

It is premature at the stage of the inception phase to analyse the progress against the specific objective. This section will therefore be described in the next year report.

4.3 Results

4.3.1 Description of the progress made

Only activities related to the inception phase took place in 2010. The start of the activities related to the results will be in January 2011. However a few observations can be provided from the activities during the inception phase.

Results 1-6

No specific activity took place (as per DTF) under specific objective 1 except for the numerous visits and planning meetings with the three districts and four hospitals. Workshops were held with all the relevant health actors in each district to review their priorities, assess their unmet needs and elaborate action plans for the steering committee to approve. Plans were discussed with the hospital and district staff and with representatives of the health centres. They were thereafter discussed at central level with the decentralization unit and feedback was provided to the districts for eventual adjustment prior to presentation to the steering committee. Upon approval by the steering committee (23 December 2011), implementation agreements will be signed between the hospitals of each districts and the project will facilitate the implementation of the activities with the support of technical assistance. Districts requested that the agreement be signed with the hospital because the time for budget revision had passed and it was too late to incorporate the activities for the current financial year (2010-2011). It is expected that future agreement will include the district management as well as the hospital.

Results 7-13

For the specific objective 2 as for the objective 1, the partner requested the project to meet with the various units to “update” the Technical and Financial Files because of the delay between the formulation and the onset of the project. Therefore activities mainly included planning meetings with individual units, consensus meetings with the all the relevant Ministry units, attendance to the Joint Health Sector Review and participation in the newly formed Technical Working Groups.

In 2007 a Memorandum of Understanding for a Sector Wide Approach (SWAp) was signed between the Ministry of Health (MOH) and Development Partners (DP) in the Rwandan Health Sector. The SWAp is defined as an approach to support the health sector’s development that is based on Rwanda’s long-term vision for socio-economic development. It is used to improve the efficiency and effectiveness with which resources are used in the Rwandan health sector. According to the Economic Development and Poverty Reduction Strategy (EDPRS), Clusters and Sector Working Groups are designed to facilitate in-depth dialogue between the Government and its Development Partners (DP) at the sector and subsector level, with a view to ensuring joint planning, coordination of aid, and joint monitoring and evaluation. The creation of the Health Sector Cluster Group (HSCG) brought together the MoH and DP including civil society to support the implementation of the Rwandan Health Sector Strategy (HSSP II). Several Technical Working Groups (TWG), operating under the authority of the HSCG, have subsequently been established to prepare policy discussions needing more technical analysis in specified sub-sectors. While Belgium, through the

Health Attaché is the co-chair of the overall Health Sector Cluster Group, BTC is the co-chair of the "Health System Strengthening Group" that oversees 7 subgroups namely: commodities, quality of service delivery, geographical access/health maintenance, Governance/decentralisation, Planning and M&E, health financing, human resources and specialized services.

In the mean time, the partner made a special request for funding the human resources strategic plan through its "Capacity Development Pooled Fund (CDPF)". The Ministry of Health had set up, with three Development Partners (German, Swiss and Belgian cooperation with addition of UK), a pool fund to ease the access to funding for human resource capacity development. This pool aims at ensuring effective coordination and at avoiding parallelism and overlapping of various Donors and agencies supporting capacity development initiatives. This pool is funded through budget support mechanisms. Considering that the Belgium Development Cooperation (DGD) had made a commitment to funding the CDPF by 31 December 2010 and that the funding for CDPF was omitted in the Belgian Budget Support programme, an envelope was secured for CDPF in the DTF of Minisanté IV under co-management (B.03.01). An implementation agreement had to be developed and signed to allow the transfer of funds under the scope of co-management. While the CDPF runs under budget support mechanisms and not co-management, the project expects to receive progress reports to assess the performance of that mechanism.

The project was also requested to fund the Performance Based Financing (PBF) for the staff at central level. While this activity was not directly included in the DTF, it was indicated that there was a need to assist in a reflexion on the PBF at central level. There was also a need to engage with the Ministry since previous meetings had agreed that PBF funding would come from budget support and not from projects. Responding to the request was to allow an entry point in the above reflexions. Funding was therefore agreed by the steering committee on a basis of a "once off" payment and as an entry point to engage with the PBF unit to explore the implementation of PBF at central level. More information is expected to be generated in 2011.

Scientific support: The School of Public Health of ULB was selected to provide scientific support to the three health projects (budget support, Kigali city and Minisanté IV) through the School of Public Health (SPH) of Rwanda. Funding of scientific support will come from the "Support to Kigali Strategic Health Plan" project for the first two years and from the Minisanté IV project for the last two years. A first visit from Prof B Dujardin of ULB took place in December to make contacts, explore the current situation of the Belgo-Rwandan health cooperation, provide support to SPH to fulfil its role, assist in the identification of priorities for improving the health system and look at ways to move from a "multi-project approach" to a "programme approach".

It is premature at this stage of inception to assess the relation between the results and the specific objectives as activities will only start in January 2011.

4.3.2 Risks and assumptions

At this stage a number of overall risks considered as “moderate” and based on various assumptions can be identified. These are related to:

- Decentralisation process: 3d phase to start in 2011 whereby decentralization will reach the community level.
- The development of a shared vision on health system strengthening: there is still lack of clarity in regard to the district structure and system since the implementation of decentralisation and the respective roles of Ministry of Health and Minaloc are not clear at operational level. There is need for some guidance to the districts to efficiently operationalize some of the decentralization process of the health sector at district level
- the capacity of the various districts and central units to identify critical activities relevant to the project objectives (institutional support) and to implement them,
- the capacity to document the performance of the activities to inform the relevant levels (operational and strategic)
- the competing demands and priorities faced by district and central units and unrelated to the project
- the attention distracted by other activities or funding from other partners such as The Global Fund
- Delays in creation of the Rwanda Biomedical Centre

Specific risks and assumptions will be reviewed once the activities start in January 2011.

4.3.3 Quality criteria and impact

These are premature at this stage of inception phase

4.3.4 Budget implementation

There has not been any particular budgetary issue during the inception phase except the request for CDPF funding (B.03.01) whereby the full amount (500,000 Euros) was disbursed at once upon request of the Ministry and the Belgian embassy Attaché. It had been planned for a yearly disbursement of 125,000 for 4 years but was transferred in full at once because the agreement around CDPF between the Ministry of Health and the Development Partners will be completed within a year

It is anticipated that the budget of line for operating costs (Z.03) is under budgeted. The issue will be reviewed and discussed with the representation in case a budget revision is needed.

4.3.5 Lessons learned and recommendations

During this first stage and contact with the stakeholders at district and central level, the project was faced with requests around funding for operating costs. While funding for operating costs can contribute towards system strengthening, the potential impact is likely to be limited over time. However this approach has allowed for an entry point in the system at both central and district level at a time where planning exercises had long gone. The project plans to utilize these entry points to identify together with the key actors the strengths and weaknesses of the system and use this information in the next planning cycle for the 2011-12 financial year. It was further agreed by the steering committee that funding for operating costs will be limited to the first 6 months of funding.

The issue of office availability within the Ministry will need to be addressed effectively because of the recruitment of project staff and the need to be in close contact with the immediate partner in the Ministry. The current offices won't accommodate all the staff. Options will be explored in the course of January to attend to the need.

Procedures will need to be identified to develop a clear view of the current situation and ensure a joint a vision of what the project aims to achieve. Past experiences with previous projects have showed the risk of the project being used as a resource for last minute or unbudgeted activities on an ongoing basis. The evolution towards "institutional support" projects is not easy to appreciate at operational level and requires change of mindset. The assistance from the "scientific support" will provide relevant support to assist in the mindset change and to identify critical and relevant priorities in a comprehensive and systemic bottom-up approach.

The move from project to programme approach will require that all BTC health sector funded projects get better coordination and efficiency. There will be need for clear understanding of the approach by the different actors with the assistance of the School of Public Health. It will be critical to identify best ways to integrate the Mental Health component (that project ends in July 2011) as an opportunity to move towards the programme approach. This move may require structural arrangements among and across the various existing projects.

5 Beneficiaries

At this stage of inception phase, only the partner (staff at central and district level) has been involved with the project activities.

Central level and district staff have been involved in the whole planning exercise and decision-making in terms of priority setting of the activities to be funded at central and district levels. Meetings and workshops took place in each of the three districts involving the “In-charge of Health and his team as well as the hospital team and representatives of the health centres. At central level, each unit was requested to identify unfunded priority activities and present them to a group meeting for discussion and priority setting. All activities were then collated into one plan to be discussed with the director of intervention, the technical coordinator and the technical assistants in anticipation of the steering committee meeting.

Districts and units expectations included numerous requests for operating costs rather than for specific activities. There was a rich discussion with the director of intervention and the technical coordinator as well as a comprehensive debate at the steering committee around the value of funding such activities. This brings the issue of efficient management and use of resources that should be taken in a global approach rather than project-related. While the final decision allowed for a large chunk of the funding for operating costs as a once-off agreement during the project life time, the question has been opened in terms of efficiency. It is anticipated that next year planning will be comprehensive and integrated with the district and central planning to maximize efficient and pertinent use of the resources.

6 Follow-up of the decisions taken by the JLCB

This will take place in January 2011 and will include administrative issues such as finalization of the recruitment of staff and signing of implementation agreements, managerial issues to assist units in implementing their approved plans and technical matters to strengthen the system.

7 Annexes

Logical framework - no changes at this stage

Annex 1: "Budget versus current (y – m)" Report

Annex 2 : Operational planning Q1-2011