BELGIAN
DEVELOPMENT AGENCY

TECHNICAL NOTE

JOINT HEALTH SECTOR SUPPORT III B

RWANDA

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TABLE OF CONTENTS

LIST OF ACRONYMS 3

BASIC DATA OF THE BELGIAN CONTRIBUTION 6

1 PROGRAMME DESCRIPTION 7

1.1 DESCRIPTION OF THE PROGRAMME 7

1.2 SUMMARY OF MOTIVATION 8

1.3 ASSESSMENT OF PERFORMANCE DURING THE PREVIOUS PHASE 9

2 RISK ASSESSMENT 11

2.1 MACRO-ECONOMIC FRAMEWORK AND PFM 11

2.2 SECTOR POLICY – SECTOR STRATEGY 18

2.3 BUDGET AND EXPENDITURE MANAGEMENT 25

2.4 INSTITUTIONAL SETTING AND CAPACITY 36

2.5 MONITORING AND EVALUATION SYSTEM 43

2.6 POLICY DIALOGUE AND DONOR COORDINATION 52

2.7 SUMMARY OF CRITICAL CHALLENGES AND MITIGATING MEASURES 57

2.8 CONCLUSION 58

3 MODALITY DESIGN 59

3.1 THE SPECIFIC OBJECTIVE AND VARIOUS INPUTS 59

3.2 BELGIAN FOCUS IN POLICY DIALOGUE (‘THE WHAT’) 62

3.3 SET UP OF POLICY DIALOGUE (‘THE HOW’) 64

3.4 DISBURSEMENT CONDITIONALITIES AND FINANCIAL PLANNING 66

4 BIBLIOGRAPHIC REFERENCES 69

5 ANNEXES 71

5.1 ANNEX 1: TOR OF BUDGET SUPPORT EXPERTS 71

5.2 ANNEX 2: SPECIFIC AGREEMENT 77

5.3 ANNEX 3: BUDGET FOR THE CONVENTION DE MISE EN ŒUVRE 81

5.4 ANNEX 4 - DETAILED ACTIVITIES AS PER HEALTH SECTOR 82

5.5 ANNEX 5: RURAL DISTRICT ORGANOGRAM JULY 2010 83

LIST OF ACRONYMS

BCC	Budget Call Circular
Bn	Billion
BSHG	Budget Support Harmonisation Group
CAAC	Cellulle d'Appui à l'Approche Contractuelle/Performance -Based Financing Department (MoH
CBHI	Community-Based Health Insurance
CDPF	Capacity Development Pooled Fund
CHW	Community Health Workers
CPAF	Common Performance Assessment Framework
DFID	Department For International Development
DGD	Directorate-General for Development Cooperation and Humanitarian Aid
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DoL	Division of Labour
DP	Development Partner
DPG	Development Partners' Group
EAC	East African Community
EDPRS	Economic Development and Poverty Reduction Strategy
EICV	Integrated Household Living Conditions Survey (Enquête Intégrale sur les Conditions de Vie des Ménages)
EUR	Euro
FMS	Financial Management System
FRA	Fiduciary Risk Assessment
FY	Fiscal Year
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoR	Government of Rwanda
GRB	Gender Responsive Budgeting
HIS	Health Information System
HMIS	Health Management Information System
HRH	Human Resources for Health
HRTT	Health Resource Tracking Tool

HSS	Health System Strengthening
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
ICP	Indicative Cooperation Programme
IFMIS	Integrated Financial Management Information System
IHP+	International Health Partnership
IMF	International Monetary Fund
INGOs	International Non-Governmental Organisations
IRAI	International Development Assistance Resource Allocation Index
JANS	Joint Assessment of National Strategies
JBSR	Joint Budget Support Review
JHSR	Joint Health Sector Review
JHSS	Joint Health Sector Support
KfW	Kreditanstalt für Wiederaufbau
M&E	Monitoring and Evaluation
MB	Mini Budget
MDGs	Millennium Development Goals
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
MINECOFIN	Ministry of Economy and Finance
Mio	Million
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NB	National Budget
OAG	Office of Auditor General
OECD-DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
PBF	Performance-Based Financing
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Public Health Care

PHC	Public Health Care
PS	Permanent Secretary
PSCBS	Public Sector Capacity Building Secretariat
PSI	Policy Support Instrument
RDSF	Rwanda Decentralization Strategic Framework
RWF	Rwandan Franc
SAI	Supreme Audit Institution
SBS	Sector Budget Support
SPIU	Single Project Implementation Unit
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TN	Technical Note
ToR	Terms of Reference
TWG	Technical Working Group
USA	United States of America
USD	United States Dollars
USG	United States Government
WB	World Bank
WHO	World Health Organisation

BASIC DATA OF THE BELGIAN CONTRIBUTION

Title of the programme	Joint Health Sector Support III
Earmarking (sector/subsector/regio)	Health Sector
Country	Rwanda
Calendar	2014 – 2016
Financial data	Total Belgian contribution
	€ 18,000,000
DAC – Code /Sector	12110 / Health
NI - Code	
NAV - Code	RWA 13 093 11
Date of the approval of Basic Note	ICP 2011-2014, 18/05/2011 Fast-track procedure is being applied.
Date of the approval of Technical note september 2011	The technical note covering the engagement of € 32 mio was approved October 2011, but engagement limited to the first € 5 mio for 2011, because Belgium lacked a proper government. A second instalment of € 9 mio is done for the FY 2013-2014, because budget constrains in the Belgian budget. This note is updated and covers the amount of € 18,000,000, the final amount that remains available for health sector budget support during the current ICP.

Calendar in Belgian FY / Tranching in Euro

Tranching	2014	2015	2016	Total
S1				
S2	9,000,000	9,000,000		18,000,000

Calender in Rwandan FY (july to june) in Euro

Tranching	2014/15	2015/16	Total
S1	9,000,000	9,000,000	18,000,000
S2			

1 PROGRAMME DESCRIPTION

1.1 DESCRIPTION OF THE PROGRAMME

Belgium provides budget support to the health sector in Rwanda since 2008 with a total value of EUR 13,000,000 EUR disbursed by December 2010. Following the signature of the new Indicative Cooperation Program between Belgium and Rwanda (2011 – 2014), with a provision of 32 million EUR for health sector budget support, a formulation mission was carried out in June 2011. This resulted in the signature of a Specific Agreement for a tranche of 5 million EUR, which was disbursed in February 2012. A second Specific Agreement for a tranche of 9 million EUR was signed in June 2013. The disbursement has taken place in October 2013 (FY 2013-2014). 18 million EUR of sector budget support remains to be engaged in support to the current Health Sector Strategic Plan (HSSP III) which was developed through a consultative process early 2012 and validated in July 2012, following an appraisal by an external team of consultants using the Joint Assessment of National Strategies (JANS) methodology. In order to respect the sequencing with the National Development strategy, the HSSP was finally integrated into the validation process of the Economic Development and Poverty Reduction Strategy 2013-2018 (EDPRS II)

The overall objective of the HSSP III is to: *ensure universal accessibility (in geographical and financial terms) of quality health services for all Rwandans. The* HSSP III covers the period July 2012- June 2018. It will guide the future development of the sector and is analysed under Chapter 2.2. of the present Technical Note.

In the Indicative Cooperation Programme 2011-2014 between Rwanda and Belgium, Joint Health Sector Support (through Sector Budget Support) is described (see box below) as part of the first component[1] of support to the Health Sector.

Box 1: Indicative Cooperation Program (ICP) 2011-2014. Health sector objectives and outcomes of the future cooperation

<u>General objective:</u>

The general objective of the health sector is to manage population growth rate and to enhance population development through enhanced family planning, improved health and nutrition status of the population and strengthened health financing and pro-poor approaches.

<u>Strategic (specific) Objectives – Outcomes:</u>

The strategic service delivery and system related specific objectives of the health sector are set out in the Health Sector Strategic Plan HSSP2 2009-2012 (and its successor plan).

Strategic objectives to be achieved in the framework of the ICP in line with the strategic service delivery objectives of the HSSP are:

- Accessibility to, quality of and demand for Maternal Health, Family Planning, Reproductive Health and Nutrition services are improved;
- Services for the prevention of disease and promotion of health are consolidated, expanded and improved;
- Services for the treatment and control of disease are consolidated, expanded and improved.

Outcomes to be achieved in relation to the system-focused specific objectives, especially at rural

[1] The other part consists of a contribution to the Capacity Development Pooled Fund (CDPF)

level are:

- The sector's institutional capacity is strengthened
- The availability and quality of human resources for health is increased
- Financial accessibility to health services for all and sustainable and equitable financing of health sector is improved
- Geographical accessibility to health services for all is ensured
- (Universal) availability and rational use of quality drugs, vaccines and consumables is improved
- The quality of health services, including referral hospitals, is improved
- Specialized services in mental health are strengthened.

1.2 SUMMARY OF MOTIVATION[2]

Belgium was in the position of lead donor in the health sector of Rwanda since 2005 until 2012 and signed the Health SWAp Memorandum of Understanding (MoU) in 2007 together with ten other Development Partners.

Belgium supports the health sector of Rwanda through a very comprehensive approach. In addition to sector budget support, the current programme also entails: (a) support to districts in rural areas, (b) support to health systems in urban areas and (c) institutional support for planning and implementation of the national health policy (d) support to the Capacity Development Pooled Fund (CDPF).

In this context, active participation in the policy and political dialogue has unfolded through the following:

- The Belgian Attaché has been co-chair of the high-level Health Sector Working Group from 2005 – 2012, which is chaired by the Minister of Health[3] ;
- Belgium also participates in the budget support harmonization group and in the Steering Committee meetings of the Capacity Development Pooled Fund and various Technical Working groups within the sector;
- In order to increase harmonization among development partners, in December 2008 Belgium launched the initiative to put in place the 'Development Partners Group in Health' (DPG) which gathers all the actors in the health sector (bilateral and multilateral organizations, INGOs, foundations, universities…).

Following the Division of Labour (DoL) exercise that was carried out by the Government of Rwanda in 2010 with the objective to limit development partners' interventions to a maximum of three sectors each, Belgium and the USA were identified as the two key donors in the health sector. This was confirmed by the new Division of Labour announced with the kick-off of the EDPRS II (September 2013). Other development partners that will continue to actively support the health sector are Switzerland, Luxemburg, USA, ONE UN (UNFPA, UNICEF, WHO).. In this context, Belgium has become the main donor providing sector budget support and is therefore in a position to continue playing a key role in the different dialogue platforms within the Health SWAp. Other

[2] Summary from the Basic Note to complete the TN with political decision taken in the programming and identification phase.

[3] USAID is the co-chair in July 2012, with LuxDev entering as shadow co-chair.

donors providing Budget Support such as DFID and EC (General and Sector Budget Support in other Social Sectors) participate in the Health Sector Working Group. Another potential Budget Support Donor for Health is the Global Fund.

1.3 ASSESSMENT OF PERFORMANCE DURING THE PREVIOUS PHASE

Over the past decade, Rwanda has achieved high growth and macroeconomic stability and made significant progress in many areas, including health.

At the level of the outcome indicators, which inform us on the performance of the sector, there has been an improvement on most items and many targets set for 2012 were achieved in 2010. For a complete overview of the evolution of health indicators since 2005, see chapter 2.5. of the present Technical note.

The table below illustrates recent trends in the specific area of child and maternal health by comparing key results of the three Demographic and Health surveys that were carried out between 2005 and 2010. These achievements are an important sign of Rwanda's commitment to the Millennium Development Goals.

Table 1 Trends in key child and maternal health indicators since 2005

Indicator	DHS 2005	Interim DHS 2007/2008	DHS 2010 *
Percentage of women aged 15-49 using modern contraceptives	10	27	45
Percentage of assisted births in an accredited health facility	30	45	69
Percentage of children aged 12-23 months fully vaccinated	75	80	90
Percentage of children under five years of age sleeping under long-lasting, insecticide treated mosquito nets	13	56	70
Under-five mortality rate (deaths per 1,000 live births)	152	103	76
Percentage of children suffering from chronic malnutrition (low height for age)	51	-	44
Maternal mortality rate (per 100,000 live births)	750	-	487

* Results of February 2012

The Common Performance Assessment Framework (CPAF), which is monitored closely by budget support donors as well as all health development partners active in the SWAp, includes 6 health indicators. For all of these, as well as for the 8 corresponding policy actions, targets were met in the last FY 2011/12[4].

[4] See Joint Health Sector Review summary report, September 2012.

Table 2: CPAF Indicators and Policy actions under scrutiny for SBS

Indicators	Target 2010/11	Actual status 2010/11	Target 2011/12	Actual Status 2011/12	Colour Scoring	Policy Actions	Rating
Percentage of women aged 15-49 using modern contraceptives	38%	45% (DHS 2010)	44%	47.7% (HMIS)		1. Implemented Community Based Distribution (CBD) of modern contraceptives in 10 new Districts.	Fully achieved
% of Children vaccinated against measles to children vaccinated against BCG	85%	95% (DHS 2010)	87%	95% (DHS 2010)		2. Community Integrated Management of Child Illnesses (IMCI) package implemented in 30 Districts.	Fully achieved
Under 5 mortality attributable to confirmed malaria decreased from 13% to <10% by 2012/13	13%	8% (HMIS 2010/11)	11.5%	10% (HMIS 2011/12)		3. Provide one additional bed net to completely vaccinated children and pregnant women	Fully achieved
Percentage of assisted births in an accredited health facility	45%	69% (DHS 2010)	50%	66.6 % (HMIS 2011/12)		4. Evaluate the impact of the incentive package for assisted delivery 5. Train 2 heath facility workers in how to undertake maternal audits in 15 additional Districts	Fully achieved
Utilization Rate of primary health care services (all visits at health centres, private dispensaries and visits by community health workers)	0.85	0.95 HMIS (2010)	0.95	Nb of per capita outpatient visit: Men:1.5 Women:1.8 (DHS 2010)		6. Develop new guidelines on “ticket moderateur” according to the recommendations of the study 7. Conduct a study to assess financial barriers to access to health care at the health center	Fully achieved
Per capita allocation to PBF for health facilities and community health cooperatives.	$2.25	$2.4 (CAAC)	2.65$	2.99 (CAAC 2010)		8. Undertake a first assessment of community PBF	Fully achieved

The last household survey (EICV3) carried out in 2010 reveals that 44.9% of the population is living under the poverty line, which is a promising decrease from the 57 % in 2006. In spite of progress made, important challenges remain due to low government revenues, a narrow export base and severe bottlenecks in infrastructure.

On the short-term, the expectation that funds from development partners may become less significant given the changing aid context and crises affecting the world economy in recent years is a factor of concern that may put Rwanda’s macroeconomic stability at risk.

2 RISK ASSESSMENT

This risk assessment methodology is based on the guidance of the Vademecum for Belgian Budget support and the EuropAid Guidelines on "Support to Sector Programmes", 2007[5].

2.1 MACRO-ECONOMIC FRAMEWORK AND PFM

2.1.1 Macroeconomic framework

2.1.1.1 Update IDA Resource Allocation– Index (IRAI)

At the outset Belgian Government prescribes as a Budget Support directive and as a minimal governance guarantee[6] an IRAI average > 2.5[7] for cluster D "Public Sector Management and Institutions" of the IRAI assessment.

The overall IRAI score of Rwanda reaches 3.8 in 2012 on par with the overall score obtained in 2009, 2010 and 2011. The cluster "Public Sector Management and Institutions" reaches a score of 3.6 in 2011 and 2012 (3.7 in 2010 and a score of 3.5 in 2009). **Rwanda IRAI thus meets the pre-condition stipulated in the directives.**

In relative terms "Public Sector Management and Institutions" is the weakest cluster albeit almost on par with the cluster "Economic Management" IRAI score 3.8 and the cluster "Structural Policies" IRAI score 3.8 but rather lower than the cluster "Policies for Social Inclusion/Equity" IRAI score 4.1.

Within the cluster "Public Sector Management and Institutions the field "Property rights & rule based government" scores significantly better from 3.0 in 2009 to 3.5 in 2010, 2011 and 2012 and the field "Quality of Public administration" decreases from a score of 4.0 in 2009 and 2010 to a score of 3.5 in 2011 and 2012.

Table 2 Summary table 2012 IDA resource Allocation Index "Public Sector Management and Institutions"

IRAI	**Public Sector Management and Institutions**						All
	Property rights & rule based government	Quality of budget & financial management	Efficiency of revenue mobilization	Quality of public administration	Transparency, Accountancy & corruption in the public sector	Avg	
Rwanda	3.5	**4.0**	3.5	3.5	3.5	**3.6**	3.8
Burundi	2.5	3.0	3.5	2.5	2.0	2.7	3.2
Kenya	3.0	3.5	4.0	3.5	3.0	3.4	3.9
Uganda	3.5	3.0	3.5	3.0	2.0	3.0	3.7
Tanzania	3.5	3.0	4.0	3.0	3.0	3.3	3.8

[5] These assessment areas refer to key elements of a sector programme, namely the macro economic context, pubic financial management, sector policy and overall strategic framework, sector budget and medium-term perspectives, institutional setting-capacity, performance monitoring system, sector and donor coordination. Where information was available updates to the previous TN of 2012 have been done, given the absence of a PFM expert at the moment and the limited time schedule the thorough analysis done, last year will stand.

[6] Vademecum for Belgian budget support.

[7] Maximum obtainable score 6.0

When compared to the members of the East Africa Community (EAC), Rwanda scores on par with Tanzania (both with an IRAI overall score of 3.8). However Rwanda obtains the highest score of EAC members for the cluster “Public Sector Management and Institutions” with an IRAI avg. score for this cluster of 3.6 whereas the avg. scores for Kenya are 3.4, for Uganda 3.0 and for Tanzania 3.3. Scores for Burundi are generally lagging with an overall IRAI score of 3.1 and for the cluster “Public Sector Management and Institutions” a score of 2.7.

2.1.1.2 Macroeconomic stability

Since 2004, Rwanda’s economy has demonstrated remarkable resilience in times of regional and global turbulence. 2011 growth rate of 8.6% for 2011 puts Rwanda’s growth performance at the top of the East African Community (EAC). It is nearly double the estimated growth for Sub-Saharan Africa (SSA) of 5%.

Despite the impact of the recent global economic crisis, the average growth rate since 2008 is estimated at 7.8% annually. Real growth accelerated to about 7.2% in 2010 and 8.6% in 2011, from 4.1% in 2009. Food crops production, construction & mining, and public expenditure-led services (education, health and public services) continue to drive growth on the production side, supported by the Government’s fiscal stimulus and strong domestic consumption, which in turn are fuelled by large foreign aid flows. But besides booming construction and mining, manufacturing activities are lagging with private investments remaining at comparably low levels (9.2% of GDP in 2011).

Despite a modest slowdown in the second half 2012, due to the suspension of budget support, real GDP growth in 2012 was 8 % (more than the forecasted 7,9 %). This growth is largely driven by the expansion of the service sector (communication and transport) and strategic construction. The forecasts for 2013 are lower and fixed at 7,5 % GDP growth. The growth of services and construction sectors is expected to slow in response to tighter economic policies. But growth in agriculture sector is supposed to increase. The new EDPRS clearly addresses the weakness of the Rwandan economy that is strongly public-led and aid depended. While aiming at maintaining macro-economic stability and rapid inclusive growth, GoR wants to reduce aid dependency by increasingly promoting private sector –led growth.

2.1.1.3 External sector developments

Rwanda’s Balance of Payment was positive until 2011/12 as current transfers (donor funding) remained high. The declining support from donors has urged the GoR to use its reserves and increase loans.

Rwanda’s current account deficit is projected to have reached a record 11,4% of GDP in 2012, reflecting the significant impact of the shortfall of aid, and the imbalance of imports and exports. The reduction in aid flows, which account for most foreign inflows, has widened the current account deficit. Import levels have remained high, reflecting robust activity in the private sector. Exports have also grown recently, especially non-traditional export products helping to diversify Rwanda’s exports beyond its traditional products, namely minerals, coffee and tea. However, this has not been enough to offset the growth of imports, and the trade deficit has widened. The widening of the current account deficit pushed the Balance of Payments into deficit for the first time since 2003, reducing international reserves by almost 20% during 2012. [8]

2.1.1.4 Fiscal developments and policy

Last fiscal year, the Rwandan government faced enormous challenges in coping with a sudden shortfall of expected Budget Support from donors. Although only 40 % of the programmed budget

[8] WB, Rwanda Economic Update, Maintaining the momentum, May 2013

support was disbursed, the Rwandan government assured its financing to the social sectors such as Education and Health. Budget Support counted for 18,3 % of the National Budget. In December the suspension of budget support created a deficit of 10 % of the budget. Since Rwanda signed a regional peace agreement in February 2013, Multilateral donors and bilateral donors, such as the World Bank and the African Development Bank, DFID and EC have resumed general and sector (education, agriculture, social protection, …) budget support disbursements for FY 2013/2014.

Nevertheless the prompt and successful reaction in macro-economic policy of the Government to stabilize the Rwandan economy, this shock again showed the vulnerable situation of Rwandan economy due to its aid dependence.

The government took various measures:

On the revenue side, they were able to increase domestic borrowing, which will increase the burden towards the future. On top of that, due to good performance in the private sector (communication and transport) and improved tax administration, tax revenue was higher than expected. The GoR launched the Agaciro Development Fund, a home grown solution aimed at improving the level of financial autonomy of Rwanda as a nation. This is a solidarity fund, based on voluntary donations. Further, for a total of 400 million USD, Eurobond has financed the completion of 3 key strategic projects: the Kigali Convention Center, Rwandair and hydro-power projects.

On the expenditure side, a revised budget was elaborated in March 2013. First of all, the Government cut spending in some categories, accumulated arrears, and postponed some investments. But they maintained spending in priority categories such as wages, interest payments, transfers and social spending.

Although the fiscal deficit has been improved in the FY 2011/12 from 3.7% of GDP to 1.4 % of GDP, due to the shortfall of grants in 2012/13 it has risen again to 6%of GDP. This, however will be the shock in decreased revenue from Grants for this specific year and has evoked improvements in tax collection but also increased a burden on the future by increased debt. ,

2.1.1.5 Monetary policy

Rwanda's inflation rate has declined throughout the second half of 2012, as food and energy prices, large components of the consumption basket, have fallen monetary authorities have also maintained a prudent policy stance, since the reduction of aid, which combined with declining import prices and a deceleration in inflation in the EAC region, contributed to the reduction in inflation. However, since October 2012, import prices have started to rise, reversing a 14-month downward trend. While the headline rate remains low, if the exchange rate continues to fall, inflationary pressures will generally start to build up throughout the economy

The financial sector (banking system) of Rwanda has been significantly modernized in many respects, but vulnerabilities remain. Like other EAC members Rwanda faces several challenges affecting financial sector development and stability. These include (i) the small size of the financial system as a whole (ii) high operating costs among the banks, by far the largest providers of finance (iii) increasing presence of banks from other countries in the region (iv) capacity constraints for qualified personnel in banks and financial sector supervision and (v) efforts to harmonize monetary and financial policy, operational and institutional frameworks within the EAC.

2.1.1.6 Poverty profile

According to official figures based on the most recent national household survey (EICV3) published in January 2012, headcount poverty (national poverty line[9]) decreased by 14% from 58,9% in 2000/01 to 44,9% in 2010/11.

[9] RWF 118,00 at the current prices of 2011.

The table below, based on EICV-3 and DHS4 (2010/11)[10] results illustrates the poverty status and the corresponding decline in poverty for Rwanda and for the 5 main provinces of which Kigali city is a separate constituency:

Table 3 Poverty status and the corresponding decline in poverty for Rwanda and for the 5 main provinces

	2000/01	**2005/06**	**2010/11**	**% Reduction 2000-2010**
Rwanda	58,9%	56,7%	44,9%	14,0%
Kigali City	22,7%	20,8%	16,8%	5,9%
Eastern Province	59,3%	52,1%	42,6%	16,7%
Northern Province	64,2%	60,5%	42,8%	21,4%
Western Province	62,3%	60,4%	48,4%	13,9%
Southern Province	65,5%	66,7%	56,5%	9,0%

The Gini coefficient also decreased slightly from 0.52 in 2005/06 to 0.49 in 2010/11, which shows a slightly improved equity, although inequity remains high in Rwanda.

World Bank analysis shows that the improving social and poverty indicators are strongly linked with public spending. On the one hand this indicates that government spending has been effective in improving the living standards at the household level. On the other hand it also suggests progress in social indicators is vulnerable to shocks in the Government budget. They calculated that the shock of suspension of 60% of the planned budget support in FY 2012/2013 leads to a shortfall of 1,4 % in GDP. Although this may seem like a small impact in relative terms, it would mean that almost 150.000 people who would have otherwise escaped poverty by the end of 2013, would remain trapped under the poverty line. [11]

2.1.1.7 Conclusion

On the basis of the previous discussion and analysis of the data, the World Bank (IDA) judges the country's macroeconomic framework to be appropriate for development policy lending[12]. The Policy Support Instrument (PSI) appraisal by IMF concluded positively to extent the programme with 7 months before preparing a new PSI programme to the Rwandan government.[13]

The budget and the medium term macroeconomic framework are adequate to support the Government's program.

[10] National Institute for Statistics of Rwanda, EICV-2 and DHS4 (2010/2011) Preliminary Results

[11] WB, Rwanda Economic Outlook, Maintaining the momentum, May 2013.

[12] IDA program document for a Proposed Ninth Poverty Reduction Support Grant in the amount for US$ 90 Mio

[13] IMF Country Report 13/177, Rwanda : Sixth Review Under the Policy Support Instrument and Request for Extension of the Policy Support Instrument, 17 june 2013.

2.1.2 Public Finance Management[14]

The most recent Public Expenditure and Financial Accountability (PEFA) findings as a framework for measuring performance in PFM are published in the GoR Public Financial Management Performance Report Final Report dated 30th November 2010. In principle a new PEFA exercise is planned in 2014..

Two donor fiduciary risk assessments (FRA's) on the other hand have been executed. More in particular a donor fiduciary risk assessment of the General Budget Support (GBS) in Rwanda has been carried out in February 2012 while a Fiduciary Risk Assessment of the Health Sector Budget Support in Rwanda was carried out in September 2011[15]. Both FRA's were commissioned by DFID in close cooperation with the African Development Bank, the European Union Delegation to Rwanda, the Royal Netherlands Embassy and USAID Rwanda.

2.1.2.1 Performance of PFM systems[16]

Credibility of the budget

Fiduciary risk	Moderate		Trajectory of change	↔

The Government has a strong track record of forecasting revenues and managing overall levels of spending, with a corresponding low risk of unplanned deficits and fiscal instability. However expenditure management is much less reliable within individual ministries and sectors, which indicates potential problems in delivering the policy intention of the budget.

Comprehensiveness and transparency

Fiduciary risk	Moderate		Trajectory of change	↑

The Rwandan budget and reporting processes capture the vast majority of public sector expenditure and budget and reporting processes are also largely transparent. There are some areas of weakness however including incomplete reporting of the Rwanda Social Security Fund, the continuing failure of many public enterprises (PE's) and autonomous government agencies (AGA's) to submit audit reports to the government, and a lack of public openness in some aspects of fiscal information.

Recent improvements include full reporting of the activities of the Road Fund as well as a substantial improvement in the quality of reporting from the districts.

The Comprehensiveness and transparency of the national budget therefore follows a positive trajectory, but in some areas of weaknesses still remain.

Policy based budgeting

Fiduciary risk	Moderate		Trajectory of change	↑

[14] The discussion and data in this chapter are derived from the GoR Public Financial Management Performance Report of 30 November 2010 and the GBD FRA and SBS Health FRA of February 2012 and September 2011 respectively.

[15] It should be noted that the Fiduciary Risk Assessment of the Health Sector Budget Support was never officially published but was made readily available within the Development Partners Group.

[16] Donor Ficuciary Risk assessment of General Budget Support (GBS) in Rwanda, DFID, Final Report, February 2012.

The Government operates a sound, productive and inclusive planning and budgeting process under an MTEF framework with firm linkages to the major policy tools (Vision 2020 & EDPRS). The annual budget preparation is robust and orderly and incorporates wide and constructive participation from centre of government, ministries, departments and agencies (MDA's), district governments and non- government stakeholders.

The policy basis for the budget however can be improved by stronger links between multiyear fiscal forecasts and subsequent budget allocation; some sector strategies reflected better into budgets and improved forward expenditure estimates linked to investment budgets. Having noted this, costed strategies do exist for a number of sectors and link reasonably well with annual budget plans. The latter is in particular the case for the health sector.

Recent improvements in policy, planning and budgeting include: a requirement for MDA's to include gender budget statements, sector review reports, draft action plans, and procurement plans as part of their budget preparation submission and the establishment and operation of new and improved sector strategies consistent with EDPRS.

Predictability and control in budget execution

Fiduciary risk	Low		Trajectory of change	↑

The Government's arrangements for budget execution are generally secure and sufficiently well understood to facilitate budget implementation.

The tax administration system (under Rwanda Revenue Authority) is efficient, clear, secure and effective.

Budget execution within budget agencies is facilitated by cash planning that is largely effective. It is also supported by limiting centrally-imposed budget changes to a single supplementary budget.

A single treasury account (STA) ensures that spare funds are not left unnecessarily unused, thereby minimizing cash flow requirements and short term borrowing, though this could be further improved by bringing government controlled donor accounts into the system hence improving the level of 'on budget' resources.

Public procurement has been strengthened through the establishment of the Rwanda Public Procurement Authority (RPPA) with open competition as the overwhelming method of procurement which is further supported through an effective procurement complaints mechanism. There are some elements of weakness however in procurement implementation capacities at district level in particular[17].

Accounting, recording and reporting

Fiduciary risk	Substantial		Trajectory of change	↑

Accounting information provides a reasonably clear view of resource flows, revenues and expenditures and the accounts reconciliation process is judged to be generally timely and fairly reliable. However 'substantial' weaknesses do exist both with regard to in-year budget reporting and end of year financial statements.

[17] The 2009/10 audit report provides some instances of procurement irregularities none of which concerns major procurement.

It should be noted that a successful Integrated Financial Management Information System (IFMIS) roll out can be expected to strengthen the quality of accounting, recording and reporting. IFMIS roll out is currently underway in the majority of the budget agencies.

The current weakness of the accounting function has its roots in the previous absence of accounting as a function in the public sector. With this as a basis the Government over the last 13 years has established the offices of the Auditor General, Accountant General and the Government Chief Internal Auditor and has worked to build up a basis of accounting skills and capacities in the public sector.

Reasonably robust legislation, accounting systems and procedure now exist where previously they didn't. Enhancing the effectiveness of this infrastructure however will remain a challenge for some time to come.

External Scrutiny and Audit

Fiduciary risk	Substantial		Trajectory of change	↑

Overall the scope and the methodology of the external audit have strengthened whilst the timeliness of the public scrutiny process has deteriorated.

Audit coverage now includes all central government agencies, all district governments and those Government Business Enterprises (GBE's) that submit accounts for audit (11% of GBE's by value).

Generally speaking external audit reports are presented within 8 months of receipt of the Consolidated Financial Statement (CFS). But according to the OAG there is a potential for improvement in the responsiveness to the recommendations of the audits.

In harmonization with East Africa Community (EAC) practice the process for legislative review of the draft budget law is now executed in two phases: through the Budget Framework Paper (BFP) explaining the macro fiscal and policy context of the budget and the proposed allocations and through the formal presentation of a draft budget law. This provides the Parliament with adequate time and opportunity to scrutinize.

Public Accounts Committee (PAC) is responsible for scrutiny of the audit report and is supported by DFID. In summary format, improvements include: increased audit coverage and enhanced timeliness; improved scope of the legislature's scrutiny of the annual budget law; recent establishment of a dedicated PAC; and some in depth hearings on key audit findings (to be maintained under PAC).

Negative progress includes deterioration of timeliness of audit scrutiny from less than 12 months to around 15 months (at least).

Overall Fiduciary Risk and trajectory of change

PEFA dimension	Risk level 2008	Risk level 2011	Trajectory of change
Credibility of the budget (1-4)	Moderate	Moderate	↔
Comprehensiveness and transparency (5-10)	Moderate	Moderate	↑
Policy based budgeting (11-12)	Moderate	Moderate	↑
Predictability and control in budget execution (13-21)	Moderate	Low	↑
Accounting recording and reporting (22-25)	Substantial	Substantial	↑
External scrutiny and audit (26-28)	Substantial	Substantial	↑

Overall there are two broad areas of PFM weakness: legislative scrutiny and accounting, recording and reporting. The February 2012 Donor Fiduciary Risk Assessment (FRA) of General Budget Support in Rwanda, assesses the overall fiduciary risk as moderate.

There has been general strengthening of PFM performance across five of the six major components of the PFM system, with some robust improvements in performance in a number of specific PFM components. The overall trajectory of change since the time of the former FRA is positive.

Finally in the most recent publication of the Transparency Index (Oct 2013), Rwanda scores 53 (best ranking partner country for Budget Support at the 49th place, before the southern European countries as Spain, Italy and Greece)

General improvements in PFM performance coupled with on-going implementation of the PFM reform strategy demonstrate a serious and credible commitment to reform from the Government.

2.2 SECTOR POLICY – SECTOR STRATEGY

2.2.1 Description of national, cross-sector and sector policies

This section first gives an overview on the relevant policies for the health sector in order to analyse the coherence and linkages in the following section. It starts with the overal development policy and mentions releveant cross-sector policies that have an impact on the health sector as well.

A. National Development Policies

Sector policies are directly connected to national policies, which are:

Vision 2020

Developed in 2000, Vision 2020 elaborates a national long-term vision in terms of goals and objectives to be achieved by the year 2020. By that year Rwanda should: be a middle-income country; have reduced by halve the percentage of people living in poverty; have raised life expectancy to 55 years; and have reduced its aid dependency. It expects to reach these goals by

means of seven strategies/pillars, which include decreasing population growth, increasing access to education and improving the health of the people. This document serves as the basis for the elaboration of national and sector plans in the medium term.

Vision 2020 acknowledges the importance of education and health in ensuring an efficient and productive workforce. It also identifies demographic pressure as a major cause of the depletion of natural resources, poverty and hunger. To improve the health status of the population, health policies should target the poorest and seek to improve access, quality, and cost of health care.

EDPRS 2 2013-2018

Rwanda's Second Economic Development and Poverty Reduction Strategy (EDPRS) is the country's medium term development plan for achieving the country's long term goals and aspirations embodied in Rwanda Vision 2020. Rwanda's vision is to become a lower middle income economy (US$ 900 per capita) operating as knowledge based service hub by 2020.

The EDPRS 2 takes into account the challenges and opportunities of the country identified during the self-assessment of the implementation of the first EDPRS. Under EDPRS 2, those challenges will be addressed and opportunities will be pursued through **Four Thematic Strategies** of:

Economic Transformation: accelerated economic growth (11,5%) and restructuring the economy towards more services and industry as they move towards a Middle Income Country status.

Rural Development : ensuring that poverty is reduced from 44,9 % to below 30% by 2018through focus on increased productivity of agriculture and enhanced linkages of social protection programs.

Productivity and Youth Employment : ensuring that growth and rural development are underpinned by appropriate skills and productive employment, especially for the growing cohort of youth (200.000 new jobs annually)

Accountable Governance: improve the overall level of service delivery and ensure citizens satisfaction above 80% and ensure increased citizen participation to increase ownership.

Foundational Issues reflect long-term on-going priorities. Here we find as 5th issue : Quality, demand and accessibility of primary health care. *The EDPRS 2 will be on improving the quality of health care services , including the management of hospitals, while continuing to expand geographical and financial accessibility.(EDPRS 2 2013)*

Rwanda's performance is impressive when looking at the number of indicator targets which have been **Cross-sector policies**

Underlying policies also touch upon the implementation of the health strategy :

Good Governance and Decentralisation Policy

The decentralisation process was launched in 2000, and entered in its second phase in 2005, with an administrative reorganisation aimed at reducing the number of provinces from 15 to 4 (in addition to Kigali) and reducing the number of districts from 106 to 30. Below the district level there are 416 sectors (*imirenge*), 2,150 cells (*akagari*) and almost 15,000 villages (*imidugudu*). The policy states that the minimum requirements are: at least one hospital for each district; at least one health centre (HC) per sector; and at least one health post (HP) for each cell. Additionally, there is a network of male and female community health workers working at grass-root level.

The Rwanda Decentralization Strategic Framework (RDSF) has been developed to guide the implementation of the Government of Rwanda's policy of decentralisation as set out in the 2000 Policy Paper. The RDSF serves as the overall framework of reference for current and future interventions towards decentralization in Rwanda. It goes beyond sectoral policy in that

decentralisation is a transversal process that imposes itself as the principal focus of governance reform, the designated motor for the coherency of governance and, finally, as an important vehicle for collaboration between the Government and its national and international development partners. This strategy is additionally meant to secure Vision 2020, the Millennium Development Goals and the EDPRS 2 in Rwanda as it is reinforcing the link between good governance and the attainment of broad reaching development objectives.

The Rwanda National Gender Policy (2010)

The GoR is highly committed to addressing gender inequalities. This is reflected through Rwanda's adherence to several key international conventions as well as gender-sensitive initiatives taken at national level, such as:

- The Convention on the Elimination of Discrimination Against Women (CEDAW);
- The Beijing Convention, which recognizes the importance of gender equality for combating poverty, hunger, disease and stimulating development;
- Millennium Development Goal # 3, which is focused on redressing gender equality;
- The Rwandan Constitution, which commits to ensuring equal rights between Rwandans and makes provision for a minimum of 30% of posts in government leadership being occupied by women;
- The integration of Gender as a cross-cutting issue of the Vision 2010 and EDPRS 2 2013-2018 plans.

A new ***National Gender Policy*** was prepared by the Ministry of Gender and Family Promotion (MIGEPROF) and adopted by the Cabinet in September 2010. In the context of this Technical Note, our attention is drawn to the following objectives of the policy[18]:

1) On Health and Population

Family planning:

- To ensure that women, men, boys and girls are provided with adequate information on reproductive health;
- To ensure that the reproductive health services delivery system is gender sensitive and easily accessibility to both men and women.

Rural health systems and referrals:

- To ensure that women and men have equal access to HIV related information for prevention, treatment and care of the victims with a special attention to women;
- To facilitate access to health facilities for both women and men and ensure that trained medical personnel and appropriate equipment and medical supplies are in place and available.

2) On Public Finance Management

- To ensure equal participation of women and men in policy design, planning, implementation and evaluation of public development programmes;
- To facilitate gender budgeting processes at central and decentralized levels;
- To ensure efficient public administration and transparency mechanisms are in place and gender sensitive.

B. Health sector policy and strategy

[18] MIGEPROF, National Gender Policy, 2010, pp. 24-25

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In July 2011 the mid-term review of the HSSP II was undertaken. The review showed that the main results of the previous sector strategy were attained earlier than foreseen.

The main conclusions are :

- The latest preliminary report of the Rwanda Demographic and Health Survey (R-DHS 2010) shows substantial improvements in impact and outcome figures.
- a strong performance based environment with mutual accountability at all levels,
- an innovative community based health insurance (CBHI) system with nation-wide coverage (91%) allowing almost 100% financial accessibility,
- a practical 'common sense' approach to bring the various activities together at the point of contact with the client, all have contributed to these remarkable results. It seems that Rwanda has been able to manage its public sector (at least in health) on the basis of a 'corporate business model'. The team found young and dedicated staff in many places working long hours in often far from ideal conditions!

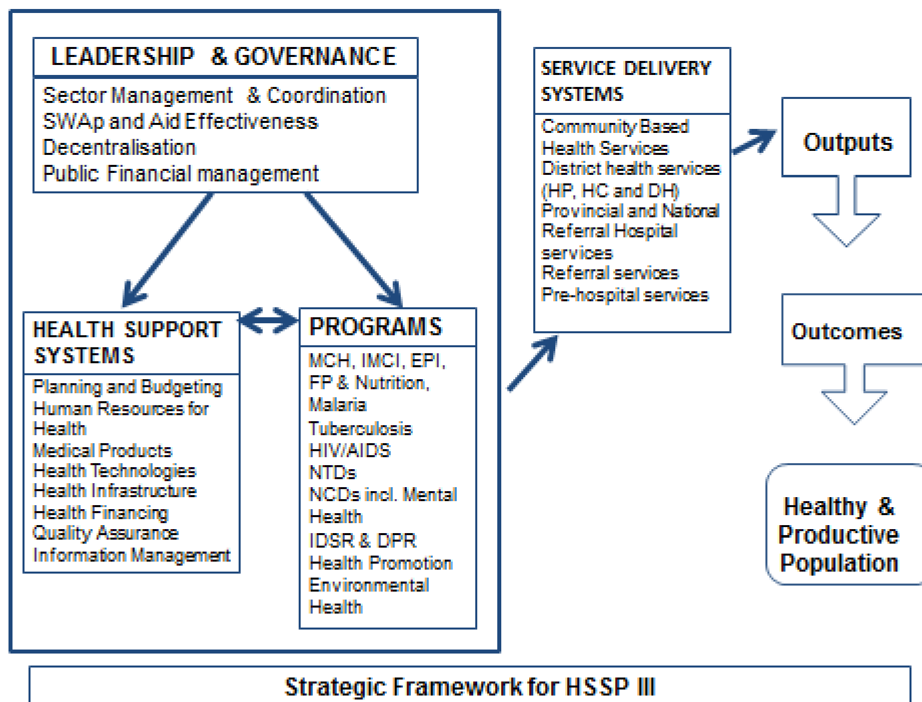
This evaluation served as input for the elaboration of the following strategy.

HSSP III 2012-2018

The third Health Sector Strategic Plan (HSSPIII), which covers a period of six years from July 2012 to June 2018, was validated during the forward looking Joint health Sector Review held on 30th July 2013. Prior to validation, additional elements were integrated in the strategic plan. These elements included the alignment of HSSP III to the objectives of Rwanda's second Economic Development and Poverty Reduction Strategy 2013-2018 (EDPRS 2) in its four thematic areas, namely economic transformation for rapid growth, rural development, productivity and youth employment and accountable governance. HSSPIII contributions to the cross cutting issues of EDPRS 2 such as gender, capacity building, regional integration, social protection and disability were also supplementary elements adjusted in the approved version.

The ambitious HSSPIII is well articulated around a conceptual framework adapted from the World Health Organisation's (WHO) *Health Systems Building blocks*. It is composed of four interrelated "components" namely i) **Programs** that provide preventive, promotive, curative and rehabilitative care; ii) **Support Systems** to allow programs to deliver results; iii) **Governance** providing leadership and guidance**;** and iv) **Service delivery.** It is aligned with the EDPRS 2 objectives and cross-cutting issues.

This is the conceptual framework of the HSSP III. For all of the sub-components, main outputs indicators and targets are defined.



Strategic Framework for HSSP III

C. Subsector Strategies

Next to the HSSP ‘s various sub-sector strategies have been developed to implement the overall Health Strategy. Whereas the status of many of these documents was not clear in 2011, they make part of the HSSPIII and reference is made to these documents. Some of them will need to be updated in terms of planning since the status was unclear before and implementation has not yet started. Others probably need to be adapted in terms of content because the context meanwhile has changed or priorities have shifted. The main issue is that potentially the ministry shows an attempt to move from policy formulation to implementation.

POLICIES	PERIOD	STRATEGIC PLAN	PERIOD
HRH Policy	Draft / December 2011	HRH Strategic Plan	2012-2015
Health Sector Policy	February 2005	Health Sector Strategic plan II	2009-2012
National Reproductive Health Policy	July 2003		
National Behavior Change communication Policy	December 2006		
Health Promotion Policy	2010		
National HIV/AIDS Policy	December 2005	National Strategic plan on HIV/AIDS	2009-2012
TB/HIV Policy	August 2005	National Tuberculosis Strategic Plan	2009-2012
Community Health Policy	2008	Community Health Strategic Plan	Draft 2009-2012
Family Planning Policy	March 2006	Family Planning Strategy	
Child Health Policy	April 2009	Plan strategic d'acceleration de la survie de l'enfant	2008-2012
		Multi Sectoral Strategy to Eliminate Malnutrition	2011-2013
Palliative Care Policy	July 2010	Palliative Care Strategic Plan	
National Medical Laboratory Policy	July 2005	National Reference Laboratory Strategic Plan	2010-2014
Traditional Medicine Policy	Draft 2010	Strategic Plan on Traditional Medicine	2009-2013
Environmental Health Policy	July 2008		
National Blood Transfusion Policy	May 2006		
Health Financing Policy	December 2009		
Quality Policy	August 2010	National Strategy for Quality Management	2008
		District Health Systems Strengthening Framework	September 2008
National Community Health Policy	2007		
		Rwanda Decentralisation Framework	
		E-health Strategic Plan	2009-2013
National Health Insurance Policy	April 2010		
Mutual Health Insurance Policy	April 2010		
National Pharmaceutical Policy		National Pharmaceutical strategic Plan	2009-2011
Mental Health Policy		Mental Health strategic Plan	2008-2012
Health Sector Research Policy	February 2012		
Adolescent Sexual Reproductive Health and Rights Policy	October 2011 (final)	National Adolescent Sexual Reproductive Health and Rights Strategic Plan	Oct 2011 (draft)

While the process of aligning some of the less recent sub strategies to the HSSPIII is underway, a proposal for merging the above 24 policies into 14 policies is currently under discussion. The proposal for health policies merging is summarized as follows;-

N°	Merged Policies	Strategic Plans
1.	National Health sector Policy	1. Health Sector Strategic Plan
		2. Health Sector Monitoring & Evaluation Strategic Plan
2.	Maternal and Child Health Policy	3. Family Planning
		4. Child Health
		5. Adolescent, sexual and Reproductive Health
		6. Road map to reduce Maternal new born mortality
3.	Nutrition Policy	7. Nutrition Strategic Plan
4.	Infectious Diseases Policy	8. HIV Strategic Plan
		9. Tuberculosis Strategic Plan
		10. Malaria Strategic Plan
		11. Epidemic and Disaster Prevention, Management and response strategic Plan
		12. Vaccine and preventable diseases

		13. Neglected Tropical Diseases
5.	Vector Control Policy	14. Vector Control Strategic Plan
6.	Non Communicable Diseases Policy	15. NCD Strategic Plan
7.	Mental health Policy	16. Mental Health Strategic Plan
8.	Health Care Service access policy	17. Laboratories Strategic Plan
		18. Blood safety Strategic Plan
		19. Medical Infrastructure Equipment & maintenance
		20. Emergency medicine (Including SAMU)
		21. Quality assurance and Accreditation process Strategic Plan
9.	Pharmaceutical Policy	22. National Pharmaceutical Strategic Plan
		23. National Logistic and supply chain Strategic Plan
10.	Human Resource for Health Policy.	24. Human Resource for health
11.	Community Health Policy	25. Community Health Strategic Plan
12.	Health Financing Policy	26. Health Financing Strategic Plan
13.	Health Promotion Policy	27. Environment Hygiene and Sanitation Strategic Plan
		28. Health promotion strategic Plan
14.	Health Research and Information access	29. Health Information System and management policy
		30. Health research Strategic Plan

It is expected that these sub policies merging will enhance coherence and integration during implementation.

2.2.2 Appreciation of the content of the policy documents

On the Vision 2020 and EDPRS 2 2013-2018

The health sector policy is well integrated in the EDPRS. Out of the 10 flagship indicators for the health sector, 7 are included in the EDPRS 2 Monitoring matrix.[19]

These indicators constitute a common evaluation framework for all donors involved in budget support. Over time, with common agreement, they can be changed if evolution is not well captured in the set of indicators chosen in the beginning.

On Good Governance and Decentralisation Policy

- The role distribution and articulation between MoH and structures of decentralization are not fully clarified.
- The increased authority of districts and sectors potentially encourages a multisectoral approach. But at the same time it contains the risk for the coherent functioning of the Local Health System, meaning an optimal flux of patients and health information.

[19] See Chapter 2.5 Monitoring and Evaluation Tabel 7 pg 43

- The introduction of a network a Community Health Services at grassroots-level may bring services closer to the local communities. But it may hamper the advantages - in terms of effectiveness and efficiency - of the integrated district health system based on two tiers (a first line with basic health services and a second line with referral health services) It could cause delays in access to the proper level of services at the right time.

On HSSP III and sub-sector policies[20]

The JANS mission team qualified the Strategic Plan as a comprehensive strategy based on thorough analysis (MTR), and building on sound sub-sector strategies. The emphasis is on quality and systems efficiency and includes a good results framework. Content is coherent with the national policy (Vision 2020) and sub-sector strategies (internal coherence).

Experts also pointed at some challenges. Despite clear focus on universal health coverage, equity issues could be better reflected. Finally the private sector's role and involvement could be better described.

They observed that the policy making process was well planned and inclusive, fostering ownership of all stakeholders. But the process did not completely follow the guidelines issued for the EDPRS II, mainly according to the thematic and cross cutting areas, annualized outcome indicators and policy actions, and resource projections. Meanwhile the necessary completion has been done to align the HSSPIII to the EDPRS II and both are finally validated and launched officially for implementation.

2.3 BUDGET AND EXPENDITURE MANAGEMENT

2.3.1 The process for Policy Based Budgeting in the Health Sector

Health sector policy and strategy tools are complemented by a consultative planning and budgeting process that incorporates participation from all the key stakeholders at central, district and sector levels. This gets underway around end October/beginning November following receipt of the first Budget Call Circular (BCC), with an instruction to staff from all of the key health sector institutions at both central and district levels, to begin the process of setting output targets for the coming budget year and the three years of the MTEF period. These are to be based on the targets and plans outlined in the Health Sector Strategic Plan (HSSP).

Next MINECOFIN issues the second BCC around February/March and sets a ceiling according to the prevailing economic plan scenarios. For example in the health sector for the FY 2012/13 the 'strictly' MINISANTE budget submission (apart from the other sub-agencies of the MoH[21]) was RWF 95,666 bn whereas the ceiling set by MINECOFIN totalled RWF 62,661 bn.

Upon communication of the budget ceiling, the heads of all departments meet to present plans and cost requirements for outputs and activities for the coming year. After reviewing these plans, sub-ceilings are allocated by MoH planning staff. Department heads are instructed to prepare detailed budgets according to these constraints.

Final draft budgets including, targets, timelines, responsible officers for implementation are then presented to MoH for consolidation and subsequent presentation to MINECOFIN.

[20] Based on the presentation during debriefing of the JANS mission for validation of HSSP III

[21] MoH and its affiliated institutions Rwanda Biomedical Centre, Central University Hospitals of Butare and Kigali, Kacyiru Police Hospital and the Neuro-psychiatric Hospital of Ndera.

2.3.2 Policy Intent and Action Plan

Whilst the process for linking budgets to policies in the health sector appears reasonably robust it happens that outputs as specified in action plans are quite high level i.e. a bit too widespread and are sometimes more in the nature of outcomes[22].

Sometimes also line submissions cover more than one output e.g. 'policies, strategies, plans and guidelines' or have no target associated with them. For policies to link clearly to budgets, however, outputs need to be specified according to a standard and relevant definition[23].

The fact that this requirement is not always met suggests that whilst there is a strong indication of policy intent in the action plan, this has not yet completely developed into a robust linkage between budgets and policies. MINECOFIN is addressing this aspect of risk in the health sector (as well in other sectors) through on-going reform. The reform is closely followed in the Steering Committee on PFM reforms co-chaired by the World Bank and monitored by MINECOFIN.

Perhaps the most obvious fiduciary concern with regard to policy and strategic planning in health relates to the financing gaps. A costing and financial gap analysis was conducted using 3 different models, the Marginal Budgeting Bottlenecks model and the Input-based costing which cover the whole 6-year period of the strategic plan as well as the MINECOFIN model which spans for 5 years from FY 2013/14 to FY 2017/2018.

The total cost of the Strategic plan based on the MINECOFIN model is RWFs 1067 billion which corresponds approximately to USD 1,6 billion (at exchange rate of 630 RWFs/1USD). A total of RWFs 758 billion from GoR, Development Partners and Private sources is estimated to be available for EDPRS2 to facilitate the implementation of HSSPIII.

Table 4. Costs and resources available in the three projection scenarios (in billions Rwf)

Parameter	Pessimistic	Mid-level	Optimistic
Projected Costs	2,339.3	2,265.5	2,265.5
MINISANTE Budget	907.3	1,032.0	1,266.6
of which external	490.6	594.3	594.3
of which internal	416.7	437.7	672.2
District MINISANTE	265.0	265.0	265.0
of which external	7.1	8.6	8.6
of which internal	257.9	256.4	256.4
Parastatal	88.7	88.7	88.7
Development Partners Off Budget	420.0	470.3	470.3
Households	360.5	316.1	316.1
Private Employers	69.7	69.7	69.7
Total Projected Resources Available	1,900.3	2,030.9	2,265.5
Funding < gap > / Surplus	<439.0>	<234.6>	<0.1>
Funding <gap>/ as Percentage of Resources available	<24.4%>	<11.9%>	<1.2%>

[22] Examples of this are 'increased family planning prevalence' or 'hygiene of hotels, restaurants and other public places improved'

[23] An appropriate definition for 'output' would be « the goods and services to be produced to contribute to the achievement of medium term objectives and the long term outcomes »

The overall funding gap of the resource projected to be available is on average across the years, about 24 percent, 12 percent for the pessimistic and mid-level scenario. The optimistic scenario is shows a slight gap of 1.2 percent; this is due to the existing funding gap through the first four years.

Subsequently HSSPIII has been approved with a +/- 30% average gap of the estimated budget. Given this gap, there is a need for the health sector to put extra efforts in mobilizing funds both from internal and external sources in order to successfully achieve the objectives set out in this ambitious Strategic Plan. Since most of the resources are external and off-budget, priority setting will need active coordination with other DPs and Ministry of Health. If the financing gap persist, probably the objectives will need to be adapted and a selection of priority of priorities will need to be set. According to the HSSPIII following areas will be given priority :

- Sustaining the high-impact interventions that enabled the country to reduce maternal and child mortality, HIV and malaria prevalence;
- Maintaining operational costs of existing health facilities (salaries, maintenance of equipment, etc.) and delaying investments in construction of new hospitals;
- Improving less-costly prevention interventions in the community (nutrition program, hygiene promotion, child growth monitoring, etc.) and in health facilities (check-up for early detection of diseases etc.) with more ownership of local government and other sectors and the participation of community leaders.
-

2.3.3 Budget Resources and allocation

Budget Resources

Table 5 gives an overview of the share of the budget of the MoH in the national budget as well as the variation of the budget in the course of the MTEF. It is noted that while considerably increasing in the next two years the budget shows a nominal increase but relative decline if seen as a percentage of the overall budget. Although in the HSSPIII the % of Health budget within the National Budget should increase up to 15 % in 2017, realism shows that this will depend on other external engagements.

***Table 5: Share and variation of the MoH budget in the national budget*[24]**

in mio RWF Rwandan FY	13/14	14/15	15/16
total expenditure MTEF	1,626,600.00	1,842,300.00	1,998,700.00
Foundational sector[25] : health MTEF	132,665.15	136,726.79	144,476.28
Support function [26]: health MTEF	6,256.88	9,354.91	10,604.44

[24] Approved the Budget Framework Paper , MINECOFIN 2013/2014 MTEF and MoH, HSSPIII, pg 152, sector performance indicators of HSSPIII

[25] Foundational issues reflect long-term ongoing priorities where, in many cases, significant progress has already been made during EDPRS I. Health and education, public finance management (PFM) and justice, peace and stability are prominent amongst the latter. Sector strategies cover both emerging priorities or thematic areas and the ongoing priorities embodied in foundational issues. Foundational issues in the EDPRS2 are not defined as sectors, but can rather be thought of as strategic areas that constitute the bedrock of Rwanda's sustainable development over the long term. (health and education account for a significant of the total foundational costs.) MINECOFIN, Budget Framework Paper MTEF 2013/2014.

[26] Support functions ensure that an environment conducive to the achievement of the thematic areas is created. Such support functions provide the necessary back-office functioning to make the implementation of the EDPRS II priorities possible. Support functions to the value of RWF 132 billion is projected for the 2013/2014 financial year and make up 8 per cent of the total projected budget. These resources are allocated to general Public services, Defense, Public order and safety, Economic Affairs, Environmental Protection, Health, 'Recreation, Culture and Religion', Education and Social Protection.

total health MTEF	138,922.03	146,081.69	155,080.72
% of health in budget (MTEF)	8.5%	7.9%	7.8%
% of health budget in NB (HSSPIII)	13.0%	13.5%	14.0%

For the FY 2014/15 It is explained by the GoR that the contributions of major funders (inter alia the Global Fund that channel their contribution partly through the national budget) are not yet ensured and that therefore despite efforts by GoR the health resources might fall. On a more general note it is also mentioned that in the later years the predictability of the budget is generally lower, precisely because of the unpredictability of external resources over a three year time span, which leads to a weakening of the MTEF predictability at the outer years.

It is also proof of the dependence of the health sector in Rwanda on external resources. A considerable portion of the Rwandan Health budget is off budget and high levels of off budget funding impose risks of sustainability of the health funding in the long run. This is even more of a risk since off budget funding mostly happens in the form of vertical funding. This is probably the biggest risk to sustainability of current and future achievements in health service delivery in Rwanda. The sustainability risk entails various levels : first there is the fact that for vertical programs, the future budgets and thus services are not assured, secondly a lot of external funding is used for investments and managed by the SPIU. There is a danger of imbalances between the development budget (mainly externally financed) and recurrent budget (mainly financed by the National budget = revenue and budget support). The risk is that big investments are executed but the national budget cannot foresee the recurrent cost to make those investments operational. (HR, Equipment, Maintenance, …).

Over the last decade the health sector has seen rapid increases in funds availability both in terms of the national budget as in the part which is accounted for by external resources.

A large proportion of this external assistance, however, is provided in the form of ring-fenced vertical support for programs, which address particular diseases (such as HIV, malaria and tuberculosis). These are the programmes channelled through the national budget where indications are that the volume will fall back and cause a decrease in the budget.

The overwhelming volume of funds is provided through project support, with much of this off-budget. Estimates of the proportion of health sector funding provided through external resources are in the region of 65 to 70%. Those funds are included in the planning through the Health Resource Tracking Tool (HRTT)[27], an instrument that helps to overcome the fragmentation of the budgeting and planning process, but up until now is not yet functioning with 100% of transparency.

Despite the drop back towards the end of the MTEF, the health budget shows a constant increase in nominal terms and hovers around 10% of the national budget in relative terms. This steady nominal increase shows the commitment of the government to continuously invest in the national health as well as in the absorption capacity of the sector.

Resource pooling – Health Insurance Schemes

Rwanda has achieved close to universal population coverage of health insurance. They have done so using a combination of mandatory insurance schemes, which are tailored to fit the needs and financial capacities of different segments of society.

Table 6 Distribution of health insurance membership and resources

[27] Health Ressource Tracking Tool see also pg 53.

Insurance Scheme	Membership proportion	Total Funding in mio RWF	Per Capita Funding in RWF
Community Based Health Insurance	97.7%	24.929	2.588
Rwanda Social Security Board	3.7%	8.590	23.532
Military Medical Insurance	0.6%	2.092	35.366
Private Health Insurance	0.4%	4.650	117.890

A Study on Health Financing in Rwanda (Dec 2012) concluded with the following findings on Health Insurance[28] :

- *Although out-of pocket spending has greatly decreased over the last few years, there is still some uncertainty over whether there is a need to increase financial protection against catastrophic expenditure at the point of use of health care services. The co-payment for CBHI can represent a significant financial barrier to accessing tertiary level care[29] for some.*
- *Significant differences in the per capita spending between the different insurance schemes indicates a degree of inequality which needs to be re-dressed*
- *The function of insurance schemes are to be further improved, e.g. there is room for strengthening the strategic purchasing of health services*
- *High administration costs for insurance providers should be addressed to increase efficiency*
- *Rising health costs for non-communicable diseases and chronic care will raise issues of financial sustainability for health insurance funds*
- *All insurance schemes provide a comprehensive benefit package but this will need to be expanded to address the rising burden of non-communicable diseases*
- *The new governing body for health insurance provision, Rwanda Health Insurance Council, will serve to improve governance and lead to a more integrated health insurance structure.*

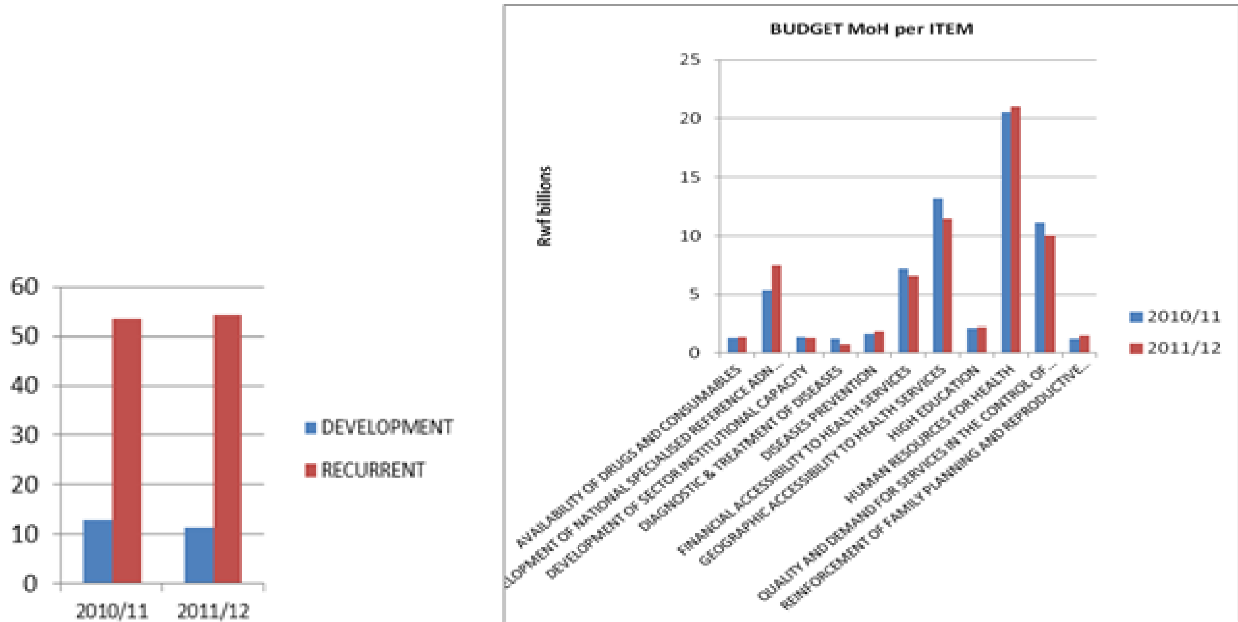
[28] Breen S. Situational analysis for Health Financing in Rwanda, Dec 2012, GIZ consultancy for GIZ.

[29] Tertiary level care : National level care e.g. National Hospital where specialized care is available.

Budget execution

The overview of the budget execution (FY's 2010/11 – 2011/12) covers the domestic budget for the entire health sector i.e. MoH and its affiliated institutions as well as the earmarked health budgets to districts.

Figure 1: Budget MoH budget execution FY's 2010/11 – 2011/12



The overall budget execution rate for the first semester of FY 2011/12 (July-December 2011) was 46.7% (RWF 30.631 bn, including RWF 10.298 bn executed at the district level) of the total budget for this FY (RWF 65.689 bn). For the recurrent budget, the execution rate was 48,65% (RWF 25.868 bn for a total of RWF 53.177 bn and for the development budget 38,37% (RWF 4.763 bn for a total of 12.412 bn). The first graph, shows the steady and high proportion of recurrent budget versus the development budget of investments within the MoH Budget. This is a classical division, since most investment is externally financed (off budget) by donors.[30]

Low budget execution rates for some program items are generally well justified and monitored. For example for the programme item "quality and demand for services in the control of diseases" (33%) the low disbursement rate was due to invoices for Performance Based Financing (PBF) in Q3/2011 for health facilities which were not timely approved. For the program item "reinforcement of family planning and reproductive health" (34%) a delay in the submission of utilization reports stalled the corresponding payments for Q2 of FY 2011/12. Figures of FY 2012/13 are not yet available.

[30]

Table 7: Budget and budget execution rate per program item

Program Item (RWF bn)	FY 2010/11			FY 2011/12		
	Budget	Outturn	%	Budget	Outturn	%
Availability of drugs & consumables	1,323	1,286	97%	1,401	0,571	41%
Development of national reference & research services	5,359	5326	99%	7,461	3,705	50%
Development of sector institutional capacity	1,363	1,361	100%	1,298	0,608	47%
Diagnostics & treatment of diseases	1,229	1,226	100%	0,728	0,045	6%
Diseases prevention	1,660	1,667	100%	1,883	1,225	67%
Financial accessibility to health services	7,153	6,914	97%	6,600	4,225	64%
Geographical accessibility to health services	13,153	12,832	98%	11,504	4,866	42%
High education	2,137	2,091	98%	2,224	1,126	51%
Human resources for health	20,551	20,420	99%	21,033	10,423	50%
Quality & demand for services in control of diseases	11,108	10,810	97%	10,022	3,304	33%
Reinforcement of family planning & reproductive health	1,246	1,240	99%	1,485	0,502	34%

For the program item “diagnostic and treatment of diseases” (6%) the low execution rate was due to unused balances of the former FY basically imposing good and prudent practices instructed by MINECOFIN.

This analysis shows that the latest years, budget execution of the Health budget is well monitored, and successfully absorbed.

Health financial mechanisms at district level[31]

The Decentralization reforms foresees a transfer of financial and overall decision-making responsibility from the deconcentrated MoH authorities to the administrative district. The resources being transferred to district level in the previous MTEF(as shown in figure 2) see are increasing both in nominal terms, as in relative terms as a proportion of the national Health budget. The exact formula for determining the size of these allocations is unclear. Probably it is based on historical criteria.[32]

Earmarked sector grants represent the largest transfers to the districts. But since 2008 no new earmarked sector grants have been introduced, and some allocations like Performance Based

[31] See BTC study carried out by consultant Sven Baeten in 2011.

[32] Breen S. Situational analysis for Health Financing in Rwanda, Dec 2012, GIZ consultancy for GIZ.

Financing (PBF) and health equipment have been reintegrated within the allocations of MoH at central level. PBF is a performance-based financing system for health facilities based upon performance in the area of maternal and child health care output indicators and (more recently) HIV/AIDS and tuberculosis indicators. PBF allocations for hospitals and health centres are transferred from MoH to the districts (although these funds remain appropriations of MoH). Performance is assessed by Steering Committees at district level.

The aggregate of the budget repartitions for all the districts combined is given in the figure below. The largest block Human Resources Development is given by renumeration and incentives. Financial Accessibility is largely given by the organisation and the regulation of the mutuelles insurance system and the subsidisation of health services. Health infrastructure is covered under Geographical Accessibility and community health is covered under Quality and Demand for Services in the Control of Diseases.

Figure 2: Health budget indications of all the MoH sub-agencies and districts for the period covered by the MTEF2012/15

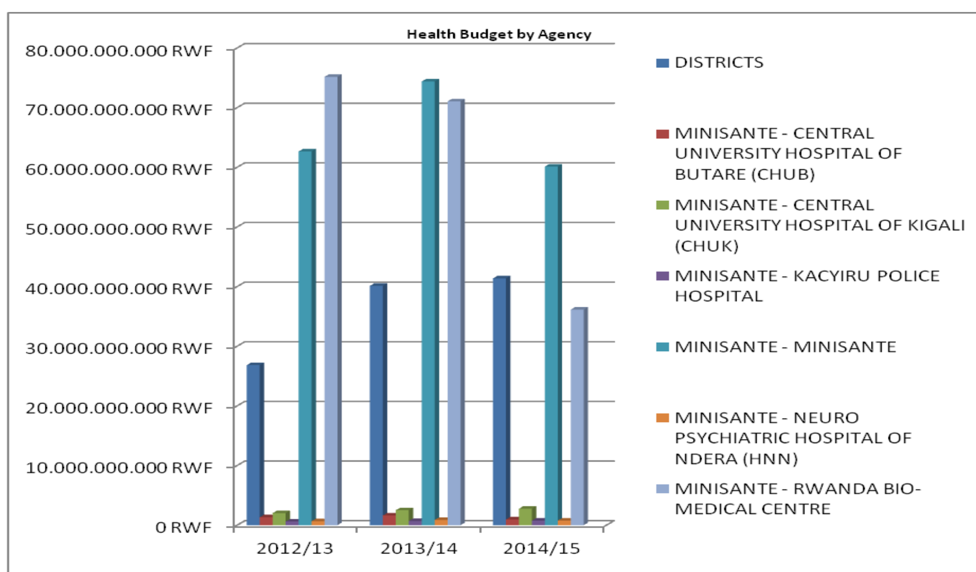
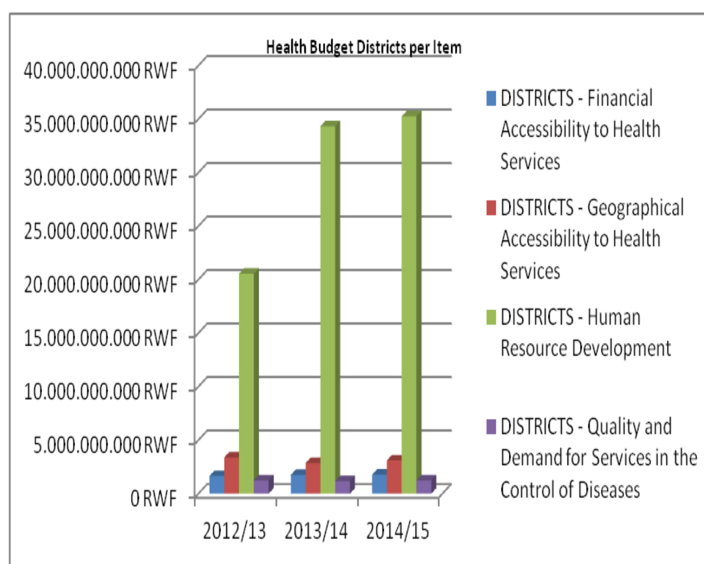


Figure 3: Health budget districts per item



Comprehensiveness and Transparency of Budget Execution

Expenditure information for all GoR-funded and some aspects of donor funded health sector activity is included in fiscal reports. This includes budget and expenditure information for MINISANTE, autonomous and semi-autonomous agencies.

Financial information on implementation of a large component of donor funded projects for which funds are not routed through government system does not generally appear in the budget information and consequently is generally not reported in GoR financial statements.

The MINISANTE-led SWAp mechanism however is succeeding in getting a better grip to capture and coordinate health sector funds and activities from all sources. This underlines the importance of the Health Resource Tracking Tool (HRTT) that is being put in place and actively supported by all major health sector donors. Still much of this information does not appear to be easily accessible to either the Government or the general public in a consolidated manner that gives a clear picture of public spending in the health sector.

2.3.4 Monitoring and control of the health budget

Accounting and reporting processes

As observed in the national Fiduciary Risk Assessments[33] the financial capacity is rather weak at decentralized levels. It is pertinent that detailed reports on the resources in cash and in kind received by the district health centres would provide essential information to the Health Management Team and would provide key inputs for the JHSR. This like so many of the other key accounting principles is first and foremost a problem of capacity.

Since July 2010 MINECOFIN has been implementing the Integrated Financial Management System (IFMIS) called smart FMS and has rolled out all major budget agencies targeting Accountants, Revenue Officers, Budget Officers and Directors of Finance. In principle thus the Government of Rwanda (GoR) accounting and reporting systems are now capable of recording the receipt of central government earmarked cash transfers by health centres through the IFMIS system.

Internal Control and Audit

It should be noted that the set-up process of auditing and control functions have been developed strongly in the years since the EDPRS reforms. Generally speaking there has been a move towards decentralizing the internal audit function to the level of the line ministries, which shows that MINECOFIN is more confident of the sector's ability to conduct budget control and overview its execution.

The internal function is improving and it is noted that a sound system of internal control for non-salary expenditure now operates under dedicated financial regulations for which a manual of guidelines has been issued, although further capacity building is required to make this effective". The Fiduciary Risk Assessment of the Health Sector Budget Support in Rwanda executed by DFID in September 2011 further assesses that the internal audit function, though improving, remains to be strengthened across all sectors, with internal audit continuing to be based mainly on transactions testing rather than on an assessment of systemic risk.

The last three heath sector audit reports (MB 2009, FY 2009/10, FY 2010/11 and FY 2011/12) have been positive.

[33] GBS-FRA DFID February 2012.

In regards to the audit report for the period ended 30 June 2012, the OAG is of the opinion that **"proper books of account have been kept and the financial statements give a true and fair view of the state of the financial affairs of MoH as at 30 June 2012 and of the receipts and expenditure for the period then ended and comply with the existing laws and regulations"** with the exception of two issues raised here below, which are the result of physical verification by the OAG:

- Delay in execution of a contract for the construction of incinerator facilities and installation of the incinerator, highlighted through weaknesses identified in the execution of a cooperation agreement signed between MoH (MINISANTE) and the Ministry of Defence (MINADEF) putting the latter in charge of the construction. One year and 10 months after its delivery, the incinerator was not yet installed and its parts are kept in an open space and are prone to corrosion which may render the equipment unusable and lead to wastage.
- Poor quality of some equipment items supplied to Kinihira hospital of a value of € 78,650 (mostly wheelchairs, tables, stools and mattresses).

With regard to Sector Budget Support (SBS), the OAG states that the Ministry of Health has complied with terms of the SBS agreements, on the basis of the following verification:

- Funds invested in the health sector have been spent according to the budget previously approved
- Approved budget corresponds with the executed budget
- Confirmation of dates and accounts where SBS contributions were actually transferred
- Confirmation of the amount of SBS contributions that were actually utilised by MoH
- Confirmation of the amount spent by MoH in the FY ended 30 June 2012
- GoR increased budget support to the health sector as agreed with donors
- GoR fulfilled commitment on counterpart funding to SBS
- Funds received for the Capacity Development pooled Fund (CDPF) were properly utilized.

2.3.5 Gender Responsive Budgeting (GRB)

Rwanda's first experiment with GRB was carried out from 2002 to 2004 as part of a large gender-mainstreaming programme supported by DFID but was not further pursued due to budgetary restrictions. Since 2008, UN Women (former UNIFEM) has played an important role in supporting MINECOFIN with a new GRB initiative involving gender mainstreaming into planning, budgeting and performance accountability in four pilot sectors (education, health, agriculture and infrastructure).

The **National Gender Policy (2010)** proposes to build on gender-sensitive achievements of previous years and ongoing reforms related to planning and budgeting, of which we note, in particular[34]:

- The gender budgeting programme adopted by MINECOFIN in partnership with MIGEPROF, seen as an important entry point for the process of institutionalising gender responsive budgeting and gender mainstreaming in central and local government institutions
- The on-going public sector reform particularly the PFM reform, which recommends the institutionalisation of gender responsive budgeting.

MINECOFIN introduced a 'Gender Budget Statement' with the 2010/11 budget, which allows sectors and districts to report on gender sensitive outputs, activities and indicators.

***Box 2**: What is Gender Responsive Budgeting?*

[34] MIGEPROF, National Gender Policy, 2010, p. 17

GRB is a tool used to ensure that "*government budgets and the policies and programs that underlie them address the needs and interests of individuals that belong to different social groups. Thus, GRB looks at biases that can arise because a person is male or female, but at the same time considers disadvantage suffered as a result of ethnicity, caste, class or poverty status, location and age. GRB is not about separate budgets for women or men nor about budgets divided equally. It is about determining where the needs of men and women are the same, and where they differ. Where the needs are different, allocations should be different.*" (Debbie Budlender 2006)

Within this context, GRB can help bridge the gap between political commitments on gender and the situation for men and women in Rwanda.

GRB seeks to answer the following questions:

- Does the allocation in the budget reflect the government's commitments to gender?
- Is the budget executed according to what was planned?
- What is the impact of government programs on gender issues?

It is worth emphasizing that success of GRB initiatives is not only measured in terms of budget changes and priorities but can also be reflected in the extent to which women begin to participate in budgetary debates and decision-making.

A number of useful **gender-sensitive instruments** exist to assess the level of implementation of governments' commitment to increase gender equality, among which: the (i) gender-aware policy appraisal, (ii) gender-disaggregated public expenditure incidence analysis, (iii) gender-disaggregated beneficiary assessments, (iv) gender-aware medium term macroeconomic policy framework, and (v) gender aware budget statements.

Given the importance within the Belgian programming for Rwanda to Gender, there is a clear opportunity to enforce the commitment of Rwanda and collaborate on this theme by supporting the Ministry of Health in Gender Responsive Budgeting. The modality of Sector Budget Support will give leverage of this theme in the policy dialogue.

2.3.6 Health Sector specific fiduciary risk issues

The dependence on external resources is probably the biggest single risk to sustainability of current and future achievements in health service delivery in Rwanda particularly given the dependence on continued growth in external resources[35] to achieve HSSP III objectives over the medium term at least. The sustainability is not assured since those external funding often is ring-fenced for specific diseases, or fund only investment without assuring the operational costs for the future.

There is very little that can be done to mitigate this risk over the short to medium term, and probably over the long term also. Perhaps the most important approach would be to seek to create longer-term commitments with existing partners (which is the policy of the Belgian Cooperation) either through a greater use of the existing SBS modality (with medium and long term commitments) and/or through the establishment of more medium to long-term formal agreements for project support in key areas.

[35] Paper on "Trends in Institutional Resources and Health Spending in Rwanda " BTC_JHSS_SBS_MT_May'2012.

Given Rwanda's morbidity and mortality data it is unsurprising that some of the key health sector funders have opted for vertical funding of particular programs. Whilst it is not within the reach of the PFM mandate or the PFM capacity to assess the use of vertical funds, it is a fact that the effective ring fencing of funds to particular areas removes any option for considering alternative use for some of those funds or ensures a commitment to the general health concerns at large. Such hypothecation is rarely used in other aspects of development budgeting.

Another key fiduciary concern in the health sector is the generally low levels of human resource capacity in variety of areas including skills and trained personnel for strategic planning, procurement, accounting, financial reporting and internal auditing. As a mitigation measure MINISANTE has developed a comprehensive human resource strategic plan, including health care specialists. A substantial funding gap remains to be addressed. The Capacity Development Pooled Fund is one of the sources through which this funding gap can be partly filled. [36]

2.4 INSTITUTIONAL SETTING AND CAPACITY

2.4.1 Institutional Capacity at the Central level

The MoH provides technical oversight and guidance to implementers at various levels. The internal coordination between programs and institutions takes place through weekly Senior Management Meetings chaired by the Minister of Health and the Monthly General Senior Management Meeting. It is especially at that level where the synergy, the coordination and priorities to deliver HSSPIII objectives are established between programs, Rwanda Biomedical Centre, training institutions and departments.

An analysis of the Internal Coordination and Management

Strengths:

- The Ministry of Health has a clear vision on the sector policy.
- There is a result-oriented leadership.
- Progress in terms of results is remarkable, both at the level of quantitative indicators and quality of care.
- There is a mechanism of sector consultation in place with as most important interfaces the Joint Health Sector Reviews (JHSR), the Health Sector Working Group (HSWG) and the Technical Working Groups (linked to the departments within the MoH). These mechanisms function as internal (national) coordination mechanisms as well as platforms with donors (see also 2.6 for more details).

Challenges:

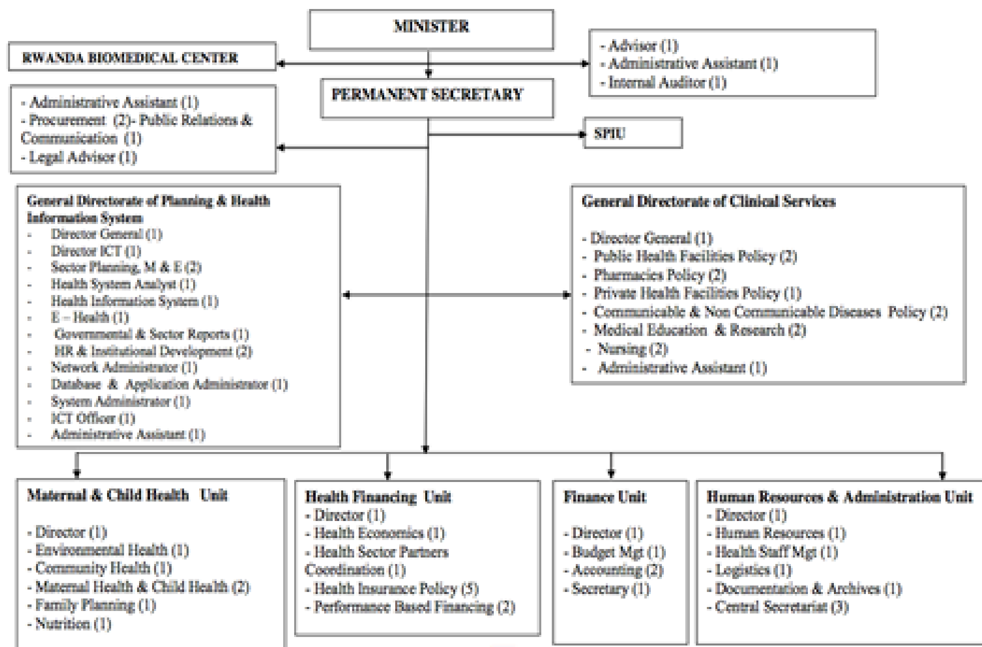
- A lot of reforms to improve the system are initiated, but there is insufficient attention to a proper consolidation of their implementation.
- There is an insufficient communication (and collaboration) around national policies/strategies within the MOH and towards other stakeholders.
- System strengthening is a priority within the health sector (for example efforts within the context of the International Health Partnership: IHP+). Nevertheless, parallel systems related to disease specific programmes still prevail.
- Not all stakeholders within the health system are represented in the spaces of concertation.

[36] See chapter 2.4.3

The link between strategic and operational level remains weak.

- The quality of the interactions both in terms of dynamic (leadership during sessions), process of consensus building and operational outputs with follow-up is insufficient.
- There are different perceptions regarding dialogue ('criticism' or 'learning to move forward'), which influences the functioning of interfaces and the link with the development of policies and strategies.
- The establishment of a Single Project Implementation Unit (SPIU) aims at better coordination of external support. However, there is problem of coordination and communication with the rest of the MoH and a risk of crowding out from the MoH (better working conditions).
- The creation of the Rwandan Biomedical Centre poses two major challenges: on the one hand the balance between the needs at operational level and the aim of creating a pool of excellence. This relates to the issue of equity. On the other hand the need for integration of different vertical (parallel) programs into a more comprehensive approach towards health and health management within the sector.
- Some donors focus more on utilization of funds (short term) rather than on progress in terms of results (long term).

Chart 1: Organogram MoH HQ



Human resources

Strengths:

- In general, the attitude of staff has improved
- The emphasis put on HRH program for specialization of Physicians and the upgrading program of A2 Nurses to A1, A0 Midwives and A1 Laboratory technicians to A2 are gradually bearing fruits leading to a better quality of care.

Challenges:

- There is a high turnover of staff in MoH due to less competitive conditions in public sector.
- There exist internal differences between working conditions (cf. between MoH and SPIU) increasing the risk of internal tensions and crowding out.
- Training schools cannot sufficiently respond to the needs in personnel, both in terms of quality and quantity.
- There is a top-down completion of HR leading to an increasing gap between urban and rural settings.
- The curricula at training schools do not respond sufficiently to the needs in terms of capacity such as need for stewardship/coaching leadership, systemic capacities and evidence-based management.
- Effective, comprehensive retention strategies are not yet operational and necessary budget for HRH salaries not yet available at District level

Quality Assurance

Strengths:

- The set-up of TWGs creates a potential for exchange between stakeholders and negotiated quality development. The involvement of academic institutions is positive.
- The integration of Rwanda into the East Africa Community will have an in impact on the progress in QA.

Challenges:

- Both process and output are weak a present at the level of the TWG.
- There is a focus on high tech specialised medicine (‘regional centres of excellence’) at the level of the national hospitals. This creates a tension with the development of good access for every citizen to basic quality services.
- There is an imbalance between the mechanisms of control and accountability and the development of a culture of innovation through participative action-research, learning and capitalisation.
- A comprehensive QA strategy linking different strategies working on QA is lacking.
- Quality control mechanisms regarding purchase and management of medicines are insufficient. The globalisation of the production of medicines requires a better link with international QA mechanisms regarding drugs.

- Accreditation process focusing more on policies and procedures with little emphasis on 'changes in the quality of Health service delivery' and client satisfaction.

2.4.2 Institutional Capacity at the Operational level

A "District Health Management System" (DHMS) is in place since June 2011, which provides for a District Health Unit (DHU) comprised of (i) the Director of Health, (ii) the Health M&E Officer, (iii) the Health Planning Officer, and (iv) the Health Prevention and Promotion Officer. All of them are posted at the district level. However, apart from the Director of the Unit, the remaining staff are recruited, placed and paid by the Ministry of Health, with minimum involvement of the district. (see chart 2)

The other health units operating at the district level include the (i) Pharmacy Unit, (ii) CBHI Unit, and (iii) District Hospitals (and health centres under them). The pharmacy and the CBHI units function out of the direct supervision by the DHU, though reporting to the Vice Mayor in charge of Social Affairs. The overall coordination of the health system at the district level is entrusted to a District Health Management Team (DHMT). It brings together all the staff of the DHU, the Pharmacy and CBHI Units, the district hospitals, a representative of health centres and a representative of Community Health Workers (CHWs) in a monthly coordination meeting.

Management of local system

Challenges:

- The articulation between health district and administrative district.
- The risks threatening a coherent, integrated functioning of the health district. This is witnessed with capacity building programs which focus only on technical staff, leaving out the administrative staff in the health system.

Human resource management

Challenges:

- Availability of competent and motivated staff, especially in rural districts is still problematic.
- High turnover of staff and absenteeism constitute a major problem, particularly in rural areas. This is to be situated in an environment of internal brain drain towards the city and the private sector. Apart from the Director of Health at district level, the other employees listed in the "District Health Management System" are recruited and paid by MoH. The consultation with the MoH have indicated that this is due to the fact that the resources utilized for this are part of development partners projects with attached limitative conditions. Besides, the Directors of Health in the districts have no supervisory control over other members of the District Health Unit, i.e. the (i) Health M&E Officer, (ii) the Health Planning Officer, and (iii) the Health Prevention and Promotion Officer. Most districts have wished that all these staff be put under the coordination of the Director of Health at district level[37].
- The PBF has contributed to the improvement of services at operational level. Nevertheless, the strategy needs to be integrated in a much more comprehensive, multi-sectoral strategy

[37] Sectoral Decentralisation Report, RGB, February 2013

regarding motivation. This involves improvement of both working and living conditions of staff, especially in rural areas.

- The A2 nurses positions that are currently being converted into A1 are not accompanied with the available budgets to the districts which allow only for A2. This forces the districts to reduce the number of nurses for the replacement of leaving nurses in the District Hospitals and Health Centres, which is likely to affect service delivery.

Resource management

Challenges:

- A comprehensive maintenance system with clear procedures, responsibilities and trained staff is not operational as yet.
- There is a large gap in the reimbursement of health services by the '*mutuelles'*

Accessibility of Care

Strengths:

- Financial accessibility has improved thanks to a remarkable increase of the percentage of the population covered by health insurance, which rose from 7% in 2003 to 93% in 2011[38]. Some concerns on the level of affiliation did arise in 2011 following the introduction of new affiliation fees to community-based health insurance (CBHI), resulting from an exercise led by MINECOFIN to address the heavy backlog of debts owed by *mutuelles* to hospitals. For the first time, categories were instituted setting differentiated tariff plans for individuals according to family income. While a decrease in the number of affiliates was initially observed in the first few months of implementation of the new policy, the level of national coverage has reached 96% according to data provided by the Ministry of Health in June 2012.
- Transport to reach referral services has improved.

Challenges:

- The role of the provincial hospitals in supporting the health districts through a complementary package of services and regular coaching and training not yet well defined.
- The conditions and resources to realize the health packages at the various levels of the health system are insufficient and not yet adapted for the urban settings
- The coordination of disease specific programmes by the district health teams is problematic. Although efforts for integration are made at central level.

Quality Assurance

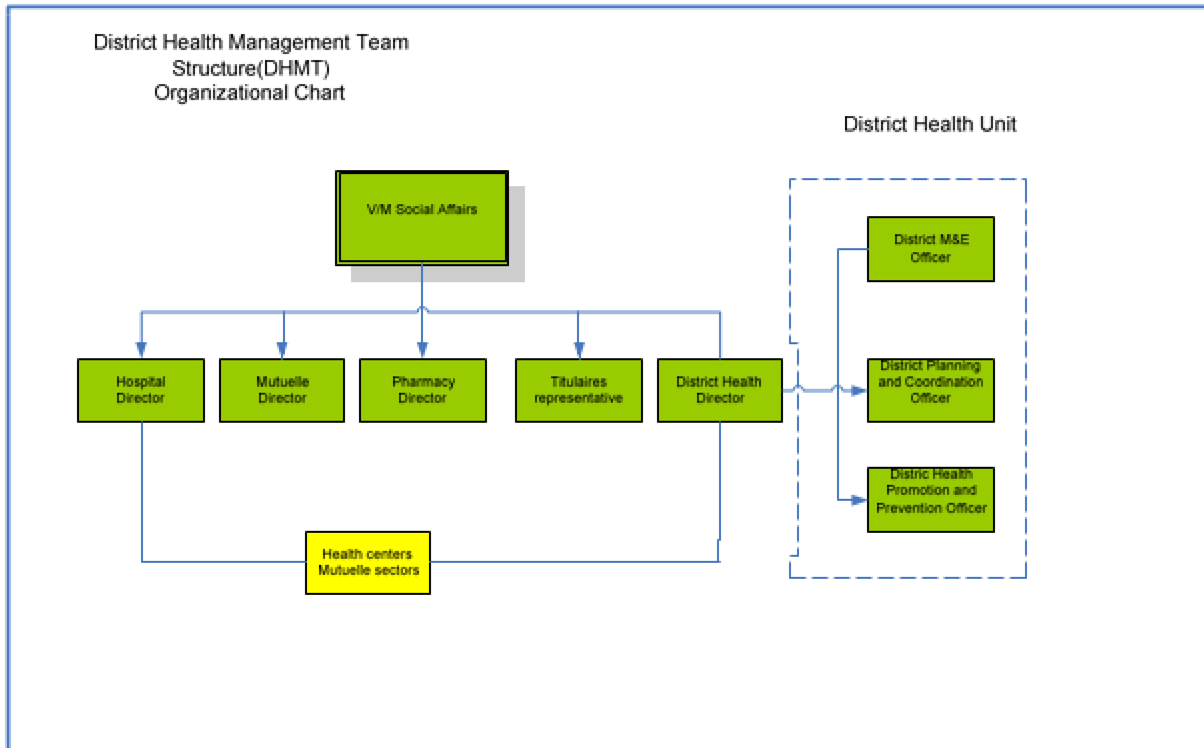
Challenges:

- Competences regarding People Centered Care and community dialogue need reinforcement.
- In the teams running health services or the (health) district, there is an insufficient level of culture of participative analysis of information and link with decision-making.

[38] Source: MINECOFIN, 2012

- Evidence-based feedback on field experiences and operational strategies towards the policy level are not systematic.

Chart 2: District Health Management Team Structure



2.4.3 Human Resources for Health and the Capacity Development Pooled Fund (CDPF)

As part of the sector strategy the Ministry developed a ***"Human Resources for Health Strategic Plan 2011-2016" (HRH SP).*** This plan guides the capacity development of the sector. The overall aim of the HRH Strategic Plan is to increase the number of appropriately skilled, motivated and equitably distributed health service providers for Rwanda. The main strategic objectives of the plan are:

1) A coordinated approach to planning across the sector based on the best available data
2) Increased number of trained and equitably distributed staff
3) Improved productivity and performance of health workers
4) Strengthened human resource planning, management and development systems at all levels.

The ***Capacity Development Pooled Fund*** (CDPF) is a multi-donor fund, where also Belgian cooperation contributes. It aims to assure effective coordination of various agencies supporting capacity development initiatives in the health sector. The fund partly finances the implementation of the HRH Strategic Plan. The focus of the CDPF is mainly on the second strategic objective and the approach is to increase the capacity of training institutes at the organisational level. The financial management is assured by the Single Project Implementation Unit of the Ministry of Health, which manages the external funding for the sector. Next to this financing tool, USG provides support to the implementation of the HRH SP under the HRH program.

Next to these initiatives, the Public Sector Capacity Building Secretariat or PSCBS (Now the National Capacity Building Secretariat), supports all public institutes (including ministries) to increase their institutional, organisational and individual capacities. The secretariat is also supported by Belgian Cooperation through a support project. However, the current capacity building programs for the youths do not adequately address their needs including unemployment, drug abuse and health related issues.[39]

2.4.4 Conclusion: recent evolutions and short-term challenges

During the year 2013, 33 District Hospitals Administrators started a Master's of Hospital Management and Administration (MHMA) with the School of Public Health and the 1st Cohort of 29 Clinical Officers graduated from Kigali Health Institute. They are currently being deployed in Health Facilities Country wide. The training of 30 Midwifery Teachers started in November,2013 at Kigali Health Institute while the 1st Cohort of Nurses and Midwives (971 students) under the upgrading training in the 5 Nursing and Midwifery Schools (Byumba, Kabgayi, Kibungo,Nyagatare and Rwamagana) will start graduating in 2014.

However several changes which have an impact on the various School programs sponsored by the CDPF were witnessed especially the transfer of the 5 Nursing and Midwifery Schools (5SNM) from Ministry of Health to Ministry of Education (MOE), the 'One UNIVERSITY of RWANDA' reform putting Schools of Nursing and Midwifery under the College of Medicine and Health Sciences in addition to the modifications of School fees from RWF 1 250 000 to RWF 600 000. These changes are likely to create misunderstanding while being implemented. Therefore, the Nursing Desk of MoH is preparing a Memorandum of Understanding clarifying roles and responsibilities of the two Ministries as a transition measure to smoothen the hand over process to MOE.

In 2014, the training of 250 A1 Medical Laboratory Technicians will commence at Kigali Health Institute and Gatagara School of laboratory Technicians in collaboration with the National Reference Laboratory while the Nursing and the Midwifery program will continue in the 5NMS. However the training of biomedical Technicians has not yet started and MoH is currently assessing two options. In addition, 283 nursing students are set to commence studies at the 5 SNMs in January 2014 but there is no budget planned specifically for them in CDPF. A part from the limited number of lecturers and instructors for clinical, placements in the 5 NMs which will be addressed with new recruitments and using Video conference equipment in teaching, main challenges to overcome will be the financial gap which is likely to occur with the revised school fees, the llimited number of donors in the pool which is partially due to the division of labour. So far only Belgium and Swiss Development Cooperation are still contributing. Moreover, the HRH strategic plan is not fully funded and CDPF fund so far contribute for less than 2% according to global financial needs of the HRH strategic plan budget.

Financial sustainability of the CDPF is not assured in the long term, although an initiative for strengthening a revolving fund for future students is been discussed through a technical Committee comprising of Rwanda Education Board for Higher Education Students Loan Department and Ministry of Health.

Table: 8 Total expected number of graduates at the end of all training programs

[39] Final Report on the Annual State of Capacity Building in the Public Sector of Rwanda,Oct 2013

Program	Total completed	Completion Date
Midwifery (2 year program)	468	March 2015
Nursing (3 year program)	590	September 2015
Clinical Officers (4 year program)	83	March 2016
Lab Techs (3 year program)	250	March 2016
Biomedical Engineering Technology (3 year program)	90	September 2016
Master's in Healthcare and Hospital Administration (MHA: 2 year program)	66	September 2014
TOTAL	**1,547 CADRES**	

2.5 MONITORING AND EVALUATION SYSTEM

In 2011 an extended assessment of the M&E system/arrangements in the health sector was conducted by IOB (University of Antwerp). This assessment focused on issues of M&E policy, methodology, organisational and systemic issues, capacity, participation of actors outside government and use of M&E outputs for learning and accountability purposes. The main conclusions are presented in this chapter and complemented by recent information provided in the situation analysis of HSSP III.

The HSSP III (2013-2018) presents a detailed Results Framework, which links goals and objectives of the new strategy with impact, outcomes, outputs and targets. For each component of the HSSP III (programmes, support systems, service delivery, governance and M&E of HSSP III) a series of output, input and process indicators are defined and linked to the MDGs, EDPRS II and Vision 2020. A total of ten indicators have been selected for follow-up in the framework of the Joint Sector Reviews (see Table 9). For the moment only 2 out of the previous 6 CPAF indicators (Table 2) are amongst the new 10 high level indicators. DPs providing GBS and SBS will continue to monitor CPAF indicators. However in the Health Sector, the shared understanding is that the 10 revised indicators will be considered as CPAF. Nevertheless the final Matrix with revised CPAF Indicators usually compiled by MINECOFIN and DPs is not yet available

M&E policy and M&E oversight unit

There is a trend to coordinate the M&E system or overarching M&E policy and strategy in the health sector. However, several 'fragmented' components of an M&E system exist as well as several documents which discuss the establishment of a health sector M&E system, policy and strategy. Coordination among these various building blocks and existing initiatives may feed into the establishment of a robust M&E system that is able to fulfil functions of learning and accountability. The M&E policy and the M&E strategy are accepted as sub-sector strategies, but need to be fine-tuned. The Directorate of planning and M&E is already in place. It will strengthen and coordinate amongst the currently existing Health Management Information System (HMIS) department and the M&E EDPRS focal point (currently positioned in the Planning Department). The latter has been appointed by the

EDPRS M&E Coordination Unit for M&E capacity development within MoH as well as to ensure the vertical upward integration of the health M&E with the overall EDPRS M&E system.

HSSP III sets out to strengthen the Planning Unit of MoH and to harmonise planning and M&E systems and procedures across institutions and levels:

- Review existing M&E frameworks and tools to identify good models to expand;
- Provide support to health institutions in order to implement harmonised M&E frameworks linked to their strategic plans;
- Standardise planning and budgeting tools

Capacity of health workers and programme managers in planning and M&E will also be strengthened and district participation in M&E and planning, as well as efforts to link results and outputs with inputs and budget.

Indicators, targets and data collection

Rwanda made considerable progress in the area of health information management during the course of HSSP II. Data collection systems were operationalized at different levels of the health system and issues related to quality data were addressed through the introduction of a standardised data quality assessment methodology both at national and district levels. Private healthcare providers around Kigali also started to report routinely in the past years.

The primary source of routine data on health services provided at different levels of the health system is the Health Information Management System (HMIS). Since 2011, all health centres have had direct access to the system, which facilitates the work of data managers of district hospitals who compile the data of the district hospital and all health centres under their responsibility. This compiled data is sent directly to the Ministry of Health. The increased coverage and the appointment of data managers at health centre level (before data was compiled by the health centres titular) increase the potential for data quality improvements. In January 2012 a new web-based HMIS was launched (HMIS-2 based on district HMIS).

Another important source for collecting routine data is the SISCom, which has been functioning since 2010 and provides data on the increasing contribution of community health workers to the provision of health service. In January 2012, key components of the system were harmonised and include standard recording and reporting formats for community health workers (and other community health volunteers like e.g. traditional birth attendants, Red Cross volunteers and traditional healers). Data collection at this level aims to include all households in the health information system. Data from the community health workers is compiled at health centre level. Both the HMIS and SISCom systems are managed by the HMIS department of MoH.

Other relevant systems for routine data collection include:

- A Human Resource Information System (HRIS) is in place and holds active records of health staff across the country. It is used by HR managers I hospitals and managed by the HR department of MoH.
- The Health Resource Tracking Tool (HRTT), which was designed to capture all national and external financial resources destined to the health sector, was upgraded and put on line in 2010.
- A Mutuelles Indicator Database for the measurement of performance indicators related to the Community-Based Health Insurance system

Several gaps still remain however in relation to data use and harmonisation of data collection in a number of areas. Many different types of software co-exist, partly due to the diversity of interventions supported by different donors. In addition, quality of routine data remains a concern of both MoH and DPs. Several measures to overcome bottlenecks identified in HMIS have already been undertaken and are further set forward in HSSP III.

Another strong building block of the Health Information System is the data provided through the census and surveys[40],which are undertaken by Rwanda's National Institute of Statistics on a multiannual basis. These methods provide important information on health-related outcomes for the entire population, including those who are currently not (yet) using health related services.

Findings of the 2010 Rwanda Demographic Health Survey (RDHS 2010), which are based upon a household questionnaire and a women's and men's questionnaire administrated in a representative sample of 492 villages spread over rural and urban areas, showed substantial progress in the areas of fertility decline, birth delivery in health facilities, vaccination of children 12-23 months and under-five child mortality (compared to results of the 2005 and 2007/08 RDHS).

The components of the M&E system that have been established so far mainly focused on the 'monitoring' component of the M&E system and more specifically on the identification of indicators, baselines, targets and the set-up of various data collection sources. While there is a continuous tendency of donors and particularly vertical health programmes to push for additional indicators, efforts have been made to prioritise and harmonise better among various indicator sets and data collection sources.

A total of ten indicators have been drawn from the HSSP III monitoring matrix for specific follow-up and will be monitored through the Joint Sector Review process between MoH and DPs.

With the design of EDPRS II a new M&E framework was also established, including a monitoring plan that is intended to facilitate tracking of progress at the national level as well as at the three levels of the EDPRS II conceptual framework, namely thematic, sector a district levels. The monitoring plan is complemented by an evaluation plan that will seek to assess the relevance and effective with the objective of enhancing policy making, planning and budgeting across the three pillars of EDPRS II. Sectors, more specifically, will prepare annual evaluation plans for their policies, programmes, and projects, which will be implemented through Sector Working Groups.

In line with the above, an evaluation plan covering the HSSP III period has also been adopted by MoH and DPs. A series of analytical work is foreseen in several sector outcome-related areas in line with the ten priority indicators related above.

In addition, a Health Sector Research Policy was adopted in 2012 and sets to "promote research which improves the availability of high quality of information and its effective use in decision-making (…) in a manner that ultimately enables Rwanda to continuously improve the health status of its people".[41]

[40] For e.g. Demographic and Health Survey (DHS), Malaria Indicator Survey and Public Expenditure Review.

[41] Ministry of Health, HSSP III, p. 78

Table 9: High level Sector Indicators (HSSPIII)

Goal/Impact		Baseline 2011-12	2012-13	13-14	14-15	15-16	16-17	17-18	MOV	Assumptions
MATERNAL HEALTH SERVICES (2)										
Outcome 1	Maternal mortality ratio/100,000	476			268			220	DHS	2015, 2018
Outcome 2	% delivery in health facilities	63%	66%	69%	71%	74%	78%	82%	HMIS	2013,2015, 2018
FAMILY PLANNING SERVICES (1)										
Alternative indicator to the previous one	Contraceptive utilization rate for modern methods by women 15-49 years	31%	33%	35%	36%	38%	39%	40%	HMIS	Annual
CHILD CARE SERVICES (1)										
Outcome 1	< 5 mortality rate/1000 live births	76			50			42	DHS	2013, 2015, 2018
HIV CARE AND TREATMENT (2)										
Outcome 1	HIV prevalence 15-49 years	3			3			3	DHS	2014, 2017
Outcome 2	Sero-positivity of HIV Pregnant Women attending Ante-natal clinics	1.5	1.3	1.2	1	1	0.8	0.6	TRACnet/ EPP Spectrum	2013, 2015, 2017
NUTRITION SERVICES(1)										
Outcome 2	Prevalence of underweight children under 5 (6-59 Months)	11			8			4	DHS	2015, 2017
SUPPORT SERVICES(1)										
Output	Per capita annual expenditure on health (USD)	39	41	42	43	44	45	45	NHA	Annual

SERVICE DELIVERY (1)										
Output	# of health facilities (DHs and RHs) under accreditation and on track as planned	3	3	13	25	45	45	45	Accreditation progress report	Annual
GOVERNANCE										
Output	% Districts that hold at least two effective DHMT meetings with Stakeholders	0	10	70	84	90	93	96	District reports	2014, 2017

Data analysis and use of M&E for learning at central and local level

Whereas there is an increasing move towards more 'integration' and possibilities for exchange of data at the level of the health management information through the strengthening of the e-health system, such exchange and cross-reading among HMIS data and survey data remains currently underexplored. This is indicative of the fact that compared to the progress in the 'monitoring' component of M&E, there is much less progress when it comes to the more analytical 'evaluation' component. There are large amounts of data available at local and central level which are currently not being analysed in a systematic way. This lack of analysis lowers the quality of the M&E outputs (including the health sector performance report, EDPRS annual progress reports), which are mainly limited to an overview of progress made without, however, providing insights into the underlying reasons behind progress or lack of progress. This also hampers the M&E feedback loop in terms of systematic learning and improving outcomes over time. It is highly probable that the need for (qualitative) analysis and disaggregation will become more prominent in the future when the achievements in the health sector will slow down and when measures will need to be taken to reach the less accessible sections of the population. While there is so far no systematic analysis and learning, there do exist ad-hoc instances of learning and changes in programmes on the basis of evidence collected on the ground. This is e.g. the case in the area of maternal and child death where Rwanda was lagging behind the SSA-average and where several measures were taken to successfully redress the situation (under five child mortality was reduced from 103/1000 in 2007/2008 to 76/1000 in 2010, maternal mortality was reduced from 750/100,000 in 2005 35 to 383/100,000 in 2008). The effective use of evidence and speed of remediation is particularly strengthened through the strong linkage among planning and M&E, government's strong leadership and the effectively functioning of government's institutional apparatus. When it comes to the more sensitive issues (amongst others related to claims of inequality in the health sector), analysis and learning is less evident.

The on-going decentralisation process has established a number of instruments which might stimulate local-level evidence-based planning and budgeting, including the elaboration of a district development plan, the Joint Action Development Forum (JADF). In addition, the district health system strengthening tool is being implemented and aims at making data more accessible to staff at both district and central level (mainly for planning purposes) with the support of the Decentralisation & Integration unit of MoH.

Performance-based financing (PBF) was introduced nationwide in 2006. PBF is a performance-based financing system for health facilities based upon performance in the area of maternal and child health care output indicators and (more recently) HIV/AIDS and tuberculosis indicators. While a first impact evaluation of PBF in Rwanda refers to positive results in e.g. the use and quality of some maternal and child health care services, others doubt if these results can only be attributed to PBF. There are also risks associated with PBF such as the 'crowding-out' effect (diminishing or erasing of intrinsic motivation due to external rewards) and 'gaming' (too much focus on indicators that are in the system hereby neglecting non rewarded indicators or falsification of results to maximise reward).

There also some efforts to increase participation of actors outside government through the use of participatory evaluation tools such as citizen report cards and community scorecards. However, given the fact that the fiscal decentralisation has so far been limited there is little local discretion in planning and spending which puts the use of information gathered through participatory tools into perspective.

Participation of actors outside government

The potential for participation of actors outside government which exists at local level is less evident at central level. Whereas national NGOs and umbrella organisation are invited to participate in Joint Technical Working Groups (TWGs), the level of effective participation in these fora is low. This observation does not only hold for the health sector and is indicative of the more generally noted fact that there is little room for outside government actors to hold government accountable. Along the same

lines, there is no clear dissemination strategy for data and M&E outputs, the oversight capacity of parliament is limited, access to information for all non-governmental actors (including donors) is restrained, the degree of independence of the oversight M&E unit which will be established in the Ministry of Health is not clear, forward looking components of the PFM system (e.g. budget planning) outperform backward looking components (reporting), and there is suboptimal functioning of the coordination and exchange fora among government and non-governmental actors.

Health sector performance

Over the past two decades, Rwanda has made unprecedented progress in health impact indicators and the country is on track to meet the Millennium Development Goals on key indicators for Maternal and Child Health (MCH) as illustrated in the table below. Notwithstanding this tremendous progress, some indicators are stagnant or rather lagging behind.

- There has been no change in HIV prevalence since 2005, though the prevalence is 3 times higher in urban areas (7.1%) than in rural areas (2.3%)
- One in five women has experienced sexual violence.
- 44% of children under five are stunted or too short for their age, which is an indication of chronic malnutrition.

Other indicators for monitoring the trend of non-communicable Diseases (NCD) are not yet properly captured in the Health Management Information System (HMIS).

The table below summarizes the trend of key impact, outcomes, outputs and inputs indicators since the year 2000.

Table 10 Trends 2000 – 2012 and targets for MDG (2015) and HSSP III (2018) in health related indicators

INDICATORS	Baseline VISION 2020	HSSP I 2005	MTR June 2008	MTR Aug 2011	TARGET CY 2014	TARGET June 2018
Source of Information	**2000**	**DHS 2005**	**I-DHS**	**DHS-2010 HMIS-2011**	**MDG**	**HSSP III**
IMPACT INDICATORS						
Population (in millions)	7.7	8.6	9.31	10.5	11.3	11.5
Life Expectancy	49			55	58	68
Infant Mortality Rate /1,000	107	86	62	50	28	22
Under Five Mortality Rate / 1,000		152	103	76	30	42
Maternal Mortality Ratio / 100,000	1,070	750	590	487	287	220
Total Fertility Rate (TFR)	6.5	6.1	5.5	4.6	4.5	3.4
Contraceptive Prevalence Rate		17	36	49	62	72
HIV Prevalence Rate among 15–49 years	1.3	1.0	NA	3.0	3.0	3.0
OUTCOME / OUTPUT INDICATORS						
Prevalence of Underweight (Wt/Age) among children 6–59 months	30	18	NA	11	8	4
Prevalence of Stunting (Ht/Age) among children 6–59 months		51	NA	44	24.5	18
% Births Attended in Health Facilities		39	45	69	78	90

INPUT INDICATORS						
% GOR Budget Allocated to Health		8.2	9.1	11	12	15
Per Capita Total Annual Health Expenditure (USD)		NA	NHA	$39.10	$ 42.00	$ 45.00
% Population Covered by CBHI		12	75	91	91	91
Doctor / population ratio	1 / 75,000	1 / 50,000	1 / 33,000	1 / 16,001	1 / 13,748	1 / 11,993
Nurse / population ratio	1 / 6,250	1 / 3,900	1 / 1,700	1 / 1,291	1 / 1,291	1 / 1,000
Midwives / population ratio	NA	NA	1 / 100,000	1 / 66,749	1 / 45,000	1 / 25,000

In terms-of **Programs'** achievements:

- The very positive evolution of **Maternal and Child Health indicators** coincided with the use of modern contraceptive methods and relates to better access to health care and more attention paid to projects implementing obstetrical and neonatal care in all health facilities.
- The burden of **malaria** declined thanks to the malaria program which focused on high use of long-lasting insecticidal nets (LLIN) by children (70%) and by pregnant women (72%), with 82 % of all households owning at least one LLIN.
- The national **Tuberculosis (TB)** Control Program high treatment success rates (86%) and very high success rates in the treatment of multidrug resistant (MDR) TB cases (89%) as well as the collaboration between the AIDS/HIV and TB programs resulted in the reduced morbidity and mortality of TB.
- However **chronic malnutrition** was not tackled appropriately. Nonetheless, the decrease in the underweight results can be allocated to a better geographical and financial access to health care.

With regard to **Health Support systems** improvements generally take more time and investment than those in service delivery**:**

- **Human resources for health**: Important achievements are also recorded in this area in a relatively short period of time with almost a doubling of the number of doctors and nurses, both surpassing the target mentioned in the EDPRS. Only the ratio for midwives has not yet reached the target. The updated Human Resources for Health (HRH) Policy and Strategic Plan, the continuous education plan for physicians in place, the innovative four-year Master of Family and Community Medicine initiated as well as e-learning for upgrading A2 nurses to A1 are initiatives funded by the Capacity Development Pooled Fund-CDPF (co-financed by several donors including Belgium) and the HRH program.
- **Medical products**: the Provision of drugs, vaccines, and consumables from the Central Drug Purchasing Agency in Rwanda (CAMERWA), now called Medical Procurement and Distribution Department (MPDD), to the 30 district pharmacies in a regular and reliable manner with rare stock-outs of drugs contributed to the positive achievements.
- **Quality assurance and accreditation:** Quality assurance (QA) measures have recently been initiated, standards and norms have been defined for district hospitals (infrastructure, equipment, HRH staffing, and pharmaceuticals), an accreditation process of three referral hospitals has started and a baseline was conducted in District hospitals.
- **Planning and budgeting:** Planning at the district and facility levels is aligned to HSSP, annual operational plans show resource commitments from various stakeholders, and the budgeting process is supported by the ceilings provided by MINECOFIN through the MTEF. Joint Health Sector Reviews (JHSRs) take place annually, assessing the performance of the

sector based on the annual health management information system (HMIS) report.

- **Financial accessibility** benefited from three recent and interrelated policies: the Health Financing Policy, the Health Insurance Policy, and the Community-Based Health Insurance Policy. As a result, achievements are recorded as increase in public expenditure by the MOH from 8.2 % (2005) to 11% (2011) of the total GOR budget, and a reduction in the percentage of external assistance from 38% to 33 %. In addition, of all external assistance, 29% goes to Performance Base Financing (PBF) and 37 % to Community Based Health Insurance (CBHI), continuing the dependency of these two reform drivers on external funding.

Regarding **Governance,** assessments of policy implementation for the last decade revealed significant progress in several areas that pertain to governance, leadership, and management. The principles and practices that underlie and define this decentralised system contributed to its improvement. Below are the key contributing elements:

- It is demand driven, with communities identifying their needs and priorities, and the health system responding to them.
- Local governments are now the focal point of accountability for health service facilities and responsible for their operations.
- Health personnel and financial resources have been decentralized to the district level, with the MOH bearing responsibility for technical supervision while district governments control the program implementation process.
- The sector, which is the administrative entity below the district, has become the point of service delivery within the new system, with health centres now present in nearly all 416 sectors.
- An expanded Community-Based Health Insurance scheme that builds up from sector-level mutuelles is the main organizing and financing mechanism for health care.
- A volunteer-based system of Community Health workers (CHWs) has likewise been expanded and represents the principal point of contact for the majority of citizen-consumers.
- Performance-based financing (PBF) is at the heart of Rwanda's system for managing human resources for health. Rwanda's PBF program covers both personnel in formal health institutions (e.g., district hospitals and sector health centres) and CHWs at the community level.
- The Zero Tolerance Policy for corruption has strengthened Rwanda's capacity for strong governance, and the GOR's strong stance on this issue has enhanced the positive results of the decentralization process and general management of health services.
- Further, social participation and system responsiveness is a major goal of the Decentralization Policy for the government, as well as for the health sector.

All these achievements from Programs, Health Systems support and Governance contributed to improved service delivery and positive trends in Health Indicators.

Although trends in Health indicators have been impressive for the past years, one needs to keep an eye on safeguarding that:

- On the programs component side, chronic malnutrition is well addressed, the findings on the burden of non-communicable diseases from the recent steps survey serve as a basis for future intervention in the area and adequate indicators are identified for tracking efforts in tackling NCDs
- On the Health Support Systems and the Service delivery side, the accreditation process underway is well implemented and the support provided to District Health Management Teams (DHMT) encompasses aspects of Capacity Building in areas of Public Finance Management among others.

- On the Governance side, the Sector Wide Approach (Swap) with its principles is decentralised at District level with the support of the Central level and Joint Health sector Review are taking place as planned.

Use of M&E for accountability

There are a limited number of outside government actors which do provide analysis and data collection on sensitive issues and who seemingly have found the balance between extreme self-censorship on the one hand and confrontation on the other hand. Strengthening the capacity of such instances of non-government M&E and research is particularly important.

While accountability towards outside government actors (both upward and downward) is limited, accountability inside the government system is strong, particularly at the level of upward accountability from the local to the central level. This is amongst others evident from the system of performance contracts (based on *Imihigo*) which district mayors have signed with the president. These contracts include a set of targets on which the different districts are yearly evaluated during a presidential ceremony. These contracts might also become a useful instrument of accountability of local authorities towards citizens, at least when citizens are also involved in the identification of objectives and targets. The ongoing decentralisation process might be an opportunity to stimulate such type of citizen participation in the future. Another instrument which adds to the instalment of a results-based management culture is the system of performance based financing. As highlighted above, similar to any system of performance based management there are also shortcomings which are mostly related to the fact that 'management for results' becomes 'management by results' which leads to a focus on 'quick wins', 'gaming', etc. While there has already been some research on the issue, it remains important to monitor and evaluate 'performance contracts' and 'PBF' further over time through independent research to mitigate possible negative side effects.

2.6 POLICY DIALOGUE AND DONOR COORDINATION

Health SWAp

A MoU establishing the Health SWAp was signed by MoH and ten DPs in 2007. The MoU was seen as a good starting point defining a general system for collaboration.

In an effort to speed up the process underway, a "Roadmap for further development of the Health SWAp" and a manual of procedures were developed in 2010. Ten priority areas were identified, for which key activities are proposed in the Roadmap:

- MoH institutional / organisational framework
- Human resources development
- Legal and regulatory framework
- Sector policy and strategic framework
- Consolidated and bottom-up planning and budgeting
- Comprehensive health district development in the context of decentralisation
- Fiduciary framework
- Coordination with DPs and of other stakeholder groups
- Coordination/partnership with non-public sector actors
- Sector monitoring & evaluation

One of the expectations with regard to the mid-term review of the HSSP II undertaken in July 2011 was that international experts from the IHP+ would provide valuable contributions to the SWAp-building process with the proposal of a comprehensive Country Compact to guide aid coordination under the implementation of the next HSSP. Recommendations should be carefully considered and followed up upon by the different actors of the Belgian Cooperation and Development Partners (DPs)

during the implementation of the new SBS programme. Currently, the DPG is reinstating the dialogue on partnership accountability mechanism between GoR and DPs in the Health Sector by suggesting to jointly work on a National COMPACT to be signed by the MOH and DPs for the implementation of HSSPIII'. This could replace the MOU signed between the MoH and the DPs in 2007.

The evaluators found that under a strong central leadership of the Ministry a positive dynamic has been developed in the last three years. Still, donor coordination remains an important challenge because Development Partners in the health sector are very heterogeneous. Many funds flow into the sector and are not integrated into the budget, which weakens the ability of the Ministry to improve efficient allocation of resources and to assure equity in terms of financial resources.

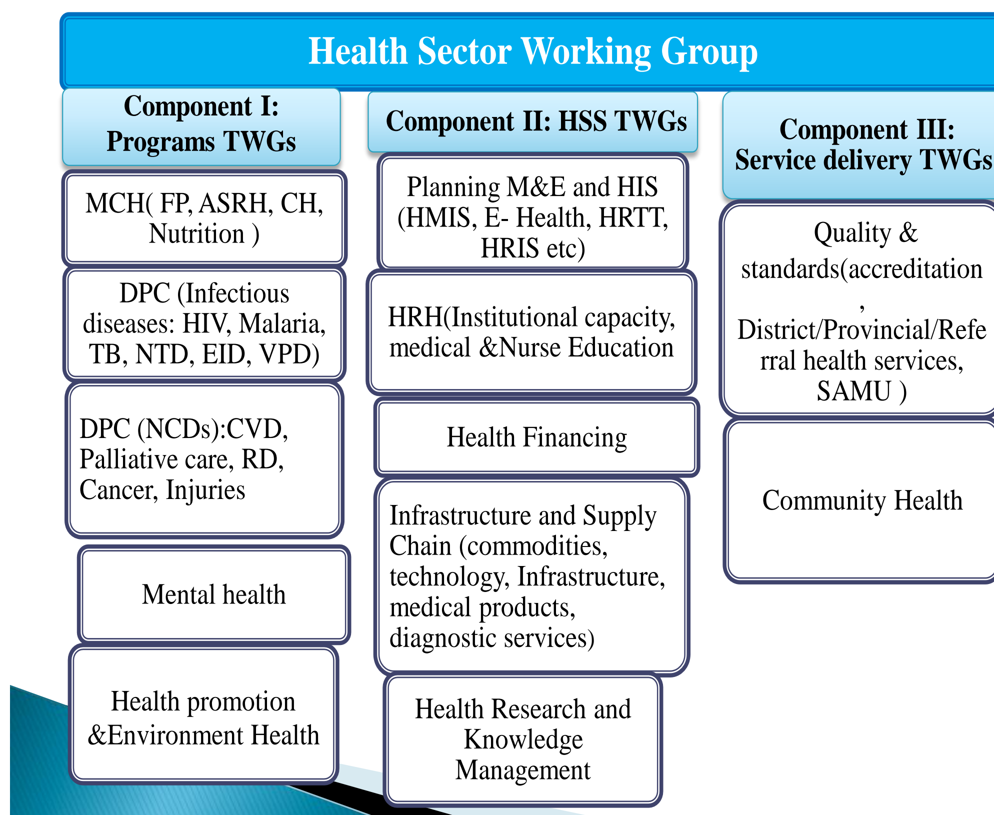
Policy dialogue

According to the EDPRS, Clusters and Sector Working Groups are designed to facilitate in-depth dialogue between the Government of Rwanda and DPs at the sector and subsector level, with a view to ensuring joint planning, coordination of support, and joint monitoring and evaluation. The creation of the Health Sector Working Group (HSWG) brought together the MoH and DPs, including civil society, to support the implementation of the Health Sector Strategic Plan (HSSPII).

Since 2009, several Technical Working Groups (TWGs) operating under the authority of the Health Sector Working Group (HSWG) were established with the main objective of supporting and advising the MOH in the overall implementation of the SWAp, including the implementation of sub-sector strategies and policies and the development of relevant guidelines and tools to be used by the implementing agencies. The TWGs were expected to facilitate the alignment of all interventions with the National Health Policy and to support the development and implementation of the Rwandan Health Sector Strategic Plans (HSSP II, III).

Findings from the MINECOFIN SWAp Assessment (2012) highlight the fact that "there were too many Technical Working Groups (TWGs) in the health sector, only a small portion of which were active and useful". The recommendation of this assessment was to reduce the number of TWGs in order to make them more active, useful and align them to the components of HSSPIII. This was also underlined among the recommendations of the Joint Assessment of HSSP II and reinforced by the past experiences of the current TWGs (Health System Strengthening and affiliated TWGs). Building on these observations and recommendations, two levels of dialogue were retained which are Health Sector Working Group (HSWG) and Health Sector Technical Working Groups (TWGs). It is expected that the new TWG structure will support HSSPIII implementation and monitoring, increase dialogue between MOH and the DPs while improving policy development, sector and subsector technical coordination.

Chart 3: New Sector Dialogue Structure (HSSPIII)



The new dialogue structures aligned to HSSP III is presented in Chart 3.

The HSWG, which is the highest-level forum in the health sector and is chaired by the Minister or Permanent Secretary of the MoH and co-chaired by the lead-donor, is held on a quarterly basis. According to the ToR of the HSWG, its goals are:

- To improve coordination of activities and harmonisation of procedures of both Government and DPs, in order to increase effectiveness and efficiency of aid in the health sector;
- To ensure better alignment of DPs behind the HSSP with an enshrined principle of mutual accountability

During the last 7 years Belgium was appointed lead-donor (co-chair of the HSWG) with USAID as shadow-co-chair, whereas USAID has become lead-donor from July 2012 onwards and Lux-Dev acts as shadow-co-chair.

In this new framework, there are 12 TWGs (2nd level) (5) under Programs, (5) under Health System Support and (2) under Service Delivery. All the 12 TWGs will be reporting on a quarterly basis to Health Sector Working Group (HSWG). MoH has already appointed Chairs of all the 12 TWGs. The Development Partners Group in health (DPG) is yet to select the Co-Chairs of TWGs. Belgium is looking to be appointed as Co-Chair of i) the Mental Health TWG, ii) Planning, M&E, HIS TWG, which covers issues related to HMIS, E- Health, HRTT (Health Resource Tracking Tool), HRIS (Human Resource Information System) and also iii) Infrastructure and supply chain. Lately BTC was very active in the iv) Health Financing TWG and had expressed its interest to be the Co-Chair after the phasing out of GIZ from the sector. As a member of the Health Financing TWG this has helped the PFM expert to make links to the upper level dialogue in the Budget Support Harmonisation Working Group which was recently dismantled.

TWGs are chaired by representatives of MoH and co-chaired by technical staff of the designated DP. Participants also include international NGOs, national civil society organizations however the latter are not very vocal. Representatives from the Private Sector are yet to be included. TWGs normally meet at least once a month, though some of these still need to be boosted and frequency of meetings vary. The Development Partners Group (DPG) meets once a month to discuss points of attention raised by the DPs involved in the different TWGs, to address some specific concerns, to prepare the HSWG, JHSR, joint assessments, field visits as well as to harmonize their position, share information, etc.

Two Joint Health Sector Reviews are held every year, one backward looking review in October to assess performance during the previous financial year (July/June) and one forward looking review in April to discuss planning and budgets for the following financial year. Quality and organisation of the sector reviews have significantly improved in the past couple of years. In addition, the two Joint Budget Support Reviews which used to take place within weeks after the sector reviews will be carried out every other year These exercises focus on broad cross-sector issues such as PFM and Decentralization as well as on trends in a selection of key sector indicators based on the Country Performance Assessment Framework (CPAF). However, input from the sector level to the Joint Budget Support Review (JBSR) is done in a formal way often leaving little room on the agenda to discuss sector issues. On the other hand, discussion on progress in cross-sector public reforms is not obvious in the health sector policy dialogue.

Whereas different fora for technical dialogue (TWGs) and policy dialogue (HSWG) and the Joint Health Sector Review (JHSR) exist in the health sector, they have not always been used in an optimal way. Several shortcomings have been noted including the lack of linkage among TWGs and the more policy-oriented HSWG, the lack of exchange and triangulation of data among different donors and non-governmental actors who have access to different types of information, lack of mapping of different donor initiatives, lack of systematic linkage among the work of the TWGs and the JHSRs which are organised twice a year (one backward looking and one forward looking). That being said, close collaboration between DPs and MoH was observed from the Mid-Term Review of the HSSP II held in July 2011 up until the process leading to the preparation and validation by DPs of the HSSP III early 2012 and officially validated by the GoR 2013 after the final validation of the EDPRS II.

In spite of the existing structure, many DPs have maintained bilateral relations with the MoH to address strategic issues. This situation puts MoH in a powerful position and undermines efforts made by donors to generate more leverage through the SWAp. The question of how the MoH perceives the dialogue should be carefully considered. Currently, the general impression is that the GoR sees policy dialogue more as an open forum providing space for criticism rather than a constructive learning process in order to move forward. This is very likely to have an influence on the functioning of interfaces that are in place.

Donor coordination

Heavy financing of specific diseases by large donors has made aid coordination challenging in the past years and resulted in less attention on and support to health systems strengthening. Experience shows that there are DPs that tend to defend a system building approach (including Belgium) and others that want visible results in the short term. National authorities have been making compromises with big donors that do not specifically address health as conceived in the context of Public Health Care (PHC), but that focus on some priority diseases such as HIV/AIDS, TB, Malaria and vaccinations while other major health concerns such as Mental Health or non-communicable chronic diseases are less addressed by those big donors. Focusing specifically on certain issues causes fragmentation and undermines the concept of integration, which is central to PHC. However the new HSSP (III) sets as a clear objective “to provide comprehensive and integrated care at all levels of service delivery in a client friendly way” by “bringing the various services of all the programmes together at the same time

and in the same place", which will undoubtedly require enhanced alignment and integration of all DP interventions into the Rwandan health system.

The bilateral negotiations going on in parallel to the formal dialogue structures sometimes give a feeling of frustration to DPs, who are faced with decisions in which they did not participate. Belgium has enforced its participation in the dialogue structure by the development of an internal coordination system (the portfolio approach). The collaboration with the School of Public Health and the scientific support are important elements contributing to enhancing the portfolio approach[42].

With the launch of the SWAp Roadmap in October 2010, DPs reaffirmed their commitment to further join efforts in harmonizing their support to the health sector of Rwanda. In line with this, DPs organised a two-day retreat in March 2011 to take stock of the achievements made in the process of the SWAp-building and share information on their respective aid interventions supporting the health sector as well as identify opportunities for better harmonisation among DPs.

By the end of 2011, most MoH budget agencies, DPs and CSOs provided their input into the 'Health resource tracking tool' set up by MoH. The compilation of information has led to a mapping of health partners active per district, per activity and includes the amount of funding provided. The HSSP III aims to strengthen the potential of the HRTT and improve data availability in order to best inform the planning and budgetary processes at district and national levels. However this initiative is hampered by the poor ownership of the tool and the minimal utilization of the information collected. Also double booking of contributions and lack of information of other contributors make the tool for the moment not perfect to address the problem of inefficient budget allocation due to external financing by projects.

During the Technical Note formulation mission in June 2011 all bilateral and multilateral DPs expressed clear willingness to improve information sharing on their respective interventions and better coordinate their analysis of the health sector as a whole in order to strengthen their position as DPs. This is an opportunity that Belgium will have to seize and work closely with in the next phase.

SBS donors

Belgium, DFID and KfW were the three bilateral DPs that have supported HSSP I and II through SBS. But they have represented a rather marginalised group next to the big donors providing large amounts of vertical funding to the health sector.

As a result of the DoL, the German Cooperation (KfW, GIZ 2011) and DFID (October 2013) pulled out of the health sector DFID and the EC as GBS donors and SBS donors in other social sectors, are increasingly interested in the performance of the Health sector and policy dialogue at sector level, in order to monitor their support through GBS.

USAID as a bilateral donor is gaining more interest in the sector as a whole, not only from the perspective of specific diseases but also looking into the overall functioning of the health system.

The Global Fund is also currently considering the application submitted by MoH and Minecofin for Health Sector Budget Support to the HIV/AIDS Single Stream of Funding (SSF) Grant planned for January 2014 to June 2015. This reinforces the potential cooperation to address issues such as sector financing and overall development of specific strategies.

With the formal dialogue structures in place, the interest of GBS donors in the results of the Health Sector (DFID and EC) and new donors such as the Global Fund planning to contribute the health system by using national procedures, Belgium is not considered to be the only SBS donor for Health.

[42] See also Chapter 3.

2.7 Summary of critical challenges and mitigating measures

The overall sector assessment shows **strong leadership** as well on the level of the government where coordination is assured by the Ministry of Economy and Finance (MINECOFIN) as within the sector through the person of the Minister.

As a whole, the government of Rwanda has a strong will to achieve development results and to improve their management systems. Within the health sector, a number of characteristics are observed on all different aspects of the policy cycle: policy and planning, implementation, financial management, monitoring and evaluation system.

The main risks to be monitored during the implementation of this new sector budget support are summarized in this chapter. Mitigating measures are generally proposed in this summary, but in a more concrete and substantive way, they are integrated in the design of the intervention (see next chapter.)

1. Pressure for results. This might urge GoR at specific moments to continuous reforms ('reformitis') with a strong focus on specific outcome indicators, without balancing a sustainable development of a well-functioning health system.

<u>Mitigating measure</u>: Instead of only focusing on performance indicators, DPs show interest in the policy and implementation process. Any opportunity to participate in evaluations and monitoring exercises need to be taken. DPs can choose to negotiate for adaptations rather than for radical reforms and build capacity through capitalisation.

2. Decentralisation reform. This possibly also creates some instability in terms of changing responsibilities and need of building capacities, though the overall impression is that the decentralisation process is adjusted to assure good service delivery and local as well as technical oversight.

<u>Mitigating measure</u>: Continue to study the effects and needs of the decentralisation process and look for good solutions within the country itself to solve capacity or oversight problems.

3. Danger of fragmentation between various levels and departments of MoH. Within the Ministry of Health coordination is done at the highest level, whereas closer collaboration is needed among the different departments. Technical Working groups are set up to assure this internal coordination. Also the process of developing the new strategy has led to an increased coordination between some of the departments and TWG's.

<u>Mitigating measure</u>: Structures are set up to overcome the fragmentation. Actively working together with the various departments in a limited number of technical working groups, where Belgium contributes expertise, reinforces internal coherence. The results and outcomes of the work in these TWG's need to be shared with non-active stakeholders (through the Health Sector Working Group). It is important that the level of HSWG really can function as a platform where information and decisions are shared among all actors in the sector. Sector Budget Support helps the Ministry strengthen the internal coherence of the implementation of the policy.

4. Tension between the realisation of an inclusive package of health services and highly specialised medicine. In most of the policy documents, such as in the Vision 2020 and EDPRSII, the inclusiveness of the policies is mentioned as important. Nevertheless the strategy on Human Resources for the health sector shows a more nuanced picture. The presence of a well-developed health system is positive to attract Foreign Direct Investment and a highly educated labour force. Highly specialised health experts will contribute to the overall quality of the health system. Since the costing of the new HSSP III does not show that the needs will be covered by resource projections, there is a danger that priorities are not clearly stated in the document. There is a risk that if external funding decreases, and resources are scarce that the universal health services are not assured out at

the detriment of the health services for the whole of the population.

Mitigating measure: Donors' role in the implementation of the HSSP III will be to assure transparent prioritization through the review of the budget and costing processes. As SBS donor Belgium has an important role to play and flag how budget allocations reflect the real priorities of the Government. Through these analyses donors can monitor the engagement and elaboration of an inclusive health system.

5. Also on the **donor side and in policy dialogue some weaknesses** exist :

- *Potential decrease of external funds and actors*: Through the division of labour in Rwanda, led by the Rwandan government, the result for the Health sector is that some traditional donors such as German cooperation have left the sector. A general decrease and cooperation funding will be added to this evolution, resulting in a stronger decrease for Health in Rwanda.
- *Pressure for results*: Donors also have a need to show results. Therefore, some donors with narrow and specific objectives only follow the performance of a small aspect of the health situation in Rwanda (eg. disease-specific programmes.) They tend to push the government health system only on their objective at the detriment of an overall functioning health system.
- *Fragmentation*: Among donors there is still a lot of work to do to exchange information and cooperate with each other and outside the government system. Even within donor programmes, various interventions could act more coherently. The Belgian efforts to strengthen this approach, which are very positive, clearly do not come automatically.

Mitigating measure: At the moment there is a clear willingness on the donor side to further invest in mutual transparency, and specific actions are being taken to enforce collaboration (eg. resource tracking tool). There is also growing interest from donors to look at the overall financing of the health sector and address the health system as a whole.

2.8 CONCLUSION

The assessment can be concluded positive.

The government of Rwanda has shown a strong commitment to sustain and develop the health sector (see budget allocation in period of budgetary constraints). There is a clear leadership within the government and the Ministry to attain the objectives set in the strategies. Sector performance measured by the indicators but also confirmed by evaluations and observations, are positive and encourage to continue supporting the sector.

All the minimum criteria set for Sector Budget Support are respected, from macro-economic stability, PFM systems, sector strategy and sector policy dialogue.

Given all these elements, we can conclude that conditions are in place to successfully monitor the implementation of the sector policy, by using Health Sector Budget Support.

3 MODALITY DESIGN

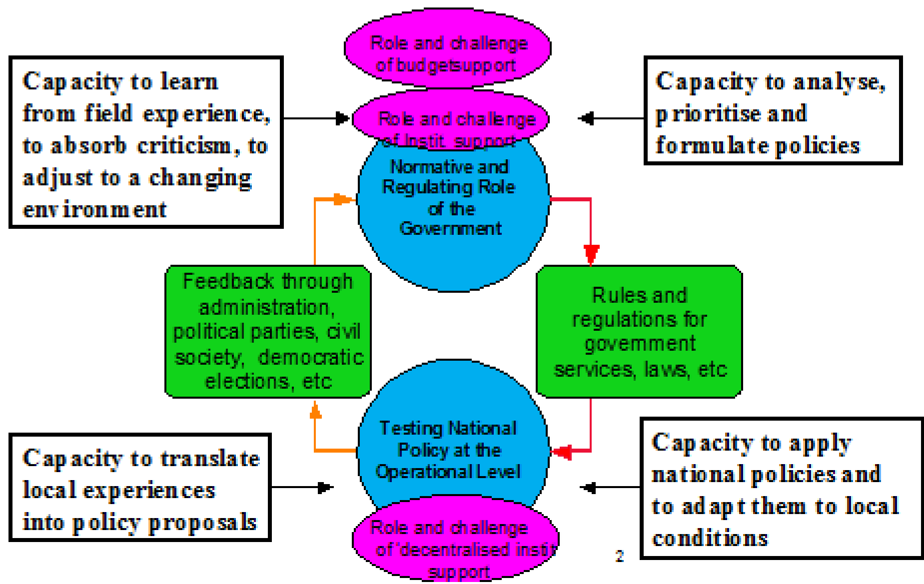
Based on the analysis of the sector (chapter 2), this chapter will present the specific objective of the sector budget support and its set-up as part of a package to support the health sector (portfolio approach). This package as a whole aims at supporting the Rwandan partner to meet the challenges identified in chapter 2.

3.1 THE SPECIFIC OBJECTIVE AND VARIOUS INPUTS

3.1.1 The specific objective

The specific purpose is to **strengthen the policy cycle** in the Health Sector in Rwanda. This will be done through promoting **learning** (loops) within the health sector, with the reinforcement of capacities at four levels and within the various systems used to design, implement, report and monitor the health policy. (Institutional development, public financial management system and M&E system). The capacities at operational level are reinforced through the technical dialogue, the capacities at strategic level through the policy and political dialogue.

Chart 4: learning (loops) within the health sector



The driving force of this learning process is **Reflective Action and Action Research**.

Box 3: What are Reflective Action and Action Research in Rwanda?

It helps actors in the sector : 1/ to analyse the design and the implementation of national policies and strategies in a critical way, at analysing their own work, whether clinical or managerial, 2/ to document experiences in order to generate evidence for policy, 3/ to organize structured feedback to the decision makers at strategic level, 4/ to guide the policy and political dialogue on how to continuously transform national health policies and strategies into more field-adapted documents and into quality services responsive to the needs of the population. Scientific support teams, both at national ('Ecole Santé Publique' at Kigali) and international (ULB) level, accompany this process. The design of this support has been worked out. and a number of indicative priorities for more in-depth reflection have been identified[43].

3.1.2 Inputs of the Joint Health Sector Support III b

The following inputs will assure the implementation of the Belgian health budget support:

1) A Sector budget support of 18 million € channelled through the national PFM system (as last part of the foreseen 32 million € SBS in the current ICP)

2) A Public Health expert and a Public Finance Management expert will assure technical input in the political/policy dialogue through the SWAp mechanisms. They will collaborate closely with the Attaché of the Belgian Embassy who is responsible to decide on Belgium's position in policy dialogue in case of political issues (see Annex Vademecum pg. 16)

Generally speaking, the experts will:

- Monitor the Health sector with the donor group through technical and policy dialogue and report on this monitoring. Monitoring is the means by which donors support the programme with substantive guidance. Attention will be given to identified risks in the sector assessment such as:
- Development of a stable health system (rather than only focus on some results) (risk 1)
- Facilitate the analysis and evaluation function of the sector M&E system (risk 1 and 5)
- Support the evolution for good articulation of the decentralisation reform in order to assure *inclusive* and qualitative service delivery risk 2 and 4)
- Actively participate in internal coordination meetings through Technical Working groups (risk 3 and 5)
- Strengthen harmonised support and monitoring of the health sector in Rwanda, with the overall aim of ensuring that joint development assistance is used effectively and efficiently in meeting the health needs of the population reaching the national indicators within the health Sector Wide Approach (SWAp). (see risk 5)
- Verify the completion of conditions for the release of funds (as agreed in the Specific Agreement). This evaluation and decision are presented in the disbursement report.
- Actively participate and contribute to the internal coordination of the Belgian Cooperation in the sector and contribute to the capitalization of experiences within the Rwandan Health sector, whether conducted in the context of the Belgian portfolio support program to the Rwandan health sector, or experiences from other development partners.

[43] Cf. documents produced by the scientific support teams

- Actively participate and contribute to Rwandan cross-sector platforms that aim at strengthening the overall governance of the public sector. (decentralisation, public finance management, capacity development, ….) and contribute to the internal coordination and capitalisation the Belgian support provided to these themes.

Both experts are needed. The **Public Health expert** will monitor and provide input into policy dialogue on health issues. He/She will analyse and give input for technical choices through the technical working groups, based on evidence by exchange with our support program at operational level.

The PFM expert will provide a general appraisal of fiduciary risk and therefore be actively involved in the technical assessment of procedures and modalities related to the execution of the Health Sector budget, the sector audit of the budget and public expenditure reviews and tracking. This is the priority area of his/her work. The expert will especially follow up within the Ministry of Health (MoH) and it's SPIU (Sector Program Implementation Unit) on sector performances, budget preparation and execution, health financing mechanisms and tracking of expenditures to ensure pro poor service delivery. Within the budgetary process the expert will support the establishment of necessary links to include in the budget of the government recurrent expenditure provisions in view of guaranteeing the sustainability of existing and donor financed structures and investments.

The PFM expert will also assess with other development partners (DPs) providing General Budget Support (GBS) and Sector Budget Support (SBS) the global macro-economic and business environment, the overall budgetary situation and the quality of the public finance system in Rwanda and will support active participation of Belgium in policy dialogue with regard to those issues in the different relevant forums between the Government of Rwanda and its DPs, in particular the Development Partner Coordination Group (DPCG) and the PFM Sector Working Group.

Finally, decentralisation being a priority and cross-cutting theme of the ongoing Rwanda-Belgian Development Cooperation Program, the expert will assess the process and accomplished progress in the area of fiscal decentralisation and its impact on pro-poor service delivery and the efficiency and performance of decentralised structures and decision making, at general level on the one hand and in the health sector in particular on the other hand.

Upon explicit request of DGD the formulation and engagement of the programmed Sector Budget support to health has been fragmented in smaller tranches. These changes have an effect on the risk mitigating and development opportunities (impact) of the whole of the intervention. Not only predictability but also quality of recruitment can be affected by this. The principle to foresee monitoring and expertise until a year after the year of the last disbursement, guarantees the follow up and dialogue linked to the reporting and audits, published one year later. In order to be efficient it is essential that the duration of an expertise contract for policy dialogue is 36 months. Essential is the network and trust that needs to be built in order to access the needed information but also use the entry points for policy dialogue and technical input. Under this period, the value for money is too limited.

The tasks described below in Annex 1 for the international Public Health expert are included in the terms of reference of the public health expert recruited for the "Capacity Development Pooled Fund (CDPF) from July 2013 until June 2015. To assure the monitoring of JHSSIIIa and b until June 2015, from July 2015 until June 2017 the budget is foreseen under the program JHSSIIIb.

PFM expertise is foreseen under the CMO JHSSIIIa until June 2014. In order to follow-up both CDPF and JHSSIIIb another 36 months of expertise will be needed.

Both experts will share their time over both the SBS Health and the participation to CDPF.

3) Technical follow-up from BTC HQ /EST will be assured through annual participation in the Health Sector Joint Review and the bi-annual backstopping missions.

4) A Consultancy budget will be at the disposal of the experts to provide specific studies or workshops, planned with the DPG (in consultation with MoH) and complementary to the action research programme (budgeted in Minisanté 4 and future Health Program in Rwanda). The topics of these studies or workshops are linked to the mechanisms and themes described in 3.1. (eg. around Gender budgeting, ….). Larger studies, planned with the partner, can also be financed through the Belgian-Rwandan Study fund.

The monitoring and inputs foreseen will not be planned in detail because the issues and opportunities in policy dialogue depend on the political dynamics of the moment. [44]

3.2 BELGIAN FOCUS IN POLICY DIALOGUE ('THE WHAT')

It is worthy to highlight that policy dialogue is a dynamic process that looks for new opportunities and therefore focus is likely to vary according to the evolution of the context of the health SWAp. The dialogue is based on:

1/ entry points to be identified within the changing context of the health system in Rwanda. (Short to medium term)

2/ models and principles used by the Belgian Cooperation and reflected in the 'Health policy note of the Belgian Cooperation'. (Long term)

3.2.1 Context-specific entry points (short-medium term)

The identification of entry points and opportunities for policy dialogue always should relate to:

- The national (sub) sector policies and strategies
- The district action plans – district health SWAps
- The priorities of the MoH
- The conclusions and issues raised during the Development Partners Coordination Group, Health Sector Working Group meetings, Joint Health Sector Reviews and Technical Working Groups and the cross-sector working groups such as : PFM sector Working Group, Decentralisation Working Group
- The conclusions of studies and evaluations analysing the (sub)system (such as the assessment in chapter 2)
- The issues raised through action-research at operational level
- Results presented through the sector M&E systems
- Follow up of recommendations of the sector audit

In this way the principle of alignment is respected.

3.2.2 Models and principles of the Belgian Cooperation that lead to behavioural change (long term)

The way of looking at the Rwandan health system by the Belgian Cooperation is based on the **Health Policy Note of the Belgian Cooperation (2009) and the Conceptual Note of Because Health**

[44] No logical framework with specific activities can be developed therefore

(2008)[45]. They constitute two important reference documents for the policy dialogue. Important to mention here is that these notes are inspired by explicit models.

The Belgian support to the health sector in Rwanda is based on a **systemic approach**. A system, in its essence, can be defined as 'actors and their interactions'. Reinforcing the system could therefore be translated as 'contributing to a constructive dialogue between all actors in the system under consideration around common concerns or goals taking context into consideration'. From that perspective it is useful to have in mind the map with the main actors influencing the health system and the main interfaces and texts/conventions regulating the relations between the actors. The way the Belgian Cooperation aims at reinforcing the interactions between the actors is based on explicit models with a clear vision and set of values.

The **model** that is used to analyse and contribute to developing the operational level (district) in order to assure access to quality health services to the population is the Model of the 'Local Health System' (Sylos: 'Système Local de Santé').

It is based on a constructivist vision of the policy cycle promoting dialogue between major stakeholders in the system and on democratic values in order to develop locally adapted policies and services responding to the real needs of the population. (see fig. on learning loops)

Focus on behavioural change (mindshifts) LT

The Belgian focus for accompanying the process of transformation within the Rwandan health sector towards proper access of the population to quality health services, is therefore expressed by **six 'mind-shifts'**.

Box 4: 6 mind- shifts

- A movement from technical quality towards more comprehensive quality ('people centered care'): this means adapting a more holistic attitude towards patients and communities using health services.
- A movement from a hierarchical style of management towards a coaching style of management: this means incorporating the modern principles of people management.
- A movement from arbitrary decision-making towards evidence-based decision-making: this means introducing learning cycles within the functioning of teams of health providers and health managers at various levels.
- A movement from an institutional approach (focused on public health service) towards a systemic approach (focused on interaction between stakeholders related to health): this means supporting the SWAp mechanisms with the involvement of all relevant stakeholders.
- A movement from a vertical approach towards an approach on the principles of an integrated district: this means avoiding parallel systems at the operational level and constructing a functional Local Health System.
- A movement from the focus on 'offer' towards a more balanced focus on both 'offer' and 'demand' of health services.

They will also be the basis for the other modalities within the portfolio of Belgian support to the Rwandan health system.

[45] This conceptual note of Because Health is more technical and served as a basis for the Health Policy Note which is more synthetic and political

3.3 SET UP OF POLICY DIALOGUE ('THE HOW')

3.3.1 Portfolio approach of the Belgian cooperation

One of the basic conditions to assure the quality of the policy dialogue is the link with the reality at operational level. Therefore, the support of the Belgian-Rwandan cooperation to the Rwandan health sector is composed of a **portfolio** of complementary interventions.

These interventions have different entry points:

- At the level of the development partners (political/policy dialogue), there is the Sector Budget Support
- At the central, strategic level within the Ministry of Health (policy/technical dialogue), there is the **institutional support to the Ministry of Health** (MINISANTE 4 – ending December 2014), which also includes the support to the National Program of Mental Health. The contribution to the **Capacity Development Pooled Fund** supports the implementation to Human Resources for Health Strategy. (2013/2014 and 2014/2015). A **new program** will be designed the coming months with the general objective to address the strengthening of quality of primary health care services in Rwanda.
- At the operational level (technical dialogue), there is the support to the integrated development of the **3 urban districts in Kigali** (PAPSDSK ending December 2013) and 3 **rural districts** (Gakenke, Rulindo, Bugesera within the intervention MINISANTE 4 – ending December 2014). In the Indicative Cooperation Program mentions also the support this level within the sector for the new program

The **anchorage** of the portfolio **at different levels** stimulates a unique dynamic of interaction between operational and strategic levels. It allows a consistent follow-up of results in terms of access to quality services and development of adequate policies.

In the design of the Sector Budget Support, the objective is to evolve from a portfolio of isolated interventions at various levels of a sector to a portfolio with active relations between all actors, working towards common objectives. This internal coordination with active interrelations between the various interventions has been developed in the course of the last 5 years.

3.3.2 Coordination within the Health Sector and Cross-sector dialogue

In the table below, a proposition is made on required and voluntary participation of the various actors in the existing structures or fora.

The Vademecum on Belgian budget support gives guidance on this, but consensus will be sought at local level, according to specific relations, capacities and responsibilities of the various actors involved.

Table 11: Required and voluntary participation of the various actors in the existing structures or fora.

Event	Required	Voluntary	Periodicity
Joint Health Sector Review	- Attaché - Both experts - BTC Bxl (once a year)	- ResRep - DGD Bxl	Every 6 months: Sept/Oct backward looking – March/April forward looking
HSWG meeting	- Attaché - Both experts	- ResRep	Quarterly

DPG Health meeting	- Attaché - Both experts		Monthly (ordinary meetings)
Technical Working Groups: - Planning, M&E and HIS - Quality of standards - HRH – Steering committee of CDPF - Health Financing	- Public health expert Both (or either) expert(s), according to relevance of topic on the agenda - PFM expert		Monthly (ordinary meetings)
Cross-sector dialogue Governance and Decentralisation Working group Public Finance Management Sector Working Group Development Partner Coordination Group	Attaché, with input from PFM expert/TA Decentralisation program Attaché, PFM expert Attaché, PFM expert		(in principle) Bi monthly Bi monthly Bi monthly

In addition to their on-going participation in Technical Working Groups, the experts will participate in quarterly meetings of the HSWG (highest level forum between the DP and MoH) and in all DPG meetings where they will play an active role in providing technical support to the group. We also strongly encourage them to be actively involved in the Budget Support Harmonisation Group (BSHG), and in assisting the DPG to provide input on the performance of the health sector for the Common Performance Assessment Framework (CPAF) in the context of the JBSR, alongside the Attaché. Other working groups that are of interest for the Belgian support to Rwanda, where technical expertise and exchange of experience from the health sector is relevant are the working groups on Decentralisation and PFM.

The Attaché is the main actor in policy dialogue on political issues at sector level. In this context, a close working relationship between the BTC health team (TA and Budget support experts included, see also next section) and the Attaché is necessary. The experts will continue to hold an advisory role towards the Attaché (as member of the DPG) who will have to consult the experts on a regular basis in

order for the Embassy to be best informed on the evolution of the health sector in view of the role it has to play in the policy and political dialogue with other development partners and high level representatives of the Government of Rwanda. Therefore continued active participation of the Attaché in the bi-monthly HSWG and monthly DPG meetings is recommended, as these platforms provide space for Belgium to voice its concerns and express its position.

3.3.3 Coordination within the Belgian portfolio in Health

The coordination mechanism for the Belgian direct bilateral support to the health sector consists of different fora:

- The coordination at the level of Sector Budget Support is assured at two levels. First of all, the Attaché (health) coordinates the political dialogue (regarding the health sector) at the level of the Belgian Cooperation. This is done with the support of the public health and PFM experts, and with the input of the 'health coordination group of the Belgian Cooperation. Secondly, the experts work in consultation with the donors that are part of the Development Partners Group (regarding the content of the work, i.e. to identify areas that require attention, specific analysis and/or where BTC adds value).
- The '*Groupe de Coordination santé de la Coopération Belge'* includes the team of the Belgian side: it consists of the international TAs/JAs, Budget support experts, ResRep, BTC Programme Officer and the Attaché. One of the TAs presides this meeting, on a rotating basis. This group harmonizes the point of view on the Belgian side and assures the coherence of this approach. This mechanism does not replace the country specific interfaces of coordination, but feeds them with relevant experiences and reflections. The approach of this structure needs to be dynamic and adapted to the context. Organisation differs when the number of TAs went from 11 to 5 at the moment.

These mechanisms assure that there is a common objective and coherent behaviour from all Belgian actors (BTC-Embassy; project-SBS,…) and linked to other actors in the sector.

The Resident Representative of BTC represents the BTC in the field and is therefore the hierarchical superior of the two experts. He assures their supervision regarding the administrative and HR aspects linked to their role as budget support advisors. To this effect, the ResRep will check that the experts are effectively fulfilling their tasks as provided in their ToR (see Technical Note and CMO). The experts will draw a list of their activities and tasks undertaken over the past quarter in an annex to their progress reports. Quality assurance of the draft reports will be done first by the Departments of Expertise (for progress reporting) and Finance (for the disbursement reports) in BTC Brussels, then by the ResRep who officially submits the reports to the Attaché.

3.4 DISBURSEMENT CONDITIONALITIES AND FINANCIAL PLANNING

3.4.1 Disbursement conditionalities

The proposal of the disbursement conditionalities is based on:

- Aide Mémoire of the Sector budget Support donors (Belgium and Germany) (2007)
- Agreements between the MoH and SBS donors during the implementation of the HSSP II
- Memorandum of Understanding between the Ministry of Health and Health Sector Development Partners
- Vademecum for Belgian Budget Support (2008) and Annexes (2011)

Reference is made to the existing documents to improve the clarity of the reporting demanded.

Instead of limiting conditions to input or system conditions, it is proposed to slowly move and integrate

some **conditions that are more performance oriented**. Hereby we respect harmonisation principles and do not add specific indicators to an existing joint sector monitoring framework on sector performance. The sector CPAF indicators also feed into a more general monitoring framework of General Budget Support.[46] This link with the monitoring of GBS is at the moment rather weak. Integrating a part of the overall framework into the Belgian sector Budget Support conditions strengthens the Belgian participation in this evaluation.

Minimal conditions for disbursement in N are:

- Joint Annual Work plan and budget N
- Technical and financial report N-2
- Annual Sector audit N-2 (OAG Audit)

Additional conditions to evaluate during disbursement:

- CPAF Health indicators N-2 (at least 60% needs to be evaluated as green and yellow)

Example for the disbursement in 2014 (FY 2014/15)

- Joint Annual Working plan and budget 2014/15
- Technical and financial sector report 2012/13
- Annual Sector audit 2012/13
- CPAF Health Indicators 2012/13

As a measure of control: all these elements need to be available to be able to execute the disbursement and to assure the predictability of the Belgian SBS contribution.

Box 5: Guiding principles on use of financial audits for Belgian Budget Support : elements to be clarified in the MoU and the Specific Agreement

- A provision stating that, in case of a negative audit, the donors can delay the budget support;
- The partner authority must draw up a “management response” after every negative audit report. Both documents are sent to the donor group.
- How, in case of a possible negative audit, communication with the authority is conducted, and how the measures announced in the “management response” will be followed up;
- What sanctions can be expected in case of serious shortcomings (repayment of funds by the national authority, or reduction of the following contribution of the donors)
- And finally, how arrangements will be made about any adaptations to the shared procedures for budget support (adaptations to the MoU, the Joint Financing Arrangement, the Vademecum or the Procedures manual).
-

3.4.2 Disbursement calendar

After assessing the context of our contribution to the sector (including other donor plans) and taking into account the good practice principles for budget support and risk mitigating measures, the following disbursement scheme was approved :

The calendar is developed according to the FY of Rwanda (July to June) but a translation has been done in the presentation to the Belgian FY.

[46] Table 2 pg 10 probably will be updated by Table 9 pg 44

FY RWA	2008	MB2009	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
FY BEL	2008	2009		2010	2011	2012	2013	2014	2015
Belgium	4.000.000		4.000.000	5.000.000	5.000.000		9.000.000	9.000.000	9,000,000
KFW			6.000.000	3.500.000	3.500.000				
DFID	4.479.283		3.359.462	2.799.552	559.910		1.795.500		
Global fund								To be defined	To be defined
Total	**8.479.283**	**0**	**13.359.462**	**11.299.552**	**9.059.910**		**10.851.852**	**10.851.852**	**10,851,852 ?**
GBS UK							44.289.000	To be defined	To be defined
GBS EC							35.750.000	To be defined	To be defined
	HSSPI		HSSP II			HSSP III			
The contribution of DFID 2013-14 w as committed but canceled due to Division of Labour									

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5 ANNEXES

5.1 ANNEX 1: TOR OF BUDGET SUPPORT EXPERTS

5.1.1 Terms of Reference of the International Public Health expert

5.1.1.1 Tasks

A. Support to the Belgian Cooperation

- Provide technical and policy advice to the Attaché with regard to his/her positioning on policy and political issues
    - Provide the Attaché with an analysis of the health sector performance prior to both the Joint Health Sector Reviews (JHSR) and the Joint Budget Support Reviews (JBSR) and make sure that public health concerns are addressed.
    - Make sure that the new policies and/or critical issues raised in TWG meetings are brought up, in due time, to the attention of the Attaché.
- Contribute actively to the existing technical coordination mechanisms, Groupe de Coordination Santé, of the Belgian support to the Health sector so as to promote a shared vision and a coherent approach; including the scientific support dynamics.
- Provide quarterly reports (2 progress reports, 1 annual report and a disbursement report) with regard to programme implementation and policy dialogue, as provided in the Vademecum for Budget Support. Quality assurance of the reports will be done first by the Departments of Expertise (for progress reporting) and Finance in BTC Brussels, then by the ResRep, who officially timely submits the reports to the Attaché.
- In particular, for the disbursement report, the adviser will systematically check whether the conditions for disbursement as defined in the Specific Agreement are met. She/he will, after internal quality check, formulate a clear advice to the Attaché in this respect. The Attaché will submit the Report with his advice to the Inspector of Finance and BTC HQ.
- Support the implementation of the health bilateral program as defined in the PIC 2011-2014, taking into account the evolution of international context
- Occasionally provide support upon request to health programmes within other partner countries of the Belgian Cooperation.
- Occasionally participate in international seminars, conditioned by the approval of the ResRep of BTC and in consultation with the Attaché.

B. Support to the SWAP coordination mechanisms

- Contribute to the achievement of more effective aid to the health sector through improved harmonisation, coordination of DPs and their alignment to the Sector Strategic Plan and policies, according to the principles of the Paris Declaration, Rwanda's Aid Policy Manual and the MoU for the health SWAp.
- Actively participate in the SWAp Committee meetings. Contribute to the sector-wide approach implementation at district level and strengthen this approach at central level.
- Actively participate in the Technical Working Groups (TWG) meetings relevant for the JHSS program follow-up in which the expert can provide valuable contributions (e.g.

Health System Strengthening TWG, Human Resources for Health TWG, Governance/decentralization TWG.)

- Actively participate in the monthly Development Partners Group (DPG) meetings and in the bi-monthly Health Sector Working Group (HSWG) meetings.
- Actively participate in the (preparatory) meetings of the bi-annual Joint Health Sector Reviews (JHSR) as well as in the drafting of the JHSR joint summary reports together with the Attaché, other DPs and the MoH representatives..
- Advise the Attaché and other DPs contributing to the Capacity Development Pooled Fund and actively participate in the CDPF DP meetings and Steering Committee meetings.
- Give feedback to the DPs on matters pertaining to health development in Rwanda, paying particular attention to the health-related cross-cutting issues, in particular those which are key for Belgium.
- Establish, develop and maintain good working relations with the Government ministries (namely MINISANTE, MINALOC, MINECOFIN, Local Governments), institutions and all partners involved in the sector.
- Develop, maintain and share an in-depth knowledge and understanding of the programme, including through field visits and networking with local actors.
- Follow, together with development partners, evolutions in international policies and discuss consequences and opportunities for the health sector in Rwanda.

C. Support to the overall functioning of the Rwandan health system

- Follow-up and analysis of the implementation of the Health Sector Strategic Plan (HSSP III).
- Monitor identified risk factors and constructively collaborate with the partner authorities within the framework of the policy dialogue to implement mitigation actions, with a strong emphasis on the quality of health care at decentralized level.

  In particular:

  - Pay attention that strategic plan implementation remains focused on quality improvement of the service delivery.
  - Facilitate the improvement of the monitoring and evaluation framework
  - Contribute to institutional capacity development.
  - Monitor the effects of the HR policy at district level (eg. availability and turnover of staff in rural areas, training and accreditation of doctors in district hospitals, development of curricula of training schools, motivation strategies including the impact of PBF
  - The development of an adapted package of care at different decentralized levels according to needs.
  - The quality of medicines.
- Support coherence and linkage of the JHSS programme with the experience and outputs of partners as well as other relevant programmes and projects from other donors.

- Promote action research and capitalisation of experiences that are relevant to further develop national policy. Where possible, take initiative for research and empirical studies in the sector and/or accompany them.
- In collaboration with other donors, initiate a political economy analysis on the SWAp process.
- Monitor transformation within the health sector based on the six mind-shifts described in the technical note[47]
- Identify opportunities and create specific entry points for dialogue in view of reinforcing the health system.

Work modalities

Work under the leadership of the Belgian BTC Resident Representative (ResRep) and in collaboration with the PFM expert, other Technical Assistants and the Attaché in order to ensure the overall coherence of the Belgian health portfolio. The BTC ResRep represents the BTC in the field and is therefore the hierarchical superior of the experts.

5.1.2 Terms of Reference of the Public Financial Management expert

5.1.2.1 Tasks

A. Support to the Belgian Cooperation

- Provide technical and policy advice to the Attaché with regard to his/her positioning on policy and potential political issues:
  - Provide the Attaché with an analysis of the budget planning/execution prior to both the Joint Health Sector Reviews (JHSR) and the Joint Budget Support Reviews (JBSR) and make sure the budgetary concerns are addressed.
  - If and when required provide the Attaché with information and advice on PFM matters arising within the Development Partner Coordination Group (DPCG).
  - Make sure the new policies and/or critical issues raised in TWG meetings are brought up, in due time, to the attention of the Attaché.
- Contribute actively to the existing technical coordination mechanisms (Groupe de Coordination Santé) of the Belgian support to the Health sector by exchanging information on health financing issues, so as to promote a shared vision and a coherent approach; including the scientific support dynamics.
- Provide quarterly reports (2 progress reports, 1 annual report, 1 disbursement report) with regard to programme implementation and policy dialogue, as provided in the Vademecum for Budget Support. Quality assurance of the reports will be done first by the Departments of Expertise (for progress reporting) and Finance (for the disbursement reports) in BTC Brussels, then by the ResRep, who officially timely submits the reports to the Attaché.
- In particular, for the disbursement report, the adviser will systematically check whether the conditions for disbursement as defined in the Specific Agreement are met. She/he will, after internal quality check, formulate a clear advice to the Attaché in this respect. The Attaché will submit the Report and his advice to the Inspector of Finance and BTC HQ.

[47] Technical Note pt. 3. Page 52

- Support the implementation of the health bilateral program as defined in the PIC 2011-2014, taking into account the evolution of the international context.
- Occasionally provide support upon request to health or budget support programmes within other partner countries of the Belgian Cooperation.
    - Occasionally participate in international seminars, conditioned by the approval of the ResRep of BTC and in consultation with the Attaché.

B. Support to the SWAp coordination mechanisms

- Contribute to the achievement of more effective aid to the health sector through improved harmonisation, coordination of DPs and their alignment to the Sector Strategic Plan and policies, according to the principles of the Paris Declaration, Rwanda's Aid Policy Manual and the MoU for the health SWAp.
- Actively participate in the SWAp Committee meetings. Contribute to the sector-wide approach implementation at district level and strengthen this approach at central level.
- Actively participate in the Technical Working Groups (TWG) meetings relevant for the JHSS program follow-up in which the expert can provide valuable contributions (e.g. Health Financing TWG, M&E TWG, Governance/decentralization TWG)
- Actively participate in the monthly Development Partners Group (DPG) meetings and in the bi-monthly Health Sector Working Group (HSWG) meetings.
- Actively participate in the (preparatory) meetings of the bi-annual Joint Health Sector Reviews (JHSR) as well as in the drafting of the JHSR joint summary reports together with the Attaché, other DPs and the MoH representatives.
- Actively participate in the Joint Budget Support Reviews and in relevant preparatory meetings, strengthening the link between PFM at sector level and macro level.
- Actively participate in the wider PFM and decentralisation dialogue, contribute with evidence and analysis from health sector level including the functioning of the PFM-system within the sector at district level. Coordinate with evidence and experiences of the Belgian program in support of the decentralisation process (fiscal decentralisation).
- Liaise with other DPs engaged in Sector/General Budget Support and participate in the PFM-related joint missions (eg: PEFA, FRA etc.) when appropriate.
- Analyse budget planning, budget execution, financial reporting, internal and external control systems in the health sector at central and local level and support the actors in the health sector in these matters.
- Analyse the annual report of the Office of the Auditor General (OAG), share findings with DPG (in particular with SBS donors) and follow up on the recommendations and corrective measures with MoH.
- Actively participate in the meetings organised with the SBS DPs, MoH and MINECOFIN.
- Advise the Attaché and other DPs contributing to the Capacity Development Pooled Fund on the financial management issues of the CDPF and actively participate in the CDPF DP meetings and Steering Committee meetings.

- Establish, develop and maintain good working relations with the Government ministries (namely MINISANTE, MINALOC, MINECOFIN, Local Governments), institutions and all partners involved in the sector.
- Develop, and share knowledge and understanding of the programme, including through field visits and networking with local actors.
- Follow, together with development partners, evolutions in international policies and discuss consequences and opportunities for the public financial management system in Rwanda.

C. Support to the overall functioning of the Rwandan health system

- Follow-up and analysis of the implementation of current Health Sector Strategic Plan (HSSP III).
- Monitor identified risk factors and constructively collaborate with the partner authorities within the policy dialogue to implement mitigating actions. In particular:
    - Analyse Health budget and expenditure within the sector and within the national budget and share information with relevant stakeholders.
    - Analyse annual audit reports available at the time of contract, share and discuss findings with DPG, MoH and MINECOFIN and follow up on recommendations and issues addressed in the reports.
- Present recommendations on planning, budget allocations and expenditures and PFM issues at sector level to the HSWG and Health financing TWG.
- Support coherence and linkage of the JHSS programme with the experience and outputs of partners as well as other relevant programmes and projects from other donors.
- Look at the integration and use of Gender-Responsive Budgeting (GRB) for health. He/she will support the Ministry in developing capacity in this area. Since Rwanda has a National Gender Policy in place, this new budget support will provide an opportunity for more analysis and insight on how GRB is being mainstreamed in the health sector.
- Follow up on development of the PFM system at hospital and health service level.
- Support the development, effective financing and implementation of strategies that will increase the likelihood of achieving the Health MDGs within the framework of the SWAp, long-term financing scenarios for the sector, and the EDPRS.
- Support the GoR in strengthening overall monitoring and evaluation in the health sector, ensuring that GoR systems – in particular the bi-annual Joint Health Sector Review – meet the needs of all stakeholders, including Development Partners.
- Do sufficient field missions to test the progress in managing health finances at district level and within health services.
- Identify opportunities and create specific entry points for dialogue in view of reinforcing the health system.

Work modalities

Work under the leadership of the Belgian BTC Resident Representative (ResRep) and in collaboration with the Public Health expert, other Technical Assistants and the Attaché in order to ensure the overall coherence of the Belgian health portfolio. The BTC ResRep represents the BTC in the field and is therefore the hierarchical superior of the experts.

5.2 ANNEX 2: SPECIFIC AGREEMENT

SPECIFIC AGREEMENT

Between

The Kingdom of Belgium

and

"The Republic of Rwanda"

on

"Joint Health Sector Support IIIb (JHSS IIIb)"

The Kingdom of Belgium, hereinafter referred to as “Belgium”,

and

The Republic of Rwanda, hereinafter referred to as “Rwanda”,

hereinafter jointly referred to as “the Parties”;

- Considering the “General Agreement on Direct Bilateral Co-operation between Rwanda and Belgium,” signed in Kigali, on May 18th 2004;
- Considering the agreed minutes of the Joint Commission on Development Co-operation between the parties, held in Kigali on May 18th 2011, Annex 8 “Belgium-Rwanda Indicative Development cooperation Program (IDCP) 2011-2014”
- Considering the Memorandum of Understanding (MoU) for joint monitoring between the Government of Rwanda and the Health Sector Development Partners, Regarding Partnership Principles for Support to the Health Sector, signed on the 17th of October 2007
- Considering the Common Performance Assessment Framework agreed between the Government of Rwanda and the Development Partners providing General and Sector Budget Support
- Considering the EDPRSII Performance and Policy Matrix agreed Between the Government of Rwanda and the Development Partners

AGREE AS FOLLOWS:

Article 1: Definition and object of the agreement

The Specific Agreement concerns the participation of Belgium in the realization of the objectives of the HSSP III, developed for the period 2012-2018.

The overall goal of HSSP III is to Ensure universal accessibility (in geographical and financial terms) of quality health services for all Rwandans.

This objective will be attained through the implementation of 4 components

1. The Programs that provide preventive, promote, curative and rehabilitative care
2. Health Support systems needed to allow programs to deliver results
3. Governance providing leadership and guidance on policy development, coordination, quality control, fund raising and oversight/monitoring of implementation
4. Health service delivery, that is being determined by the three components above, through the quantity and quality of services that are provided at the levels of the community, the district health services and the National Referral Hospitals

Article 2: Responsibilities of both Parties

2.1 The Belgian Party designates :

2.1.1 The “Directorate General for Development Cooperation”, of the Federal Public Service Foreign Affairs, Foreign Trade and Development Cooperation, hereinafter called DGD, as the Belgian administrative entity, responsible for the Belgian contribution. DGD is represented in Rwanda by the Attaché for International Cooperation based in the Embassy in Kigali

2.1.2 The "Belgian Technical Cooperation", hereinafter referred to as BTC, as the Belgian entity responsible for the Belgian participation in the monitoring of the implementation of the JHSS III and the transfer of funds. BTC is represented in Rwanda by its Resident Representative in Kigali.

2.2. The Rwandan Party designates :

2.2.1. The Ministry of Economy and Finance (MINECOFIN) as the Rwandan administrative entity, responsible for the Rwanda contribution to the HSSP III

2.2.2. The Ministry of Health (MINISANTE) as the Rwandan entity responsible for the implementation of the HSSP III.

Article 3: Contribution of the Parties

3.1 The Belgian grant to the HSSP III is 18.000.000 € for the financial years 2014/15 and 2015/16 The Belgian contribution to the sector budget will contribute to an annual increase in the allocation to the Health budget, during this period.

A first instalment of 9.000.000 € for the Rwandan budget year 2014/15 will be transferred after submission of :

- *Annual work plan and budget 2014/15*
- *Technical and financial sector report on FY 2012/13*
- *Annual Sector Audit on 2012/13*
- *General Satisfactory evaluation of the CPAF Health Indicators 2012/13*

A second instalment of 9.000.000 € for the Rwandan budget year 2015/16 will be transferred after :

- *Annual work plan and budget 2015/16*
- *Technical and financial sector report on FY 2013/14*
- *Annual Sector Audit on 2013/14*
- *General Satisfactory evaluation of the CPAF Health Indicators 2013/14*

Belgium will transfer its contribution to the SBS foreign Exchange account at the National Bank of Rwanda as will be specified by the Ministry of Economy and Finance (MINECOFIN).

Within a month of the transfer being made by Belgium, the National Bank of Rwanda will issue a receipt to the BTC Resident Representative in Kigali, confirming the amount received and the bank account to which it was lodged.

3.2 In case of a negative audit, a management response is needed. An action plan for implementation of the management response needs to be presented by the country and approved by the development partners. This is a sufficient condition for the transfer of funds.

Article 4: Monitoring, Control and evaluation

4.1 The parties shall take all necessary administrative and budgetary measures to achieve the objectives of this Specific Agreement, including joint or separate technical, administrative and financial control and evaluations as mentioned in the MoU. The Parties shall inform each other about the results and possible recommendations of these control and evaluation exercises.

4.2 The Joint Health Sector Review shall be held at least once a year. The mission will review the performance of the sector during the previous year and agree on sector priorities and resource allocation for the next financial year.

4.3 BTC is responsible for the Belgian participation in the monitoring of the implementation of the program in close collaboration with the Attaché for International Cooperation at the Embassy of Belgium in Kigali. The Belgian technical expertise, provided by BTC and based in Kigali will work closely with the other Development Partners and within the existing framework of monitoring mechanisms.

4.4 Belgian focus in policy dialogue will be on :

- The development of a stable and sustainable health system
- The implementation of the national decentralisation reform process, with assurance of good service delivery and local as well as technical oversight.
- Good internal coordination of technical debate and decision making for the health sector
- The development of an inclusive health system for the whole of Rwandan population

Article 5: Entry into force, Duration, Modifications and Termination

5.1. This Specific Agreement will enter into force on the date of its signature by both parties.

5.2. This Specific Agreement is valid for a period of 36 months starting from its date of signing.

5.3. The provisions of this Specific Agreement may be modified by mutual agreement between the Parties, through exchange of letters.

5.4. Any disputes related to the application and interpretation of this Specific Agreement shall be settled through bilateral negotiation.

5.5. This Specific Agreement may be denounced by each of the Parties, through verbal note, subject to a six months' notice.

Article 6: Notifications

All notifications related to this Specific Agreement and more specifically modifications and interpretations of this Agreement, shall be communicated through diplomatic channels at the following addresses:

for Rwanda, to

The Permanent Secretary

Ministry of Economy and Finance

P.O. Box 158

KIGALI

for Belgium, to

Embassy of Belgium

P.O. Box 81

KIGALI

All notifications related to the execution of this Agreement shall be addressed at following institutions:

for Rwanda, to

Ministry of Health

P.O. Box 84

KIGALI

for Belgium, to

BTC Rwanda

P.O. Box 6089

KIGALI

Article 7: Final dispositions

In witness whereof, the undersigned, duly authorized thereto, have signed the present Specific Agreement.

Done in duplicate at KIGALI , on the ______________________

in the English language, both copies being equally authentic.

For the Republic of Rwanda

Name

Minister of Foreign Affairs

and Cooperation

For the Kingdom of Belgium

Name

Ambassador

5.3 ANNEX 3: BUDGET FOR THE CONVENTION DE MISE EN ŒUVRE

Code Budget	Description des postes budgétaires	Code Tâche	Code Secteur	Coût unitaire	Nombre	COUT TOTAL CONTRIBUTION BELGE	2014		2015		2016		2017	
							S1	S2	S1	S2	S1	S2	S1	S2
A_01_01	**Prix : *Expertise***													
	Expert(e) santé publique	Régie	12110	15,000	24	***360,000***				90,000	90,000	90,000	90,000	
A_01_02	Expert(e) Gestion Finances Publiques	Régie	12110	15,000	36	***540,000***		90,000	90,000	90,000	90,000	90,000	90,000	
A_01_03	Missions des 2 experts	Régie	12110	4,000	6	***24,000***		4,000	4,000	4,000	4,000	4,000	4,000	
A_01_04	Coûts de fonctionnement par expert	Régie	12110	400	60	***24,000***		2,400	2,400	4,800	4,800	4,800	4,800	
A_01_05	Investissements	Régie	12110			***0***								
A_01_06	Participation Review mission expert CTB (siège)	Régie	12110	6,000	2	***12,000***				6,000		6,000		
A_01_07	Consultancy (Audit & analyses technique, conseil, évaluation, …)	Régie	12110	25,000	2	***50,000***				25,000		25,000		
	SOUS TOTAL					***1,010,000***	**0**	**96,400**	**96,400**	**219,800**	**188,800**	**219,800**	**188,800**	
	Prix: *Bénéfices*													
	1%					***10,100***	0	964	964	2,198	1,888	2,198	1,888	
	SOUS TOTAL PRIX					***1,020,100***	***0***	***97,364***	***97,364***	***221,998***	***190,688***	***221,998***	***190,688***	
B_01_01	**Don: Contribution au "JHSS III"**													
	Art. 3 Convention Spécifique	Aide budgétaire	12110			**18,000,000**	0	9,000,000		9,000,000				
	SOUS TOTAL DON					**18,000,000**	0	9,000,000	0	9,000,000	0	0	0	
	TOTAL					**19,020,100**	**0**	**9,097,364**	**97,364**	**9,221,998**	**190,688**	**221,998**	**190,688**	

l'année 2014/15 pour l' expert santé publique et suivi HQ sont financés sur CMO CDPF RWA 1208711

5.4 Annex 4 - Detailed activities as per Health Sector

Functions	Central Government	Local Government
Human resources for health	- Recruitment/contracting (Doctors, Nurses, M& E, DHPPO and DHPO) - Deployment (Doctors, Nurses, M& E, DHPPO and DHPO) - Training/capacity building - Remuneration - Evaluation(Doctors, Nurses, M& E, DHPPO and DHPO) - Promotion and - Demotion of staff	- Recruitment plan - Recruitment/contracting(Health h Institution Support staff, DDH and Mutuelles and pharmacy staff) - Training/capacity building - Remuneration(administration of salaries for all health staff) - Evaluation - Promotion and - Demotion of staff
Financial accessibility	- Procedures/frameworks for budgeting - Mobilising resources - Allocating resources - Distributing resources	- Mutual health system administration at district level
Geographic accessibility	- Building construction and rehabilitation - Water and Energy provision - Equipment provision and maintenance - Transportation facilitation - IT and communication infrastructure provision	- Procurement of works - Management of infrastructures and equipment - Maintenance of infrastructures and equipment
Drugs, vaccines and consumables	- Procurement plan - Procuring/contracting - Ordering and receiving - Distribution - Storing/keeping - Pricing policy - Local production	- Ordering and receiving of drugs - Storing of drugs - Distribution of drugs
Quality assurance	- Defining measurable indicators	- Monitoring and evaluation

5.5 ANNEX 5: RURAL DISTRICT ORGANOGRAM JULY 2010