HEALTH IN RWANDA IS IMPROVING!

MID TERM REVIEW (MTR) OF THE RWANDA

SECOND HEALTH SECTOR STRATEGIC PLAN

(HSSP II, JULY 2009 – JUNE 2012)

External Evaluation Team

18th July – 03rd August 2011

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International Health Partnership + Related Initiatives

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Jarl Chabot,
Addis Ababa, 30.08.2011

Rwanda MTR / JANS, team composition

The MTR and JANS was carried out by an international team of experts together with national counterparts

Team members

Mr Abebe Alebachew	Health Financing, Health Systems	Breakthrough International Consult, Ethiopia
Mrs Diane Muhongerwa	Health Financing, PBF - CBHI	WHO, Kigali
Dr Mohamed Lamine Dramé	Public Health, Disease Control	Department for Health System Governance and Service Delivery, WHO-HQ/Geneva
Dr Jarl Chabot	Public Health, MCH, Team Leader	ETC Crystal, Netherlands
Dr Manasse Nzayirambaho	Public Health, Training	School of Public Health, Kigali
Ms Torun Reite	Public Financial Management and Procurement	Scan team, Norway
Dr Vincent Rusanganwa	Public Health, Health Systems	MOH, Medical Education & Research, Kigali

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SECTOR PERFORMANCE INDICATORS HSSP I + II, 2005 – 2011
(Baseline 2005 – 2011 and targets 2012 and 2015)

INDICATORS	BASELINE 2005	MTR June 2008	MTR Aug 2011	TARGET 2012	TARGET 2015
Source of Information	DHS2005	I-DHS	DHS2010	EDPRS	MDGs
IMPACT INDICATORS					
Population (Million)	8.6 M	9.31 M	10.4 M		
Infant Mortality Rate / 1000	86	62	50	37	28
Under Five Mortality Rate / 1000	152	103	76	66	47
Maternal Mortality Ratio / 100.000	750	590**	forthcoming	600	268
Total Fertility Rate (%)	6.1	5.5	4.6	4.5	
OUTCOME INDICATORS					
Prevalence of underweight (Wt/Age)	18	NA	11	14	14.5
Prevalence of Stunting (Ht/Age)	51	NA	44	27	24.5
Prevalence of Wasting (Ht/Wt)	5	NA	3	2.5	2
CPR among married women (%)	17	36	52	70	
% Births attended by skilled HW/HF	39	45	69	75	
% PW receiving 4 ANC Visits	13	24	35	50	
Caesarian Section Rate %		NA	12.5*	NS	
% Women / Men (15-49 yr) reporting condom use in most recent high risk sex intercourse	26 / 39	NA	91/92	35 / 50	
HIV Prevalence Rate in 15-24 yrs %	1.0	NA	forthcoming	0.5	
Number HF with VCT / PMTCT services	234	374VCT, 341 PMTCT*	404 VCT, 434 PMTCT*	433	
% HF providing IMCI services		80	100	50	
% Children Fully immunized / Measles	75 / NA	80 / 75	90 / 95	85	
Malaria Prevalence Women / Children (%)	NA	1,4 / 2,6	0,7 / 1,4	0.7 / 1.4	0.4 / 0.7
% children < 5 yr sleeping under ITN	18	60	70	90	
% TB Treatm Success Rate / DOTS	58	86	85*	87	
Prevalence of Anemia (children 6-59)	56	40	38		
% children 6-59 months, with one dose Vitamin A in last 6 months	69	+/- 50	108*		
Average OPD attendance / pp / yr	0,33	0,72	0,95*	0.8	
INPUT INDICATORS					
# District hospitals / HCs		40 / 406	42 / 438		
# Community Health Workers (CHW)		NA	60.000		
Per capita GDP Growth rate (USD)	7.1	6.3	NA	NA	
% of GOR budget allocated to health	8.2	9.1	11.5	12	
Pc annual GOR expenditure on health (USD)	6.0	11.1			
% Population covered by 'mutuelles'.	12	75	91	91	
Per capita allocation to PBF (USD)	NA	1.65	1.8	2.0	
% MOH budget to districts (grant)	11.1 (2006)	17.9	40		
Doctor / Pop Ratio	1 / 50.000	1 / 33.000	1 / 17.240	1 / 20.000	1 /
Nurse / Pop Ratio	1 / 3.900	1 / 1.700	1 / 1.294	1 / 5.000	1 /
Midwives / Pop Ratio	NA	1 / 100.000	1 / 66.749	1 / 20.000	1 /

Italics = Included in CPAF as part of SBS funding; NA = Not Available.
* = MOH Statistical Booklet 2008 and/or Annual report 2010.
** = Murray et al. Maternal Mortality for 181 countries, 1980–2008: a systematic analysis of progress towards MDG 5.

ABBREVIATIONS AND ACRONYMS

ACAME	Association des Centrales d'Achats Africaines des Médicaments Essentiels
ACM	Central Maintenance Workshop (Atelier Central de Maintenance)
ACT	Artemisinine Combination Therapy
AIDS / SIDA	Acquired Immuno-Deficiency Syndrome
ANC / CPN	Ante Natal Care/ Consultation Pre-Natale
AOP	Annual Operational Plan (at district levels)
AR	Annual Report
ASRH&R	Adolescent Sexual and Reproductive Health and Rights
ARI	Acute Respiratory Infections (=IAVRI)
ART / V	Anti-Retroviral Treatment / Drugs
ASC / CHW	Agent de Santé Communautaire / Community Health Worker
BCC	Behavioural Change and Communication
BEOC	Basic Emergency Obstetric Care
BOR	Bed Occupancy Rate
BTC / CTB	Belgian Technical Cooperation / Coopération Technique Belge
BUFMAR	Office for the Non-for-profit Medical Facilities in Rwanda
CAMERWA	Central d'achat des medicaments essentiels du Rwanda. Central Drug Purchasing Agency in Rwanda (ED)
CBC	Communication for Behaviour Change
CBD	Community Based Distribution (of contraceptive commodities)
CBHI	Community Based Health Insurance schemes (= Mutuelles)
CBNP	Community Based Nutrition Programme
CBO	Community Based Organisations
CDC	Centre for Disease Control
CDR	Case Detection Rate (TB)
CDT	Centre for Diagnosis and Treatment (TB) / Centre de Dépistage et Traitement
CDLS	Commission District de Lutte contre le SIDA
CDPF	Capacity Development Pooled Fund
CDV	Conseil et Dépistage Volontaire (see VCT)
CEPEX	Central Public Investment and External Finance Bureau
CEmOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CHU	Centre Hospitalo-Universitaire
CHUB	Butare University Hospital (teaching hospital)
CHUK	Kigali University Hospital (teaching hospital)
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Child Illnesses
CNF	Conseil National des Femmes
CNLS	National AIDS Commission / Commission Nationale de Lutte contre le SIDA
CNTS	National Blood Transfusion Centre / Centre National de Transfusion Sanguin
COC	Code of Conduct
CPAF	Common Performance Assessment Framework (used for GBS and SBS donors)
CPN	Consultation PréNatale (=ANC)
CPR	Contraceptive Prevalence Rate
CS	Centre de Santé (= HC)
CS	Caesarian Section
CSO	Civil Society Organisations
CSR	Civil Service Reforms

CTB	Coopération Technique Belge (Belgian Technical Cooperation)
DBS	Direct Budget Support (=GBS)
DDP	District Development Plan
DFID	Department of International Development
DH	District Hospital
DHEd	Division for Health Education
DHS+	Demographic and Health Survey (+ = with HIV testing, done in 2005)
DIP	Decentralised Implementation Plan
DMU	Disaster Management Unit
DOTS	Directly Observed Treatment Scheme / Short Course
DP	Development Partners
DPEM	District Plan to Eliminate Malnutrition
DPH	Division of Public Hygiene (within MOH)
DPT	Diphtheria, Pertussis and Tetanus
DSS	Department of Health Care (Département des Services Sanitaires)
EBF	Exclusive Breast Feeding
ED	Essential Drugs
EDPRS	Economic Development and Poverty Reduction Strategy
EDSR	Enquête Démographique et de Santé au Rwanda (=DHS)
EHCP	Essential Health Care Package
EHP	Environmental Health Policy (July 2008)
EPI	Expanded / Enlarged Programme for Immunisation
ESP	School of Public Health (SPH)
FAMCO	Family and Community Medicine Masters Programme (4 years)
FBO	Faith Based Organisation
FM	Financial Management
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support (=DBS)
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, TB and Malaria (=GF)
GHI	Global Health Initiative
GOR	Government of Rwanda
GTZ / GIZ	Deutsche Gesellschaft fur Technische Zusammenarbeit / German Technical Cooperation
HBM	Home Based treatment of Malaria
HC	Health Centre (= CS)
HC/TF	Health Care Task Force
HF	Health Facilities (see FOSA)
HF	Health Financing
HH	Households
HIS	Health Information System
HIV / VIH	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HP	Health Post (= Dispensary)
HRH	Human Resources for Health
HSCG	Health Sector Cluster Group
HSP	Health Sector Policy
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group (new name for HSCG)

HW	Health Workers
ICT	Information Communication Technology
I-DHS	Interim (or mini) Demographic and Health Survey (done in 2007)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses (=PECIME)
IMNCI	Integrated Management of Neonatal and Child Ilnesses
IMR	Infant Mortality Rate (/ 1000 live births)
IOV	Indicateurs Objectivement Vérifiables
IPT	Intermittent Presumptive / Prevention Treatment (for Malaria in Pregnant Women)
IT	Information Technology
ITN	Insecticide / Impregnated Treated Bed Nets
JRM	Joint Review Mission
JBSR	Joint Budget Support Review
JSR	Joint Sector Review
KAP	Knowledge, Attitude and Practice
KFH	King Faysal Hospital
KfW	Kreditanstalt für Wiederaufbau / German Financial Cooperation
KHI	Kigali Health Institute
LLIN	Long Lasting Impregnated Bed Nets
LMIS	Logistic Management Information System
LNR	Laboratoire National de Référence
LABOPHAR	Laboratoire Pharmaceutique du Rwanda
MBB	Marginal Budgeting for Bottlenecks
MDG	Millenium Development Goals
MDR	Multiple Drug Resistance (TB)
M&E	Monitoring and Evaluation
MH	Mental Health (Sante Mental)
MIFOTRA	Ministry of Public Service and Labour
MIGEPROF	Ministry of Gender and Family Promotion
MIJESPOC	Ministry of Youth, Sport and Culture
MINAFRA	Ministry of Infrastructure
MINALOC	Ministry of Local Administration, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology ad Research
MOH / MINISANTE	Ministry of Health
MIS	Management Information System
MMR	Maternal Mortality Ratio (/100,000 births)
MOU	Memorandum of Understanding
MPPD	Medical Production and Procurement Department
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
NA	Not Available
NCBT	National Centre for Blood Transfusion
NDA	National Drug Agency
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NLTCP	National Leprosy an TB Control Programme (= PNILT)

NNSP	National Nutrition Strategic Plan
NRL	National Reference Laboratory (Laboratoire National de Référence)
NS	Not Stated
NNS	National Nutrition Strategy
NU	Nations Unies
OP	Operational Plan
OPD	Out-Patient Department
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
ONUSIDA	Organisation des Nations Unis pour le SIDA (UNAIDS)
PAC	Post Abortion Care
PBF / PBC	Performance Based Financing / Performance Based Contracting
PBM	Performance Based Management
PBP	Performance Based Planning / Payment schemes
PECIME	Prise en Charge Integrée des Maladies de l'Enfance (= IMCI)
PEFA	Public Expenditure and Financial Accountability (assessment)
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PFM	Public Financial Management
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PLWHA	People Living With HIV and AIDS (see PVVIH)
PMA	Paquet Minimum des Activités / Rwanda Basic Package of health services
PMI	Presidential Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNBC	Programme Nutritionel à Base Communautaire (= C-Nutrition)
PNC	Post Natal Care
PNILP	National Malaria Control Programme
PNILT	National Tuberculosis and Leprosy Programme
PNLS	Programme National de Lutte Contre le SIDA
PNSM	National Mental Health (Programme National Sante Mentale)
P4P	Pay-for-Performance
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper (2004 – 2006)
PS	Permanent Secretary
PS	Private Sector
PSI	Population Services International
PTF	Pharmacy Task Force
PTME	Prévention de la Transmission Mère à Enfant (=PMTCT)
PW	Pregnant Women
QA	Quality Assurance
QC	Quality Control
RAMA	Rwanda's Medical Insurance Agency (employed in public sector); (Rwandaise d'Assurance Maladie)
RBC	Rwanda Biomedical Centre
RCBT	Regional Centre for Blood Transfusion
RCHC	Rwanda Centre for Health Communication (= CRCS)
RDHS	Rwanda Demographic and Health Survey (= DHS)
RDT	Rapid Diagnostic Tests (for Malaria)

RDU	Rational Drug Use
RED	Reach Every District (EPI Strategy)
RH	Reproductive Health
RHCC	Rwanda Health Communication Centre
R-SPA	Rwanda Service Provision Assessment Study (2007)
RWF	Rwandan Franc
SAMU	Service d'Aide Médicale d'Urgence
SBS	Sector Budget Support
SC	Steering Committee
SGBV	Sexual and Gender Based Violence
SIS	Système d'Information Sanitaire (=HIS)
SP	Strategic Plan
SP	Sulfadoxine-Pyrimethamine
SPA	Service Provision Assessment (2007)
SPH	School of Public Health
SPIU	Single Project Implementation Unit
SS	Support Systems
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TB	Tuberculosis
TBD	To Be Determined
TF	Task Force
TH	Traditional Healers
TOR	Terms Of Reference
TOT	Training of Trainers
TRAC	AIDS Treatment and Research Centre (Centre de Recherche sur le SIDA)
TRAC +	Centre for Infectious Disease Control (CIDC)
TT	Tetanus Toxoid
TWG	Technical Working Group
UEPM	Unité d'Epidémiologie et Prévention des Malades
UFMR	Under Five Mortality Rate (/1000 live births)
UNFPA	United Nations Fund for Family and Population
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	US Dollars
USF	Unité Santé Famille et Protection des Droits de L'Enfant
USG	United States Government
VCT	Voluntary Counselling and Testing
VLDP	Virtual Leadership Development Centre
YFC	Youth Friendly Centre
WB	World Bank
WHO / OMS	World Health Organisation
WRA	Women in Reproductive Age

Conversion Rates (in July 2011):

- **1 USD = 595 RWF (or 100 RWF = 0.167 USD)** (in 2008: 1 USD = 533 RWF)
- **1 Euro = 845 RWF (or 100 RWF = 0.118 Euro)** (in 2008 1 Euro = 826 RWF)

EXECUTIVE SUMMARY

1. Introduction

The Ministry of Health (MOH) in collaboration with its Health Sector Development Partners (DPs) is implementing the second National Health Sector Strategic Plan (HSSP II, July 2009- June 2012). HSSP II has been operational over the last two years. Just one year remains before the next HSSP will be initiated. MOH and stakeholders therefore considered it timely to conduct a Mid Term Review (MTR) of HSSP II, looking back and assess achievements and constraints during its two years of implementation, but also looking forward and prepare for the formulation of the next National Health Sector Strategic Plan (HSSP III), taking into consideration the various attributes of the Joint Assessment of National Strategies (JANS). A steering committee with representatives from MOH and key stakeholders was established to oversee the MTR.

Between the 18th of July and the 4th of August an external and independent team conducted the assignment on the basis of a detailed Terms of Reference (Annex 1). Before arrival, the team had received extensive background reading (Annex 4) and a detailed work programme (Annex 2).
In country, the team interviewed senior- and mid level staff of the MOH and the Ministry of Finance and Economic Development (MINECOFIN), various DP representatives and some Civil Society Organisations (Annex 3). During the two days field visit, four districts were visited (one in each province). District authorities were interviewed, followed by senior management of the District Hospitals, staff in two Health Centres (HCs) per district and Community Health Workers.
Before finalising the assignment, debriefings took place, first with the Steering Committee and a few days later with all stakeholders, chaired by the Honorable Minister of Health.

This document is structured as follows:
A one page summary of the main Sector Performance Indicators between 2005 – 2011 is provided at the beginning of the document. This includes MDG and CPAF indicators and covers the period of both HSSP I and HSSP II.
Part A presents achievements, challenges and recommendations of the three strategic objectives of HSSP II, mainly related to service delivery.
Part B presents the same for the seven strategic programme areas that address all the relevant system related interventions of HSSP II.
Finally, part C presents the 16 attributes of the revised JANS, discussing for each of them how they would be rated now as part of HSSP II and what are the lessons MOH and DPs can learn for the upcoming elaboration of HSSP III.

2. Overall conclusions

The Government of Rwanda, the Ministry of Health and all stakeholders involved in the health sector are congratulated with the outstanding results the country has achieved to improve the health status of its population within a very short time frame of just five years (since the start of the HSSP in 2005). The latest preliminary report of the Rwanda Demographic and Health Survey (R-DHS 2010) shows substantial improvements in impact and outcome figures.
A combination of (i) strong country ownership; (ii) a performance based environment with mutual accountability at all levels, (iii) an innovative community based health insurance (CBHI) system with nationwide coverage (91%) allowing almost 100% financial accessibility, and (iv) a pragmatic approach to bring the various interventions together where services meet the patient, 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 often in far from ideal conditions!
Other achievements worth mentioning here are (v) the proximity of the national HMIS figures with the DHS figures, allowing substantial confidence in the reliability of the HMIS; (vi) the availability of community level data, using SIS-Com; and (vii) the strong coordination structures - horizontally and vertically – between the various Ministries, within the MOH itself and between MOH and its DPs and the umbrella organisations of Civil Society.

3. Strategic objectives / service delivery (part A)

3.1. Achievements of HSSP II[1]

The most important achievements in the area of maternal and child health are (i) the increase in facility based deliveries (from 45 to 69%), EmONC in all District Hospitals (DH) and the start of maternal and child death audits in all health facilities (HF), (ii) an increase in Contraceptive Prevalence Rate (from 36 to 52) and Total Fertility Rate going down (from 5.5 to 4.6), (iii) the increase in vaccination coverage (Measles from 75% to 95% and fully vaccinated from 80% to 90%) and (iv) over a five year period (since 2005), improvements in nutritional status (underweight from 18% to 11%; stunting from 51% to 44% and wasted from 5% to 3%).
The community health programme has achieved nationwide coverage. All villages have 4 CHW, each with well defined tasks. The CHW are remunerated for their work through the Community PBF on a performance basis. Their income goes into a cooperative fund from where profit yielding investments are made for the adherents (being all the CHW that are part of the Health Centre). An innovative e-Health system has provided all CHW with mobile phones to be used for (i) consultation with the HC staff and (ii) the community based alert system (using rapid SMS) that is linked to the emergency ambulance services in all districts. New interventions are undertaken in Adolescent Sexual and Reproductive Health and Rights and Gender Based Violence.

In the area of disease prevention and health promotion achievements are an expected reduction in HIV prevalence (DHS figures expected soon), an almost 100% coverage of HIV testing during ANC visits and more than 90% of HIV+ pregnant women being on ART prophylaxis.
The Malaria program reports very high use of Long Lasting Impregnated Nets (LLIN use by children 70% and by pregnant women 72%) with 82% of household owning at least 1 LLIN.
The environmental and health promotion activities achieved the presence of hygienic clubs in most villages. These are responsible for promoting hand washing, introduction of improved latrines and other behaviour changes.

In the area of disease control and treatment, 84% of HIV+ people are covered by ART and 273 HCs (out of the total of 438 HCs) provide the full package of HIV related services (62%)[2].
In the last two years, the Malaria Prevalence has gone down, in children from 2.6% to 1.4% and in women from 1.4% to 0.7%. The Malaria program will now soon enter its pre-elimination phase.
The Home Based Malaria program achieved 91% of children under five to be treated within 24 hours. Currently CHWs in 28 out of 30 districts are testing (RDT) all suspected malaria cases at community level before any treatment for fever is given to children under-five.

The national TB Control programme reports high treatment success rates (86%) and very high success rates in the treatment of Multi Drug Resistant TB Cases: 89%. Collaboration between the AIDS/HIV and TB programme results in 97% of suspected TB cases tested for HIV. A prevalence study to determine the actual Case Detection Rates is underway.

3.2. Challenges and recommendations

Many of the challenges mentioned by the various programs relate to (i) the still limited technical performance of the staff in health centres and district hospitals, (ii) the less than 100% coverage of the health infrastructure, requiring expensive and time consuming outreach services, (iii) the sometimes old equipment in the hospitals and HCs, (iv) the limited linkage of some programs with the HSSP II (in planning, budgeting and use of indicators), (v) the challenge to sustain funding , and (vi) the need to re-focus several of the programs to new target groups (FP, EPI, Community Health). Specific recommendations are included for each of these challenges in the text below.

[1] Findings relate to the achievements of HSSP II. Therefore the figures compare 2008 and 2010.
[2] Rwanda's health infrastructure consists of 4 Referral Hospitals, 42 District Hospitals, 438 Health Centres. Administratively, there are 30 District Administrations, 416 sectors, 2148 Cells and 15.000 villages.

4. Strategic programme areas / systems (part B)

4.1. Achievements of HSSP II

Due to their complexity, improvements in systems generally take more time and investment than those in service delivery. However, also in this area important achievements are recorded in a relatively short period of time:

Human Resource for Health has seen almost a doubling of the number of doctors and nurses (Dr / Population ratio being 1 / 17.240 and Nurses being 1 / 1.290), both surpassing the target mentioned in the EDPRS. Only midwives have not yet reached that target and stand at a ratio of 1 midwife / 66.700 population. The HRH policy and strategy have been updated; a continuous education plan for physicians is in place and an innovative four year Masters in Family and Community Medicine has been initiated, as well as E-learning for upgrading A2 nurses to A1.
A medical education and research department has been created in the MOH. Most important of all is the fact that all health related training / research institutions have been brought under the responsibility of the MOH.

Provision of drugs, vaccines and consumables from the central level (CAMERWA) to the 30 District Pharmacies is regular and reliable, stock-out of drugs are rare and often related to late requests by the HFs. CHWs receive drugs regularly from the same supply route. New regulations and laws have been developed that wait for approval by Parliament; a system to ensure drug quality is in place. Rational Drug Use (RDU) by prescribers is promoted through Drug Therapeutic Committees, but no recent data on RDU are available. Recent audits undertaken by USG and GFATM have given CAMERWA the green light to procure drugs directly with USG funds.

Quality Assurance measures have recently been initiated, standards and norms have been defined for district hospitals (infrastructure, equipment, HRH staffing, and pharmaceuticals), and an accreditation process of three referral hospitals has started with an evaluation by COHSASA.

Planning at district and facility level is aligned to HSSP I and II, 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 (JHSR) take place annually, assessing the performance of the sector based on the annual HMIS report. The information system provides a core set of (output) indicators timely and completely, data quality audits are carried out in each HF quarterly.

Financial accessibility benefits from three recent and interrelated policies: the health financing policy, the health insurance policy and the community health insurance policy. Together they translate the HSSP II into concrete policy actions. As a result, achievements are recorded as: increase in public expenditure by MOH from 6.5% to 11.5%; and a reduction in the % of external assistance from 38% to 33%. In addition, of all external assistance 29% goes to PBF and 37% to CBHI, continuing the dependency of these two 'reform drivers' on external funding. Preliminary figures indicate that about 83% of the health sector is funded by external assistance, but only 1% of all external funds is channeled through sector budget support mechanisms[3]. The new CBHI reforms are expected to take out the regressive aspects of the old CBHI, in place till June 2011.

Harmonisation and Alignment shows that DPs are broadly aligned to the HSSP II, the same guidelines are used and there is a joint harmonised GOR-DP planning and reporting calendar. Mutual accountability is institutionalised (based on a Common Performance Assessment Framework) between MOH and DPs that use GBS and SBS channels. Seven Technical Working Groups (TWG) are established under the umbrella of the HSWG. Technical staff from MOH and DPs meet in these TWGs to review performance and discuss new plans and challenges. A newly established Single Project Implementation Unit aims at reducing the administrative burden of the

[3] There are only three SBS donors (German and Belgian Cooperation and DFID). This number has remained the same since its start, whereas the German Cooperation will leave the sector in June 2012.

MOH that has to manage many different donor agencies. At present the use of donor specific procedures for budget execution and accounting, financial reporting and procurement is the rule rather than the exception within the sector.

The GOR is entering its third phase of **decentralisation**. The Ministry of Local Government has published an implementation plan (2011-2015), while the MOH with its DPs has 'translated' the implementation of the decentralisation within the context of the health sector in a "Concept Note". The GOR has recently approved a revised Financial and Fiscal Decentralisation Policy that will impact on the specific roles and responsibilities in resource allocation, planning, budgeting, budget execution and financial reporting. It will transfer more of these responsibilities and processes to the district level, impacting on administrative capacity and skills of the district administration and the health facilities. The process of fine tuning this process in the health sector will need harmonised and updated guidelines for the effective implementation of a devolved health service delivery system.

4.2. Challenges and recommendations

An overarching challenge in all system related departments and units, is to harmonise their policies and strategies with the format and time line of the upcoming HSSP III. The most important challenges and a few recommendations have been brought together below:

In HRH, challenges are the high turnover of staff (A2 nurses), the shortage of professionals (mainly midwives in HCs and medical specialists) and the absence of biomedical engineers, causing very poor performance in all maintenance systems (infrastructure and equipment).
Quality control in the management of pharmaceuticals is weak, as a National Drug Authority is not yet established and most of the recording is still paper based. However, an automated LMIS system will be established shortly within CAMERWA.
As the Quality Assurance unit and the medical education and research department have only recently been established, their performance is still to be assessed, once they have established themselves with baseline indicators and targets in HSSP III.

Challenges in planning and budgeting relate to the poor predictability of many DP resources to the HSSP II, the large amounts of off-budget resources that are not included in the sector plans and the unclear relationships between the district hospitals and district health unit on one hand and the resource planning by the DPs on the other. In terms of decentralised planning, MOH could do more, providing capacity building to district level staff and guidelines on how to prioritise and allocate resources. Information on the overall health sector budget allocation is not easily accessible in a consolidated manner, allowing a clear picture of public spending in the sector. The capacity to manage the implementation of the M&E framework is still weak at central level. In addition, as information systems follow the calendar rather than the budget year, linking results to funding will be difficult.

Financial accessibility through the CBHI, faces challenges of (financial and institutional) sustainability. The new CBHI reforms will allow more equitable access to health services, but the need for adequate safety nets to take care of the very poor will remain for some time to come.
For PBF the challenge is to continue to reward priority services, when results show differences over time (moving from good to poor performers). Tariffs then need to be regularly adjusted.

Harmonisation and Alignment suffer from poor participation by other DPs in available pooled funding modalities, some of them contributing substantial resources outside the 'harmonised aid modality'. The amount of off-budget aid flows in the health sector, both at central and district levels is assessed to be one of the largest constraints to strategic resource allocation and overall management of the HSSP II. It distorts the MOH ability to assess equity in terms of resource allocation and does not allow an appreciation of the effectiveness and efficiency of its services.
This MTR report concludes that DPs do not seem to give sufficient effort to consider the use of government systems, whereas MOH could review in more detail what constraints the DPs face to use the available government systems.

Finally, challenges in decentralisation relate to the different and asymmetrical responses given to decentralisation by different sectors. In the design of the district health system, attention needs to be given to how other sectors design the resource allocation, planning and budgeting, budget execution, financial reporting etc. Vertical sector solutions (silos) should be avoided at the level of the district administrations. Capacity building is – once more – of crucial importance.

5. The Joint Assessment of National Strategies (JANS)[4].

The other objective of this assignment was to undertake Joint Assessment of National Strategies (JANS), based on the recently revised tools (with 16 attributes). This assessment analysed the content of HSSP II and the practice of its implementation. The strength of HSSP II includes:

- Existence of sound situation analysis with the exception of analyzing the implication of government wide reforms to the health sector;
- Priorities, goals and main objectives are clearly defined and aligned with EDPRS objectives;
- The HSSP II interventions at all levels were high impact interventions that are appropriate and cost effective to achieve the MDGs, with some of these interventions piloted and experimented (CBHI, PBF, community health etc) before scaling up to the national level;
- There was considerable participation by development partners and civil society NGOs;
- There has been a high political commitment in its development and implementation;
- Two costing methodologies were used and their assumptions were clear; the fiscal space analysis also had clear assumptions'.
- Most of the operational plans and sub-programme strategies are aligned to HSSP II;
- There are clear governance and coordination structures that are working reasonably well in the health sector both at the central and district levels; and
- Finally, M&E process indicators and joint decision making structures are working well.

We also found 'areas for improvement' to be considered when starting the development of HSSP III. These are presented in detail in section C of this report, here we summarise them as follows:

- Ensure the development and implementation of a road map for the development of HSSP III in a consultative manner;
- Assess (i) the implication of government reforms, such as decentralization (both administrative and fiscal), (ii) the multi-sectoral intervention issues and (iii) institutional assessment and the need for capacity building at the decentralized level and decide how these will become part of the HSSP III development process;
- Establish a link between the strategic and programme objectives to have a better monitorable plan; the next HSSP also needs indicators and a target on overall government wide reforms and institutional development;
- Ensure exclusive linkages between each strategic objective with some of the 7 programme objectives in HSSP III to help the development and implementation of subsequent costing of sub strategic and operational plans; Use only one costing methodology; Costing / financing is recommended to be disaggregated by level of services and defined service package;
- The potential of improving aid predictability and use of government system needs special attention from all partners in HSSP II.
- The timeline of the HSSP III and EDPRS II needs reflection and eventual decision-making;
- Contingency plans for health needs as well as a risk assessment and related mitigation measures need to be taken into account in HSSP III, more than HSSP II;
- Include more districts and other sectors participation in the development of HSSP III.
- Ensure districts develop aligned and consolidated operational plans; and
- Sector specific institutional capacity strengthening including PFM and procurement should be considered as part of systems strengthening exercise.

[4] For this assignment a revised version (version 2, 17th June 2011) of the JANS has been used.

INTRODUCTION

Background to the MTR/JANS 2011 assignment

The Government of Rwanda (GOR), represented by the Ministry of Health (MOH) in collaboration with its health sector Development Partners (DPs) is implementing the second National Health Sector Strategic Plan (HSSP II, July 2009- June 2012) and the National Development Strategy (EDPRS, July 2008 – June 2013). The purpose of HSSP II is to provide an overarching framework and clear direction to the development of the health sector over a medium timeframe. The document distinguishes 3 strategic objectives to improve service delivery and 7 cross-cutting strategic programs, providing an enabling environment for service delivery.

HSSP II has been operational over the last two years. Just one year remains before the next HSSP will be initiated. It is therefore timely for the MOH and all stakeholders to conduct a Mid Term Review (MTR) of HSSP II, looking back and assess achievements and constraints during its two years of implementation, but also looking forward and prepare for the formulation of the next National Health Sector Strategic Plan (HSSP III). The forward looking assessment is to be guided by undertaking a Joint Assessment of National Strategies (JANS), using the format and attributes, as developed by the IHP+ secretariat that has been used in various other countries.

Both reviews are undertaken to establish the comprehensiveness of the plan and to document the progress made so far with regard to its implementation. It is therefore expected that the two interrelated processes will contribute to the information required to prepare the HSSP III, starting in July 2012.

It is against this background that an external and independent evaluation was commissioned to work on the basis of a Terms of Reference (Annex 1). Guided primarily by the performance framework of the HSSP II (including its indicators, targets and milestones) and using the standard evaluation criteria (relevance; effectiveness, efficiency; sustainability), the MTR of HSSP II will specifically:

- Assess progress towards the achievement of HSSP II targets;
- Review of the implementation of management arrangements/systems related to HSSP II at national and decentralized levels;
- Assess new interventions used in the implementation of HSSP II.
- Analyse challenges and constrains in implementing the HSSP II policies and strategies, including an assessment of the appropriateness and relevance of these policies;
- Inventorise best practices, lessons leant and recommendations for next steps to sustain and improve MOH performance.

The principal objective of the JANS in this assignment is to assess how the JANS attributes can be used in the preparations of HSSP III that will start in July 2012.

Methodology

Between the 18th of July and the 4th of August, a team of four public health specialists and three economists conducted the MTR/JANS assignment, adopting the following methodology:

- Document Review: A wealth of background documentation was made available to the team well in advance of the start of the assignment that provided valuable information on what is working and what not in the health sector (Annex 4);
- Study the 'revised' JANS attributes: The IHP+ Secretariat sent a revised (shortened) set of attributes (vs 2, 17th June 2011), that was shared with MOH / DPs and used in Section C (Annex 6);
- Prepare interview tools: On the first day of the assignment, the team prepared an outline of various relevant questions and tools to be used during the interviews and during the field visit (Annex 5);

- Interviews: A variety of persons were interviewed at central level (MOH, DPs, NGOs, MINECOFIN), District authorities, staff working in 4 District Hospitals, 8 Health Centres and Community Health Workers. The list of people interviewed is given in Annex 3.
- Field Visit: The review team visited one district in each of the four provinces and in each district it conducted interviews with the administrative authorities, the Hospital Director, the staff of two Health Centres and CHW workers. Criteria for the inclusion of the districts were good / poor HMIS indicators related to quality of care.

At the end of the assignment, debriefings were held, first with Honorable Minister, the Steering Committee and later with all interested stakeholders of MOH, DPs and NGOs. The objective of these meetings was to (i) present the team's preliminary analysis of the performance of HSSP II and (ii) test its findings / recommendations and receive feedback from all those present.

Limitations

There are various limitations when conducting a full sector review and JANS in a relatively short period of time. Among the few limitations we just mention that only 2 days were available for the visit to the field (but we did visit 4 districts and 8 Health Centres).

PART A. STRATEGIC OBJECTIVES

1. Improve Mother, Child and Adolescent health services

The MCH Unit of the MOH is composed of several 'desks' and 'sub-desks', as follows:

- Maternal (including Fistula) and Child Health Units (with sub-desks in ASRH&R, GBV)
- Family Planning Desk
- Nutrition Desk
- Community Health Desk
- Environmental Desk
- The EPI Desk (This desk has recently been moved to RBC)

Most of these desks and sub-desks work as part of '(technical) working groups', in which all the required technical expertise is brought together.
From the very limited experience of the MTR team, it seems that the internal coordination of this complex MCH Unit could be improved.

1.1. Maternal Health (MH)

Table 1. Findings in Maternal Health (Logical framework. p. 33/34)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS AND BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Promote 4 ANC Visits	% PW with 4 ANCs from 24% to 50%	35% in 2010
2. % Deliveries in HF	% Deliveries up from 45% to 60%	69% in 2010

Achievements (Qualitative Information)

1. The incentive package (CHW/supply side & women/demand side) for assisted delivery implemented in 130 sectors by June 2011 (EDPRS): Since October 2010, about 200 sectors are implementing the demand and/or supply PBF model (50 Demand, 50 Supply, 50 Demand and Supply, and 50 control). Results will be available around April 2012.
2. Service providers of DH trained in Emergency Management of Obstetric Neonatal Care (EmONC) and Kangaroo Mother Care of health centers / district hospitals in ante- / postnatal, and post abortion care services in 10 districts by June 2011 (MTEF). In 29 district hospitals, 346 health providers have been trained in EmONC, including antenatal, postnatal and post-abortion care services, while 112 health providers were supervised and certified in EmONC.
3. One out of the 4 CHWs is responsible for RH. They have been trained and are in charge to contact PW and support them at community level.
4. Training on Community maternal and newborn care for CHWs (C-MNCH) is implemented in 5 districts (Rubavu, Ngororero,Musanze,Nyabihu, Gakenke,Burera,Kayonza, Rwamagana).
5. MCH weeks are being done twice a year (as an outreach activity)
6. Referral system strengthened by provision of 40 ambulances and community based Alert System using Rapid SMS in all districts by June 2011.
7. Maternal deaths audit has started in 2009 and is now carried out in all health facilities. Maternal deaths audit in the community started in November 2010.

Challenges (Qualitative Information)

- Limited technical performance of the nursing staff. Capacity building to improve the quality of the ANC, as timely risk detection by the nurses is not always happening
- Geographic accessibility for deliveries is limited with ANC outreach only twice a year, as some parts of the country not yet having a fully functioning Maternity as part of the HC
- The current Strategic Plan to reduce maternal and neonatal morbidity and mortality needs to be reviewed and updated in the light of the many diverse developments in this area.
- Cultural beliefs traditional practices (use of herbs) around child birth are still very strong. This has a negative impact on the health of the women and the delivery of their babies

Table 2. Recommendations for Maternal Health

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1:	Review and update the Strategic Plan to reduce maternal and neonatal morbidity and mortality by June 2012	Follow up the implementation of the incentive package for assisted delivery in 130 sectors **(**EDPRS)
Action 2	Train additional service providers in DH and HCs in all districts in Emergency Management of Obstetric Neonatal Care by June 2012	Strengthening the capacities of community health workers to promote maternal health
Action 3		Expand full MNCH package to all HCs (Maternity, BEmOC, PMTCT etc)

1.2. Family Planning

Table 3. Findings in Family Planning (Logical Framework p. 33/34 ff)

EXPECTED OUTPUTS / OUTCOMES HSSP II	INDICATORS, TARGETS, ACTIVITIES AND BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Total Fertility Rate	Total Fertility Rate from 5.5 to 4.5	TFR 4.6 (2010)
2. % Women 15-49 using modern contraceptives	Modern contraceptives from 27 to 40% (40% in 2012, at the end of HSSP II)	Modern contraceptives 45% (2010) EDPRS has a target of 70% in 2012.

Achievements (Qualitative Information)
MOH provides a range of different contraceptives for the population to choose form.
Quarterly meeting with all stakeholders to review consumption and decide on procurement
Strong political backing for the policy, all talking the same message reinforced by IEC materials
Coverage of all the services is widely spread over the country;
Training of medical doctors in performing vasectomy has been done in 12 districts, and 23 District Hospitals are performing successful vasectomy.
Training of CHWs in provision of modern contraceptives initiated. The first phase of rolling out C-FP has started in three Districts (condom distribution and Depo Provera). After evaluation it will be expanded to 10 districts and then all 30.

Constraints / Challenges (Qualitative Information)
The adolescent age group (15-24) years is difficult to reach (still in school, radio limited). Special attention and focused intervention for this group are not yet available
Private Sector Partners (and faith-based organisations?) are not (yet) much involved in FP.

Table 4. Recommendations for Family Planning

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Focus on Adolescent Reproductive Health	Expand ARH programme all over the country
Action 2	Continue Community FP programme	Scale up Community FP
Action 3	Expand distribution of condoms in Public and Private Sector	Expand distribution of condoms in Public and Private Sector
Action 4	Deepen collaboration with Private Sector	Deepen collaboration with Private Sector

1.3. Child health and IMCI

Table 5. Findings in Child Health and IMCI (Logical Framework p. 33/34)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS AND BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Expansion IMCI	No indicators mentioned in the log frame of HSSP II	

Achievements (Qualitative Information)

IMCI is implemented in all districts.
Neonatal and child death audit (IMNCH) was introduced in all district hospitals (DHs) and in 8 districts at community level (verbal autopsy)
Review of all IMNCI tools was undertaken, while new protocols on Malaria, Malnutrition and HIV were included. A new IMCI register was developed
The revised IMCI course is shortened from 12 days to 6 days according WHO instructions (reduce training cost).
Several other activities were initiated:
In 2010, 2 additional health providers from 21 district hospitals were trained. Now 17 HCs have 4 providers trained on IMCI, in other districts, HCs have at least 2 health providers trained in IMCI
3 health providers for each of the 30 1 physician and 1 nurse in all DH were trained in neonatal and child death audit. DH were trained in Newborn care
2 health providers in 8 districts were trained in verbal child death autopsy at community level
Plans have started to integrate IMCI into the nursing school curriculum.

Constraints / Challenges (Qualitative Information)

Quality measures of IMNCI interventions in most health facilities is not always applied;
Not all supervisors are trained in IMNCI;
There is instability of health providers
Implementation of IMNCI needs to accelerate its integration into the nursing schools curriculum
Reporting on neonatal / child death audit is going slowly; quality of these reports is low

Table 6. Recommendations for Child Health and IMCI

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Train more health providers on IMNCI and reinforce supervision of all child and neonatal programs	Improve and reinforce management of child health programme including IMNCI Improve the child death audit in all districts Ensure effective integration of IMNCI in all nursing schools Initiate operation research for identification of the quality of each programme area.
Action 2	Initiate preparation of the next 5 year comprehensive Child Survival Strategic Plan (Plan, budget and M&E)	
Action 3	Implement neonatal and child death audit in all HF and at community level (verbal autopsy) Produce quarterly report on neonatal /child death audit	

1.4. Immunisation / EPI

Table 7. Findings in immunisation (Logical Framework p. 34)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS AND BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Children fully immunised	% Immunised up from 80.4% to 90%	% fully immunised 90% in 2010
2. Measles coverage increased	Measles up from 75% to 95%	% Measles Coverage 95% in 2010
3. Pneumococcal vaccine	Included in national schedule	Included since April 2009
4. Rota Virus vaccine (oral)	Included in national schedule	To be included in first half of 2012.
5. HPV vaccine	Included in national schedule	Included since April 2011

Achievements (Qualitative Information)
This very good result has been achieved thanks to a combination of factors, such as:
The wide network of CHW (60.000 in all villages)
The wide network of some 420 Health Facilities with cold chain equipment
Good performing cold chain (regular maintenance and new equipment); no vaccine stock-outs
EPI Outreach Programme monthly covers all villages (Health Posts) in the district (motor bike)
Functional micro planning at district level and financial support from Government and Partners;
Good capacity building programme and supportive supervision;
Integration of other child survival services (LLIN, Vit A distribution)
HPV introduced recently countrywide through schools (94% Dose 1 and 97% Dose 2)
Distribution of LLIN to children at 9 months of age during measles vaccination.

According to the EPI Manager, this very high coverage is likely to be maintained as EPI indicators are included in the performance contract of the Village Leader and the people and also in the contract between the HC Nurse and the District Hospital

Constraints / Challenges (Qualitative Information)
As new vaccines will be included (e.g. Rota Virus) in the EPI programme, continuous training and capacity building of the staff will be necessary.
Integration of the EPI programme with other programmes will be necessary, in particular when EPI will start testing those children that were born from HIV+ mothers (that did not come back to the HC to have their child checked on its HIV status).
Continued maintenance of the EPI equipment (cold chain, transport), esp. for outreach services
Finally, a serious challenge is the risk of epidemic diseases (Measles, Polio) importation from neighboring countries) with less advanced health services.

Table 8. Recommendations for immunisation

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Prepare for the introduction of Rota Vaccine	Continue Rota Vaccination as part of the national programme
Action 2	Continue surveillance, esp at the border regions,	Expand HPV vaccination from primary school to secondary school
Action 3		Continue preventive polio and measles supplementary immunization activities

1.5. Nutrition

Table 9. Findings in Nutrition (Logical Framework p. 33/34)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS AND BASELINE	PROGRESS BETWEEN July 2009- June 2011
Reduce malnutrition in children 6 - 59 ms Reduce thinness among PW and lactating women	Wasting from 4.6% to 3%, Stunting from 52% to 36% Underweight from 15.8% to 10.3%. Reduce thinness PW 7% to 4.5%	Wasting: 3% Stunting: 44 % Underweight: 11% No figures for PW
Reach 80% of the population with community based nutrition (CBN) and district plans to eliminate malnutrition (DPEM) by 2013;	% of districts with CBNP % districts with DPEM	No data No data
Reduce micronutrient deficiencies (IDA, VAD, IDD) by 40% among children under the age of five years and PW by 2013;	Baseline figures NA % IDA, % VAD, % IDD	NA
Exclusive Breast Feeding (EBF)	EBF 38%	No new information

Achievements (Qualitative Information)

Since May 2009, the President of the Republic declared the fight against malnutrition as a government priority. Since then, a lot has been done:

- The emergency plan to eliminate malnutrition consisted of screening all U5 children. This has to be repeated every year.
- Development and implementation of District plans to eliminate malnutrition in progress
- The 1st Nutrition Summit consensus made recommendations that lead to important actions such as the development of a National Nutrition Strategic Plan (NNSP) to eliminate malnutrition, including a "District Plan to Eliminate Malnutrition (DPEM)"
- The intersectoral DPEM package aims at implementing the NNSP at district level and community level (CBNP) and even at reaching the HH level (home-based food fortification).
- A first draft of Infant and Young Child Feeding Strategic Plan (IYCF) exists;
- An integrated counseling course in IYCF was developed, 5 facilitators + 18 TOT were trained,
- Food fortification at central and home based level undertaken since 2008

Constraints / Challenges (Qualitative Information)

- Lack of qualified Nutritionists at decentralized levels: hospitals and health centers
- Insufficient funds and personnel to implement the NNSP and the DPEM, hence the need to continue raising funds and request technical assistance in the Nutrition area.
- Need to review / revise the tools to detect the nutritional status of the children.
- Need to reduce chronic malnutrition by accelerating the finalization of IYCF strategic plan.

Table 10. Recommendations for Nutrition

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Sustain political commitment to the fight against malnutrition	Initiate NOW preparation of the next 5 year NNSP and DPEM (Plans, budgets and M&E)
Action 2	Review first experiences of the Community Based Nutrition Programme	Scale up Community Based Nutrition Programme nationwide, use Lessons Learned
Action 3	Review DPEM and its relation with CBNP	Reinforce coordination between DPEM / CBNP
Action 4	Test training materials and train all health providers on IYCF	Train all health providers on Maternal, Infant and Young Child Feeding at all levels
Action 5	Initiate campaign to promote BF and provision of Iron Folate to PW / children	Revisit BCC strategy on nutrition using radio and other communication channels

1.6. Community Health

Achievements (Qualitative Information)

The Community Health Programme in fact is a cross cutting intervention that relates with most of Service Delivery (MCH, EPI, Nutrition, TB, Malaria), but also with many of the System Strengthening interventions (finance, M&E, transport). HSSP II does not include any specific indicator or target to be used to assess its performance. However, compared with the MTR of HSSP 1, many improvements have been observed:

- The package of services to be provided at community level by the Community Health Workers (CHW) has been clearly defined in the National Community Health Strategic Plan 2009-2012, that is currently being implemented
- All villages in Rwanda now have four CHW: two are trained to provide care and treatment of the three main diseases (Malaria, Pneumonia and Diarrhea), (iii) a third is responsible for mother and child health, making sure that women go in time to the HC for control and delivery, and (iv) the fourth being a 'social worker', trained in prevention, nutrition and environmental health[5]. This means that some 60.000 CHW are providing first line care, prevention and treatment, closely linked to the formal service delivery system. They provide service for 30 House Holds per community health worker.
- The community Performance Based Finance (PBF) also addresses the remuneration of these CHW through a contribution to a total of 429 Cooperatives[6] in which they participate as members: depending on their output and performance, they will receive part of the money that is funding the cooperative, thus contributing to its sustainability. Their technical performance is evaluated every quarter to determine their gain in C-PBF. The management of the Cooperative is being supervised by local NGOs that are present in all the districts (and will receive motor bikes from the MOH for this work.
- CHW receive drugs (Coartem, Amoxicillin and Zinc) and RDTs (to test for Malaria) from the District Pharmacy through the HC.
- Referrals made by the CHW (for patients that participate in the mutuelles) will be paid for at the level of the HC, the DH or even at the level of the Referral Hospital. This stepwise referral system ensures that patients do not easily 'bypass' the system, as in that case they will have to pay the bill themselves.
- A Community Information System (C-HMIS) is being rolled out that combines all the information required to supervise their work (including both HIV/AIDS and general health related information). The CHW produces one report per sector and has one information system being consolidated among themselves.
- All CHW have been given a mobile phone and the number of the nearest health facility (as part of the Phone for Health programme). In case of an emergency or in need of advice the CHW can call his supervisor. As the nurse in-charge of a HC commented on this recent innovation by the MOH: "This is a stroke of genius". However, the use of these Mobile phones do pose some challenges (charging the battery, loss and break downs)
- Finally, all HCs of the MOH are currently making an inventory of all the Traditional Practitioners in their catchment area. It is expected that this will allow the MOH to initiate their formal registration and open a dialogue on the merits of their work,
- Since April 2010, female community health workers were trained in the management of mother and new born care within the community.

Challenges (Qualitative Information)

Challenges related to the Community Health programme are around coordination (e.g. coordination of their many training programs), supervision and the financial management of the PBF system.

[5] The fourth CHW, being the social worker, is under the responsibility of the Ministry of Local Government.
[6] In principle there is one Cooperative for the catchment area of the Health Centre. Only CHW can be members of the Cooperative that need to be formally registered at sector, district and national level.

- Sustainability of the Community Health Programme is highly dependent on the functioning of the cooperatives. Currently, while the 3 CHW under the MOH are engaged in the provision of services and rewarded for their efforts, the fourth CHW is also rewarded but does not provide similar efforts. This could create tensions among the CHW and need to be addressed.
- The effort spent in providing services and accompanying pregnant women to the health centre takes time and energy. This is felt as they provide the service on voluntary basis.
- The CHWs require proper skills to deliver their community curative care. They need to be continuously being upgraded.
- There is a real risk that the 4 CHW per village become overburdened with all the tasks they are getting. The Community Health Department within the MOH is therefore already planning to expand the CHW team with two additional members, whose task still needs to be determined. There is a possibility that one of these CHW might be a Traditional Healer, as the policy of the MOH is to integrate those Traditional Healers that have registered themselves into the service delivery system of the government.
- The technical supervisor (nurse at the HC) and/or the controller of the cooperative sometimes lack adequate transport mechanisms to supervise and support CHWs.
- There are often substantial delays in the arrival of the PBF money from the central level to the bank offices in the Districts and the sectors. As these systems are still paper based, information sometimes take a month or more to reach the beneficiary.

Table 11. Recommendations for Community Health

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Evaluate the Community Health Programme before the start of the HSSP III	Initiate the preparation of a new Community Health Strategic Plan as part of HSSP III
Action 2	Continue skill upgrading trainings for CHWs.	Provide motorbikes for CHW supervisor.

1.7. Adolescent Sexual and Reproductive Health and Rights (ASRH&R)

Table 12. Findings in ASRH&R (Logical framework. p. 33/34)

EXPECTED OUTPUTS / OUTCOMES HSSP II	**TARGETS / BASELINE**	**PROGRESS BETWEEN July 2009- June 2011**
Output 1: % HF providing Adolescent SRH services	Adolescent RH services from 0% to 100%	No information provided
Output 2: ASRH&R services in youth friendly centers (YFC) promoted, through training of providers	# YFCs trained to deliver a minimum package of ARH to adolescents	15 districts have 17 YFC of which providers received un-harmonised training
Output 3: IEC materials on ASRH&R for in- and out school adolescents and young adults developed.	# of IEC materials sets developed and validated by the MOH	1 set developed and validated

Achievements (Qualitative Information)

- Initiation and coordination of Sub-Working Group on ASRH&R
- ASRH&R assessment done and draft policy & strategic plan developed (including elaborated definition of minimum package for HCs and YFC's);)
- National training manual for health providers was developed
- ASRH&R / IEC materials for FP developed and adopted by the MOH
- Support the first National HPV vaccination campaign of girls in Primary 6.
- Several other activities have been undertaken:

Several partners are implementing ASRH&R, but programs are different / un-harmonised in the past, as there was no policy and SP was not yet finalized. 12 HCs with at least 2 trained providers deliver ASRH services

Constraints / Challenges (Qualitative Information)

- No harmonised Policy & Strategic Plan, hence uncoordinated implementation of programs
- ASRH&R not sufficiently prioritised by stakeholders
- Lack of funds (government & partners)
- Poor coordination between ministries
- ASRH&R not integrated in primary & secondary and teacher / medical school curricula
- High risk groups insufficiently covered

Table 13. Recommendations for ASRH&R

Summary Actions	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1:	Finalize & validate the policy & strategic plan Advocacy on all levels	Advocacy on all levels; ASRH&R law enforcement Develop programs targeting parents
Action 2	All HCs of 15 districts train 2 providers/HC (30) Training of service providers in existing YFCs (20)	Complete training of providers of Health centers and YFC's
Action 3:	Joint annual planning by ASRH&R Sub-Working Group, including financial gap analysis & resource mobilization. Creation of district ARH committees & development of district ASRH&R plans	Implement teaching on ASRH&R of youth in P&S schools according standard curriculum In-service training for teachers and medical staff includes ASRH&R Scale up 12 + programme to all districts
Action 4:	Train adolescents and young people of high risk in ASRH&R in 20 districts	Scale up training of adolescents and young people of high risk in ASRH&R in all districts

1.8. Gender Based Violence (GBV)

Table 14. Findings in GBV

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. # HCs providing care and counseling to GBV victims	No indicators / targets provided in HSSP II, as the programme was conceived after HSSP started	NA

Achievements (Qualitative Information)

Gender-Based Violence is a new initiative under the MCH TWG that was not included 2 years ago, when HSSP II was developed. Different baseline studies (e.g. MIGEPROF/UNFPA GBV mapping 2008) and the GBV initiative showed existence of substantial violence at the household level with women and children as the most affected groups. However, available data do not provide the complete dimension or the true scale of GBV. Victims often do not report the violence out of shame, fear, poor knowledge of their rights and lack of appropriate services. This is also the reason why there are no data available on GBV against men in Rwanda. Disclosure of GBV against male victims does not match with the stereotype associated to men in Rwandan society.

As first step, the Sub-Working Group on GBV in the MOH developed guidelines for the clinical management of GBV cases. Implementation in the HF has been introduced through extensive training at all levels, such as TOT, training of health service providers and focal points in the health facilities, CHWs, but also the police, local leaders and the wider community.

Beyond the health sector, a lack of consistent data and no data sharing mechanism, M&E or coordination makes it difficult to offer harmonized GBV services. Therefore, a national policy and strategy has been developed with other sectors under the roof of MIGEPROF.

Challenges (Qualitative Information)

Data collection and entry, history taking and reporting still needs to be strengthened at all levels of the health system. HCs do not use checklists and tools in a harmonized way. It is in this context that the Sub-Working Group on GBV is currently harmonizing forms, tools and indicators (to be included in HSSP III) for history taking, examination, documentation, and reporting.

GBV prevention and response needs a multi-sectoral approach since a wide variety of services provide support to GBV victims, including medical, psycho-social, legal aid, protection and socio-economic services. However, constraints exist in the way how these services are provided. MIGEPROF / MOH jointly plan to develop multi-sectoral guidelines, the "One-Stop-Centers[7]".

In general, a misunderstanding of "gender" leads to misinformation and misunderstanding of what GBV is. Many acts of gender-based violence, particularly domestic violence, are not clearly understood.

Table 15. Recommendations for GBV

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1. One Stop Centres	One Stop Centres to be expanded	Elaboration of strategy to scale up OSC
Action 2: Training	Training of Health Centre Staff	

[7] A 'One-Stop Center' offers medical, police, legal and psycho-social services to victims of gender based violence in one place, under one roof. It aims to provide comprehensive, timely, affordable and effective services. Currently, there are 2 One-Stop Centers in Rwanda: One in Kigali and one in Rusizi but the MOH together with its DPs plan to scale-up One-Stop Centers in every province starting in 2011.

2. Expand/improve disease prevention and health promotion

2.1. HIV

Table 16. Findings in HIV (Logical framework. p. 34/35)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. HIV Prevalence 15-24 down	HIV Prevalence down from 1% to 0.5% (TRAC)	DHS results to be published
2. % PW tested during ANC	% PW tested up from 75% to 90%	98%
3. % HIV+ PW receive ART	% HIV+ PW on ART up from 67% to 90%	91%
4. Use of condom in last high risk sex intercourse	Female up from 26% to 35% Male up from 39% to 50%	DHS results to be published

Achievements (Qualitative Information)

Activities are implemented through the following programs: Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMCT), Male Circumcision, Prevention for positive and discordant couples. Activities related to all these five programs are implemented in an integrated package of services at Health Facility (HF) levels: district hospitals and health centers. HIV related activities are not yet integrated to the community health programme

Achievements can be summarized as follows:

- 82% HF implemented the full package of activities related to the different preventive activities
- Prisons and some private facilities are also providing VCT services
- Budget is already available with the support of PEPFAR and GF to cover the remaining health facilities with the full package of preventive activities
- Around eight thousands (8000) males have been circumcised during phase one of the 'male circumcision initiative' that started in 2009, being a result of joint work done by the former "Comité National de Lutte contre le VIH/SIDA" (CNLS) and the HIV National Programme. Activities were based on a Knowledge, Attitude and Practice (KAP) base-line survey.
- Health Centre workers have been trained countrywide in providing preventive services to "People Living With HIV/AIDS (PLWHA). Algorithms to facilitate technical decisions have been distributed to all health workers.
- Activities targeting "discordant couple" have been initiated and cover 2% of the country

Challenges (Qualitative Information)

- Insufficient qualified staff at all health facilities represents the major constraints to expand activities with the required quality.
- Turnover of trained health service providers in health facilities
- Insufficient integration of HIV services at decentralized levels: community, HC, DH
- Collaboration between the health services with the Traditional Healers not consistent among the various programs

Table 17. Recommendations for HIV

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Integration of HIV services within the community programme	Continue the integration of HIV services within the community programme
Action 2	Emphasis on pre service trainings for health professionals	Enhance the collaboration with traditional healers at all levels and supervise their activities.

2.2. Malaria

Table 18. Findings in Malaria (Logical framework. p. 35)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
Increased proportion of children and pregnant women sleeping under insecticide treated bed nets	Children up from 58% to 85%	Use LLINs by U5 children: 70%
	Pregnant Women up from 62% to 85%	Use LLINs by PW: 72%
Increased proportion of households possessing one LLIN or 2/more LLINs	HH having 1 LLIN up from 55% to 85% HH having 2 LLIN up from 23% to 80%	HH with 1 LLIN: 82% HH with 2 LLIN: 54%
Malaria Prevalence in U5 children Malaria Prevalence in Pregnant Women	2.6% in U5 children 1.4% in pregnant women	1.4% in U5 children 0.7% in pregnant women

Achievements (Qualitative Information)

The malaria control programme is fully integrated into the whole chain of health care in the country, assuring universal coverage in prevention and treatment. The network of CHW and health professionals has increased the geographical accessibility. The Community Based Insurance has contributed to improve the financial accessibility.

Some major achievements are:

- Community mobilization on LLINs use in collaboration with GF Round 8 sub recipients
- Solid evidence of impact on better knowledge information utilization and community involvement in malaria control
- More than one million LLIN have been distributed after the DHS data collection. This has been done through various MOH technical units like the ANC and EPI services. Figures in the table above will be revised this year considering this new improvement.

Challenges (Qualitative Information)

- Failure to replace discounted LLIN in 2008 led to decline in effective universal LLIN coverage from 51% in 2007 to 24% in 2009, resulting in the 2009 nationwide upsurge in malaria cases in 38 of 40 districts.
- Improve the community based LLIN distribution mechanism
- Ensure continuous delivery of LLINs to replace expired nets and cover new sleeping spaces
- Financing is ensured to maintain the gains of malaria control.

Table 19. Recommendations for Malaria

Summary Actions to be undertaken	Short-term HSSP II August 2011 – June 2012	Long term HSSP III Beyond June 2012
Action 1	LLINs replacement by MOH	CHW to monitor LLIN use by quarterly visits
Action 2	Prevent LLINs stock out in the country	Monitoring of LLIN insecticide efficacy

2.3. Health Promotion and Environmental health

Table 20. Findings in Environmental Health (Logical framework. p. 35/36)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Tobacco Law	Tobacco law passed	No Information
2. Alcohol and drug abuse	Regulations signed	No Information
4. HH using latrines	HH with latrines up from 28% to 80% HH hand washing up from 34% to 80%	DHS results to be published soon
5. Improved drinking water in households and schools	HH exercising safe drinking water handling up to 80% Schools exercising safe drinking water up to 80%	DHS results to be published soon
6. Environmental health data published on MOH website	Environmental health data published quarterly	Not done
7. Safe health care waste handling and disposal	Safe health care waste disposal from 55% to 80%	NA
5. Hygiene clubs in the village	# Hygiene clubs in place	79% of all villages have hygiene clubs

The environmental and hygiene conditions are considered one of the major priorities. They receive strong political support from the highest country leadership. A multi sectoral approach involving all relevant sectors with a sound coordination mechanism at central, district and community levels represents the major focus of this national priority.
In the health sector, health promotion and environmental health services are under the directorate of Mother and Child Health (MCH). The Environmental health desk has a technical working group and is responsible for hygiene promotion. It has a lead role in household sanitation.
The Environmental health programme focuses on: food safety, drinking water quality surveillance, promotion of use of hygienic latrines, waste disposal and family hygiene. The content and main priorities of the programme are based on the situation analysis. Some results achieved by the programme are as follows:

Achievements

- A multi sectoral policy and strategy has been designed based on the findings of a situational analysis.
- MOH launched the Community Based Environmental Health Promotion Programme (CBEHPP) and developed the CBEHPP road map, outlining the priority interventions and setting the 'gold indicators' for good environmental health services. MOH also developed a draft food safety policy that emphasises decentralization of hygiene inspections and the grading of food establishments.
- A presidential hygiene and sanitation campaign was organized in 2010 that focused on hand wash campaign,
- Hygienic latrines are being constructed by families themselves. Those that can not afford them, will receive support from government
- "Hygiene Clubs" have been established but are not yet operational. With support from CHW, they will address hygiene issues, such as clean water, sanitation and behaviour changes. Tools for dialogue have been developed.
- Guidelines and standards have been developed for all district hygiene committees and school hygiene curricula.
- Training of the health staff in charge of hygiene, including "training of trainers".
- Training of health workers on health care waste management (HCWM) and injection safety and the construction of multipurpose health care waste pits in health centres.
- Purchase of National industrial incinerator which has the capacity of incinerating 200 kg/hr that will be installed in Kigali.

Constraints

- Sanitation and hygiene activities are not well captured by the HMIS;
- A household survey on hygiene behaviour changes has never been done to establish the baseline information for hygiene and sanitation messages.
- Few hygiene clubs are currently functional;
- Budget related constraints, as no funds were allocated to CBEHPP.

Table 21. Recommendations for Environmental Health

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Develop a health promotion & environmental health sub-information system	Develop training plan for all professional categories to manage information flow
Action 2	Establish an inventory of hygiene and sanitation through household hygiene and sanitation assessment.	Integrate environmental health and hygiene in all health sector initiatives. Ensure supervision and coordination
Action 3	Finalize the national drinking water quality surveillance strategic action plan	Continue with surveillance of quality of drinking water in all districts
Action4	Finalize the national food safety policy	Strengthen decentralization of hygiene inspections and operationalise hygiene grading system in hotels and restaurants
Action 5	Finalize the hygiene / sanitation regulations	Enforce regulations through capacity building of Environmental health officers
Action 6	Develop environmental health strategic plan	Improve the funding of the environmental health programme for supervision etc
Action 7	Finalize the training of CHWs, Hygiene Clubs executive committees and dialogue sessions in 10 districts on CBEHPP approach.	Strengthen the functionality of hygiene clubs and hygiene committees at all levels, health care waste management and injection safety

2.4. Development and mainstreaming of health communication

This function is taken care of by the Rwanda Health Communication Centre. It has recently been established as part of the RBC. It collaborates and supports the many technical units and programmes in the sector through the advisory services of its Focal Points, being health promotion specialists in various domains.
Its mandate is to support:

- All activities from the various MOH Units, desks and departments related to "Communication for Behaviour Change (CBC)";
- Mainstreaming the media information flow within and outside of the sector, including public relations of the MOH.

Achievements

- Development of CBC strategy for the MCH components
- CBC messages through various channels: radio, TV, newspapers

Constraints

- Staff shortage
- Donor dependency: lack of financial management flexibility

Recommendations

- Build a core team at central level with strong institutional capacity
- Elaborate a health promotion policy and strategy
- Develop a network of expertise countrywide that can be called when needed
- Where possible outsource technical services to private professionals

3. Expand/improve disease treatment and control

3.1. HIV/AIDS

Table 22. Findings in HIV/AIDS (Logical framework. p. 36/37)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. # HC/Hosp with 'full package (VCT/PMTC/ART)	HC up from 142 to 508 (341 CT/PMTC) Hospitals up from 44 to 46 full package	273 HC (62%) full package All DH have a full package
2. % ARV coverage HIV+	90% of HIV+ people with CD4 < 200 70% of HIV+ people with CD4 < 350	NA NA
3. % HIV+ covered by ARV	Women from 55% to 90% Men from 50% to 90%, Children 80 to 90	84% of HIV+ are covered by ARV
4. > than 12 ms treatment	Adults and children from 90% to >91%	Not available to integrate within TRAC+

Achievements (Qualitative Information)

National guidelines for comprehensive care and treatment of PLWHA, Opportunistic Infections, STI, Post Exposure Prophylaxis, Psychosocial, pediatric norms and procedures; HIV prevention guidelines are available in French and English, approved by MOH; disseminated in all health facilities and are used by the health care providers

Various technical, working tools and guidelines are developed or revised and are available in health facilities; some are:

- Patient files in hard copies and electronic forms
- Availability of 3rd line treatment for patients failing 2nd line has just started
- HIV prevention and global care & treatment indicators
- The registers according to the new indicators have been elaborated, printed and used by health care providers
- Nutrition implementation plan is developed and implemented
- Monthly reporting forms revised according to the new changes.

A comprehensive and up-to-date training programme has been designed and implemented for all health professionals, nutritionists, social workers (including a training of trainers' programme)

A supervision and mentorship programme (with relevant tools and guidelines) has been elaborated and is being implemented at all levels

Challenges (Qualitative Information)

- management of treatment failure and limited lab capacity
- While drugs are available to cover all HIV+ persons, some do not continue their treatment while others do not come back after testing.
- long time co-infection management
- Diagnosis of HIV in children is difficult and hence enrolment remains low
- Inadequate integration of HIV services at decentralized level

Table 23. Recommendations for HIV/AIDS

Summary Actions to be undertaken	Short-term HSSP II August 2011 –June 2012	Long term HSSP III Beyond June 2012
Action 1	Emphasise quality of care through task shifting	Integration of HIV services within CHW programme and within Health Facilities
Action 2	Focus on specific ages (children, adolescent)	Emphasise pre-service trainings
Action 3	Emphasis the link between testing and care to minimize Lost Treatment Follow Up (CHW)	

3.2. Malaria

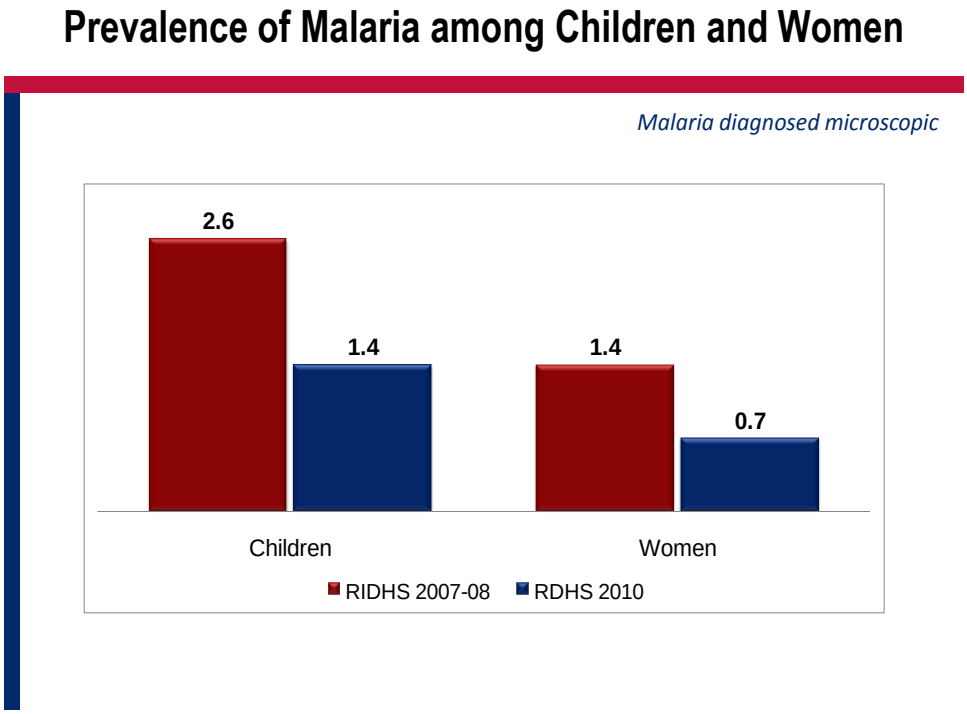
Table 24. Findings in Malaria (Logical framework. p. 37)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Proportion of U5 with malaria that receive correct, affordable treatment within 24 hours after the onset of symptoms	% < 5 yrs treated within 24 hrs up from 85% in 19 HBM districts to 90% (2012)	91%
2. % of suspected malaria cases Confirmed by either microscopy or RDT	Confirmed by RDT from 85% to 90%	94%

Achievements (Qualitative Information)

- Malaria treatment, using ACTs countrywide with 94% lab confirmation in all suspected cases
- 91% of children under-five treated for malaria within 24 hours
- Effective referral system supported by ambulances at hospitals and cell phones by CHWs
- Good collaboration with HF and commitment from CHWs to treat confirmed cases.
- The graph below shows the decrease of the malaria prevalence among children and women.

Figure 1. Prevalence of Malaria among children and women (DHS 2010)



Challenges (Qualitative Information)

- Delay of CCM implementation with RDTs confirmation before treatment in districts supported by Presidential Malaria Initiative (as RDT is a new initiative and PMI planning done 2 years before); No data on RDTs in the HMIS reporting tools.
- Private sector health care providers are not benefitting from the training provided to public sector staff.
- Treatment of severe malaria cases at the level of the district hospital.

Table 25. Recommendations for Malaria

Summary Actions to be undertaken	**Short-term HSSP II August 2011 – June 2012**	**Long term HSSP III Beyond June 2012**
Action 1	Review the management of severe malaria to identify potential areas for improvement	Continue ensure universal and equitable access to diagnosis and treatment at community level with the support of the health insurance scheme.
Action 2	Integrate RDTs in the HMIS reporting tool	Conduct studies for emergency pre-referral treatment of complicated malaria cases by CHWs to higher level HF by using rectal artesunate.
Action 3	Continue monitoring of drug efficacy	Advocate for better compliance on malaria policy in the private sector

3.3. Tuberculosis (TB)

Table 26. Findings in TB (Logical framework. p. 37/38)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. R/ Success Rate (DOTS)	Up from 76% (2005) to 87% (2012)	86%
2. MDR/TB cases	Success treatment up from 86% to 87%	89%
3. % TB patients tested HIV	TB tested for HIV up from 96% to >98%	97%

Achievements (Qualitative Information)

The success achieved by the TB programme is due to the integration of the related activities in the whole health care delivery chain, from the community level through the CHW to the health facilities. This integration includes elaborating training activities, formative supervision, follow up of patients, financial accessibility scheme, etc. The TB programme has also developed joint activities with the HIV/AIDS programme, such as:

1. Establishing mechanisms for collaboration through

- Setting up a national coordination body for TB/HIV activities
- Conducting surveillance of HIV/AIDS prevalence among tuberculosis patients
- Carrying out joint TB/HIV planning
- Monitoring and evaluation of collaborative TB/HIV activities

2. Developing activities to decrease the burden of TB among people living with HIV/AIDS:

- Establish intensified tuberculosis case-finding
- Provide HIV counseling and testing
- Introduce HIV prevention methods
- Introduce co-trimoxazole preventive therapy
- Ensure HIV/AIDS care and support
- Introduce antiretroviral therapy

Challenges

- Low TB case detection despite existing strategies to improve it. It is commendable to support the already initiated TB prevalence survey.

3.4. Non-Communicable Diseases (NCDs)

Table 27. Findings in NCDs (Logical framework. p. 38)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Prevalence studies	Prev / risk factors diabetes, hypertension, CVD and cancers are known (in 2010)	Not yet initiated
2. Output	% HF providing chronic care (TBD)	NA

The epidemiology and clinical management of the Non Communicable Diseases[8] (NCD) are not fully captured in the HSSP II. A desk staffed with two professionals was created by the MOH in March 2011 that will have to address the NCD related problems. Some activities have already started:

Achievements

- The development of a strategic plan for cervical cancer is at an early stage. It will be drafted in collaboration with the MCH Unit, as the promotional and preventive activities are under their responsibility.
- Increased public awareness of cardiovascular disease through yearly sensitisation campaigns organised by MOH and Heart Foundation.
- Existence of Cancer registration in two referral hospitals.

Constraints

- The development of an integrated chronic care policy and strategic plan which includes NCDs has not yet been initiated.
- The relation of this recently created unit with other units / departments within MOH has not been clarified.

Table 28. Recommendations for NCDs

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Finalize the ongoing base line survey	Provide institutional reinforcement and support to the NCD unit
Action 2	Develop the NCD policy and finalize the strategic plan	

[8] Non Communicable Diseases (NCD) refers to various groups of diseases such as Cardio-Vascular Diseases, Chronic Pulmonary Diseases, Diabetes, Cancers and Disabilities.

3.5. Neglected Tropical Diseases (NTDs) and other Infectious Diseases

Table 29. Findings in NTDs (Logical framework. p. 38)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Prevalence soil transmitted helminths in school age	Prevalence down from 65% to 50%	No data available
2. # Surv Officers training	# Surveillance Officers trained: 0 to 70.	No data available

The unit of Neglected Tropical Diseases[9] (NTDs) was situated under the Division of Other Epidemiological Infectious Diseases. It has recently (partly) been moved to the Division of Malaria and other Parasitic Diseases.
A few prevalence studies were done to guide prevention and treatment of NTDs.
In general, the unit has not been very active, due to insufficient staff and the prevalence of some of these NTD is rare in the country. They will not be further discussed here.

However, the division of 'Other Epidemiological Infectious Diseases' has been quite active, mainly focussing on "Emergency Preparedness and Response (EP&R)".
With technical and financial support mainly from CDC and with Master students from the School of Public Health, the division has been able to prepare itself for the various disasters in the area of infectious diseases that might strike the country, such as Avian Flu, Ebola Virus and others.

Achievements
The division has trained different staff (doctors, nurses, lab experts) at all levels, set up the necessary (field) laboratory tests, constructed isolation wards and has an adequate software system in place.
It developed a five year strategic plan that ensures that MOH after these five years will be able to continue EP&R without external financial support (from CDC).
The division is therefore confident that it is well prepared for any emergency preparedness and capable to provide an adequate response in a matter of hours / days.

Constraints
- While the Integrated Health Emergency, Contingency Plan (EP&R) address all issues related to health in epidemics and disasters, the current EP&R approach is still mainly confined within the health sector, whereas a multi sector response is needed if emergency were to strike the country.
- The programme is funded to a large extent by the CDC, other DPs are phasing out.

Table 30. Recommendations for NTDs

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1		Develop a multi sectoral approach to plan and implement a comprehensive NTD programme

[9] Neglected Tropical Diseases (NTDs) refer to diseases such as Trachoma, Schistosomiasis and Soil Transmitted Helminths (all present in the country); Trypanosomiasis, Onchocercosis (their presence still to be determined) and Filariasis (non existent in the country)

PART B. STRATEGIC PROGRAMME AREAS / SYSTEMS

1. Strengthen the sector's Institutional capacity

1.1. Planning and monitoring the sector

Table 31. Findings in Planning and M&E (Logical framework. p. 39)

Strategic Area	Indicators	Baseline	Target 2012	Achievements MTR 2011	
				Achievements	% target
Planning and M&E	% of facilities with fully costed strategic plans	NA	100	100% of District Hospitals have an annual operational plan	100
	% districts with operational SWAp	NA	30	NA	
	% of HFs reporting according to HMIS reports	NA		100% of public health facilities* give HMIS report on time (100% compliance) to HMIS Unit/MOH	
	% of districts with 1 HC per sector	NA	30	NA	
	% of HFs with full package of activities (CPA and MPA)	NA	100	100	100
	% of DPs signed up to SWAp MoU	NA		NA	

* Note: Private health facilities that report are very few; their total number is not yet known.

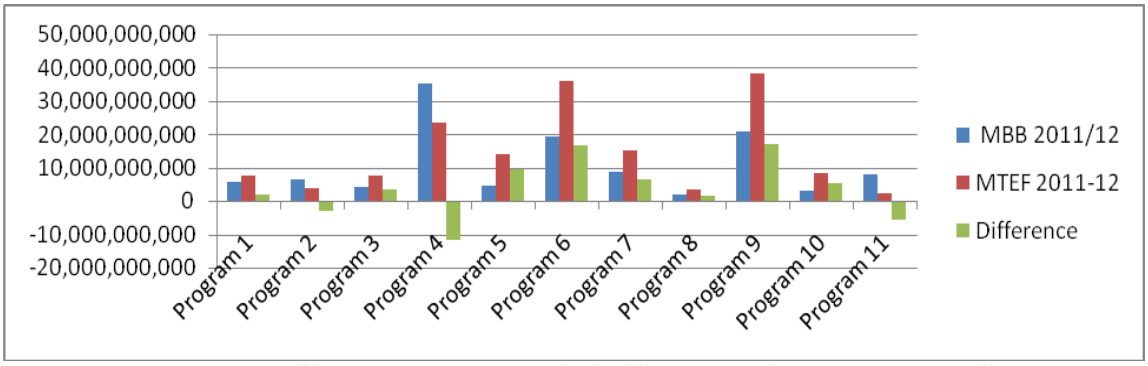
Achievements (Qualitative Information)

The HSSP II is aligned with EDPRS, the government's overall plan. The districts have strategic plan between 2007 and 2012 in which the sector plans are included. These health strategic plans are more aligned to HSSP I than to HSSP II. The health facilities (districts hospitals and health centers are implementing annual operational plans that are aligned to the HSSP II strategic objectives, showing resource commitments from different sources. There are forward and backward looking reviews with stakeholders to reach consensus on targets, budgets and CPAF indicators for the coming year and to review performance of the last year respectively.

The Ministry of Health has recently started building the capacity of District Health Teams in Planning and Budgeting, by providing MBB training in 5 Districts. The roll out will come in the near future after putting in place other district health staff (M&E have already been recruited waiting placement). During the roll out, the need-based MBB planning tool should not overtake the resource constrained planning process that is in place at present. There is progress, though slow in fiscal decentralization. The sector started in 2007 to decentralise 4 programs: Human Resources, Quality, Geographical and Financial access. There are also efforts to send money of the remaining programs as "earmarked transfers", as districts report directly to MINECOFIN on these programs.

The planning and budgeting process is being supported by MTEF (resource ceiling provided by Ministry of Finance) and a resource tracking tool. There is a clear commitment to bring the various expenditure tracking instruments (NHA, resource tracking and public expenditure reviews) into one system through the resource tracking tool. The health sector is credited not only for having a better planning and budgeting process compared to other sectors both at the district and national levels, but also for putting a good case for increased resource allocation for MINECOFIN (see figure 2). The figure shows overfunding in some programme areas (such as HIV/AIDS and Malaria) and underfunded areas (like infrastructure) using MBB and MTEF frameworks at the same time.

Figure 2. Priorities of the various MOH programs as submitted to MTEF



Source: MOH, 2011, Health sector statement of priorities, MTEF (June 2011 - 2012)

Sector Performance Reviews are undertaken annually as part of a Joint Health Sector Reviews (JHSR), based on annual and periodic performance and process indicators as well as MTEF monitoring. The findings of the review with required actions are monitored and disseminated to all stakeholders.

Significant strides are being made to strengthen the information system. A strategic plan guiding the development and implementation of various independent but interrelated information systems is place. These efforts have increased the reporting rate, coverage and to some degree quality of data. PBF has facilitated the environment for better reporting by introducing not only incentives for performance and its reporting but also putting penalties for late or incorrect reporting (10% reduction of PBF funding until next audit for 5% error in reporting). The selection of the minimum health indicators has been finalized; HMIS forms revised to reduce the transaction cost for health workers; community based information system introduced throughout the country; data quality strategies and structures have been established at central and district levels. Automation of the various subsystems are ongoing, some are functional while others are being developed. Data quality audit is being carried out to each facility every quarter by the district and headquarters. Improved HRIS and LMIS are under development as well as the establishment of a data warehouse and web-enabled dashboard and SOPs for data management and use.

Constraints (Qualitative Information)

There are some constraints and gaps observed in the planning, budgeting and M&E frameworks, including:

- Knowing the contribution of development partners: predictability is poor, as most of the DPs provide one year of information for the MTEF process. The resource tracking tool results have not been able to provide commitments in the form of the mapping of resources before the onset of the planning process (ideally during the time when MINECOFIN provides the ceilings to sectors). This is complicated by the inability of some of the DPs to know their budget due to differences in budget calendar. There is a disconnect between the vision and the practical use of the tracking tool at the moment. The vision to making it comprehensive and 'catch' everything may have compromised its instrumental role to guide the resource constrained planning process. The potential of the tracking tool, the joint annual work plan and the district health systems tools have not been effectively utilized to inform the planning and budgeting process.
- Bringing off-budget resources to the table. Though the annual review process provides a forum at which DPs and government present performances as part of mutual accountability, significant portion of the resources remain off-budget.
- Currently the MOH has well decentralized internally its service delivery. However, it could do much more in district decentralizing than what it is doing now. There are limited discretionary funds available at the district level in the form of district pool. Plans are more driven by central guidelines than by local priorities. District level comprehensive planning remains weak, even

weaker than the health facilities. The capacity and ability to prioritize interventions at the district level leaves a lot to be desired. With the narrow decision space on resource allocation and priorities at the district level (weak fiscal decentralization), the development of a district level consolidated plan (district SWAp) and the effectiveness of creating a viable district health coordination unit remains questionable. As there is a revised fiscal and financial decentralization policy adopted by the cabinet in 2011, there is a need to enhance the effort to strengthen the district health unit even more than what is planned in the Reorganization of District Health System Concept Note.

- There is unclear working relationship between district hospitals and district health unit on one hand and their planning relationships with DPs on the other. The district hospitals are better resourced and capacitated than the health unit. As a result, DHs do most of the coordination of the health centers. The DP are financing DHs to do what the health unit is supposed to do. All stakeholders need to consider a shift of priority and focus both in terms of skills, human resources as well as financing.
- Current production of information systems follow calendar rather than budget year. This will make it difficult to attribute results to funding. There are too many interventions being implemented and there is a need to set priorities from among competing sub information systems. The capacity to manage the implementation of the M&E framework at the central level remains weak and forced shifting some of its responsibilities to partners. There are also capacity gaps in analyzing the information generated from public health facilities and use it to inform planning and decision making at all levels. There is room for improving data use at all levels; not all health sector stakeholders (NGOs and private sector for instance) are reporting using the national system. Other challenges related to building the information system are constraints imposed by other infrastructure development sector ministries (infrastructure, ICT)

Table 32. Recommendations for Planning and M&E

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Rollout the district health implementation Unit guidelines and employ competent officers that can lead the development of a comprehensive district health plan	Strengthen the implementation of the exiting intervention in M&E and HMIS
Action 2	Asses the practice of the resource tracking and district health systems assessment tools. Devise strategies to ensure they effectively inform the annual operational planning process	Enhance data use at all levels
Action 3	Enhance the quality of facility, district and national plans in terms of quality and comprehensiveness through provision of training on evidence based, resource constrained prioritization and target setting.	Strengthen the link between planning, budgeting, execution and reporting processes by setting up mechanisms and incentives in the system Consider developing regulation for NGOs private sector to report through HMIS
Action 4	Work out a clear strategy of decentralization (taking into account the recent fiscal decentralization strategy) in consultation with Ministry of Local Government.	

1.2. Governance, decentralisation and regulation

Table 33. Findings in Governance (Logical framework. p. 39)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Districts with SWAp	% District SWAp up from 0% to 100%	NA
2. Coverage of HCs in the districts	% Districts with 1 HC in each sector Baseline TBD	86% of districts have at least 1 HC in each sector (6 sectors in 6 districts don't have HC)
3. HF with full package	% HF with full package (CPA, MPA) Baseline TBD	42 DHs and 438 HC provide full package of care

Achievements (Qualitative Information)
Decentralization has been a key policy of the Government of Rwanda (GOR) since 2000 when the National Decentralization Policy was adopted with the overall objective of ensuring equitable political, economic, and social development throughout the country and making the district the centre of the development trajectory necessary to reduce poverty. Decentralization is enshrined in Rwanda's Constitution. Article 167 of the Constitution of Rwanda provides for decentralized entities and reiterates that they are the foundations of community development.

Decentralization and strengthening of Local Governance is reflected in the EDPRS and the Vision 2020 and the Government of Rwanda programme for 2010-2017. The decentralization policy was approved in 2001 and defined three phases of implementation. From 2001 to 2005, a first phase was implemented, aiming at establishing democratically elected and community development structures at the Local Government. The focus was to put in place the necessary legal, institutional and policy reforms, which institutionalized decentralization in Rwanda.

In the second phase, from 2005-2010, the focus was on carrying out a territorial restructuring, which considerably reduced the number of administrative entities (from 11 to 4 provinces, 106 to 30 districts, 1545 to 416 sectors, and 9165 to 2148 cells), and aimed at consolidating progress on national priorities.

The GOR is now entering the third phase of decentralization. A decentralization implementation plan 2011-2015, from Ministry of Local Government (MINALOC), has been put forward. The MOH together with relevant DPs in the health sector have put forward a 'Concept Note' (May 2011) with district health system re-organization guidelines, which has been sent to MINALOC in the capacity as responsible Ministry. The final outcome of this discussion is not known. Moreover, the GOR has recently (May 2011) approved a Revised Financial and Fiscal Decentralization Policy which will have an impact on the health sector, specifically on the roles and responsibilities in areas such as; resource allocation, planning, budgeting, budget execution, financial reporting among others. These recent changes have not yet been reflected in the MOH's Concept note, which might thus need to be updated to reflect the new policy.

Within the health sector service delivery decentralization has taken place and has shown service delivery results. However, fiscal decentralization so far has not yet taken place. As from fiscal year 2011/2012 considerably more funds will be channeled directly to the districts as inter-agency transfers have been reduced. Consequences of this change seem not to have been broadly discussed within the HSWG, including TWGs.

A commission under the Joint Action Development Forum (JADF) is proposed which could not only play the two key roles to promote the implementation of SWAP, but also actively promote the further Aid effectiveness and alignment agenda, ref 1.3. below.

The overall conclusion is that there is still need to further enhance and establish:

- Harmonized and updated decentralization guidelines for effective implementation of devolved health service delivery,

- Further clarify roles and responsibilities of the MOH and District administration/district health units and between MoH and district administration/health unit with the service providing units.
- Communicate to ensure the legal and regulatory framework is non-ambiguous with common interpretation by all entities.

Challenges (Qualitative Information)
A challenge highlighted in the recent Decentralised Implementation Plan 2011-2015 related to Sectoral Decentralization is that there have been different and asymmetrical responses to decentralization by different sectors. In the design of the district health system, attention needs to be given to how other sectors design the resource allocation, planning and budgeting, budget execution, financial reporting etc. Vertical sector solutions (silos) should be avoided for generic functions at the district administrations. This is also a way of making the structures more cost-efficient.

The MOH and DPs have so far been proactive in the design, but could have benefited from giving some more attention to: clarifying the future role of the MOH and the districts respectively in public health administration; giving more attention to the institutional capacity constraints facing both the district administration and their health units in taking on more responsibilities as fiscal decentralization proceeds. There are institutional capacity constraints at district level which need to be addressed in the HSSP III. The weaknesses in the present PFM systems indicate that both institutional capacity but also intermediate safeguard measures to mitigate fiduciary risk are needed.

There are risks related to inadequate guidelines on service delivery performance standards and norms in the health service provision. These risks are being addressed with protocols and guidelines that are currently being developed. This is an area that is further discussed under Quality Assurance in this report.

Table 34. Recommendations for Governance

Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Reassess the Concept note based on Revised Financial and Fiscal Decentralisation policy and other recently adopted policies/strategies and directives. Assess potential for symmetrical solutions with other sectors for generic functions at District administration. Decentralization involves all TWG and coordination is crucial to ensure a comprehensive perspective.	Design and implement a decentralization Road Map as part of HSSP III that is aligned to the overall government decentralization policies and strategies in consultation of MINECOFIN and MINALOC.
Action 2	Design Road map for improving PFM in District administration and health facilities, based on capacity assessment. Link to broader PFM reform, but mirror at health sector level	Develop and implement decentralized capacity building plan to strengthen the district health team (number and skills) for all institutional issues.
Action 3	Incorporate the various consequences for MOH of the decentralization proceeds as part of the development of protocols and guidelines, currently underway.	

1.3. Aid Architecture, Harmonisation and Alignment

Table 35. Findings in Aid Architecture and H&A

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
DPs signed SWAp MOU	DPs signed up from 32% to 100%	Situation unchanged or risks to become worse as per MTR

Achievements (Qualitative Information)
The Government of Rwanda (GOR), represented by the MOH and supported by MINECOFIN, the overall responsible ministry, is committed to pursue the Paris Declaration on Aid effectiveness, harmonization and alignment and the Accra Agenda. Clear objectives for the whole of government are stated in the Aid Policy and supporting strategies.

Mutual accountability is institutionalized and the Development Partners' (DP) performance is measured regularly according to the agreed indicators in the Common Performance Assessment Framework (CPAF) for the General Budget Support (GBS) and Sector Budget Support (SBS) partners. CPAF includes important indicators such as: % on aid included in budget documents, portfolio composition (% of aid as budget support, programmatic support or project support, specific administrative requirements on procurement, financial reporting and auditing etc.). There are regular joint sector review meetings both at the central and district levels between government and development partners.

The DPs engaged in the health sector are broadly aligned to the HSSP II which is a great advantage in the sense that there is one jointly agreed plan between the GOR/MOH and most DPs, giving direction to the priorities to develop service delivery and health systems. This included the use of jointly agreed and uniform performance and monitoring systems, which is, to a large extent, based on HMIS data. There is also alignment of using the same guidelines and implementation among development partners when working at the districts, paying same type of salaries to human resources using government scales.

The MOH demonstrates a strong leadership at the highest level. Within the different units capacities and leadership varies and some areas needs to be strengthened. The overall architecture of joint management / monitoring, with a joint GOR-DP harmonized calendar, is well structured and provides clarity on the links between the joint assessments and monitoring of the overall government programme and the links between the sector and the district assessment.

Moreover, thematic working groups (TWG) are established in the health sector for joint management and monitoring of the HSSP II, under the umbrella of a Health Sector Working Group (HSWG), previously the Health Sector Cluster Group. The total number of TWG and sub-groups are consolidated to around 23, organized under 7 main working groups[10].

The recent enforcement of the Single Project Implementation Unit (SPIU) aims at reducing the number of separate PIU's and eventually to reduce the administrative burden. MOH was the first to establish this unit in March 2011.
A SWAp implementation manual and a Road Map have been developed and endorsed in October 2010. The implementation manual still has some gaps, and could have been further developed to clarify the management procedures, the commitment and decisions of partners, disbursements procedures, development of a disbursement schedule for all DPs, clarifying reporting requirements and the reference documents linked to a management calendar for the SWAp, among others. Donor coordination could have been made more explicitly described.

[10] These working groups are (i) MCH/FP (including Nutrition and Community health); ((ii) Prevention of diseases (including BCC, environmental health); (iii) Treatment and control of diseases; (iv) Health system strengthening (HSS); (v) social mitigation; (vi) health sector research and (vii) e-Health.

Challenges (Qualitative Information)
The DPs in the health sector are heterogeneous and some have advanced in harmonization, such as the One UN, streamlining UN agencies procedures, together reducing their specific requirements on procurement and thus becoming more aligned. Other DPs are more aligned in Rwanda than in other countries. USG is channeling some of its resources through government systems (programs through MINECOFIN and Ministry of Health). It is also preparing a program to be managed by SPIU .The first wave will concern mainly CDC Grants. However, overall, the use of parallel systems for budget execution / accounting, including financial reporting, procurement and auditing (external) still prevails. It are these areas where alignment should be more actively pursued.

The amount of off-budget aid flows in the health sector, both at central and district levels is assessed to be one of the largest constraints to strategic resource allocation and overall management of the HSSP II, distorting the MOH ability to assess equity in terms of resource allocation, and effectiveness and efficiency of the health system and service delivery. This is reflected in the overfunding of some of the programs (HIV/AIDS, TB and malaria) and while underfunding of some of the programme areas, like human resources and infrastructure.

One of the great challenges in the Rwandese context is the limited institutional capacity, which is further accentuated by the decentralization process. The amount of parallel systems and DP specific requirements for budget execution and accounting, financial reporting, procurement, auditing etc all contribute to substantial increases of the administrative burden on the GOR/MOH, and on HF (hospitals, HCs). Reducing the administrative burden should be a top priority.

In its present form and mode of operation, the SPIU in the health sector may fall short of addressing the key constraints, some of which are: multiple DP procedures not yet streamlined or harmonized; different tools applied in parallel (SmartFMS, Tompro, Sage Pastell, Excel); different reporting requirements. All these non-aligned requirements contribute to increase the administrative cost / transaction cost of receiving aid and drain the administrative resources, increase complexity of financial management and increase its fiduciary risk. These parallel systems are presently applied in the financial departments of the MOH, in the SPIU and even, to some extent, in health facilities. As the decentralization process proceeds, more specifically the fiscal decentralization, these parallel systems will be in use at district level, both in the district administration (health units and financial departments) and at health facility level.

The GOR's Public Financial Management (PFM) reform has contributed to improvements in many key areas of Public Financial Management. However Public Expenditure and Financial Accountability assessments (PEFA 2008 and 2010) and other reviews, including this MTR, reveal weaknesses in the present budget execution and accounting system, in annual financial reporting, end of fiscal year financial statements etc. Our impression is that the weaknesses in the PFM systems, and the fiduciary risk, have not been sufficiently addressed as an integral part SWAp management and programme implementation.

Table 36. Recommendations for Aid Architecture and H&A

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	DPs to work out mechanism for further streamlining their procedures when working with SPIU rather than coming up with separate units / procedures.	Feasibility assessment on DP alignment
Action 3	Strengthen coordination unit or establish secretariat to support the HSWG in HSSP II management	SWAP Road map enforcement
Action 4	Task force to actively use Resource mapping and DAD to address off-budget flows	
Action 5	Create Road map to strengthen PFM in health sector and consider safeguard measures for risk mitigation	

2. Increase availability and quality of Human Resources

Table 37. Findings in HRH (Logical framework. p. 39/40)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Ratio Med Drs to Pop	In 2008 1 / 33.000 up to 1 / 20.000 in 2010	1 / 17.240
2. Ratio Nurses to Pop	In 2008 1 / 1700 up to 1 / 5000 in 2010	1 / 1294
3. Ratio midwife to Pop	In 2008 1 / 100.000 up to 1 / 20.000	1 / 66.749
4. % Health staff outside Kigali	Staff outside Kigali from 68% to 90%	NA
5. % CHW Basic Package	Trained in BP up from 0% to 100%	100%

The MOH has developed norms for HRH for the different levels of the health services: administrative support staff and heath care delivery at health facility level. These norms are aligned to the essential package of health care that every level is responsible for.
The HRH Technical Working Group has been created to advise the Ministry in policies, strategies plans and implementation.
Substantial efforts have been deployed by the MOH to respond to the HRH needs in order to improve the accessibility to better health care for the country. The targets for the number of doctors and nurses have been met (and surpassed, see table 37). Only the numbers of midwives still need to increase substantially. Other achievements are as follows:

Achievements

- A comprehensive HRH Strategic plan 2011-2016 developed.
- Continuous Education Plan for physicians has been elaborated. Other health professionals will also get the opportunity to participate.
- The public service has developed a Capacity Development Plan for which assessment tools are now available.
- A formal four year Masters Programme (Family and Community Medicine / FAMCO) has been initiated (competency based training) and is now in its third year.
- Licensing of health professions initiated: physicians, nurses & midwives, pharmacists and allied health professionals.
- Workload indicators for the various staff categories developed and analysed in 30 districts
- Improvement of all HRH categories ratios at all health facilities.
- Medical education under direct authority of the MOH in charge to develop consistent HRH training policy and strategy according to needs.
- HRH norms defined with standards and regulation.
- Existence of functional institutions for HRH production (Faculty of Medicine, Faculty of Pharmacy, School of Public Health, KHI, 5 nursing schools etc.)

Constraints

- Instability and high turn-over of staff (more in remote areas).
- Unbalanced distribution between rural and urban areas.
- Shortage of various health professionals (in quantity and quality), such as medical specialists (in district and tertiary hospitals); midwives in HCs; and (bio) engineers in the maintenance department (central level) and in referral and district hospitals. There is also a serious shortage of laboratory technicians, especially in HCs.
- Weak HRH information system, such as little information on reasons for attrition and absence of a comprehensive situation analysis to inform HRH Policy.

Table 38. Recommendations for HRH

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Implement the Continuous Education Plan	Support and formalise the FAMCO Masters programme
Action 2	Strengthen the Medical Education and Research department	Undertake a Capacity Needs assessment Develop capacity development programme
Action 3	Document the HRHIS requirements	Put in place full HRI System.
Action 4	Develop a HRH Policy document	Update / align HRH strategic plan to HSSP III
Action 5	Train different categories of middle level cadre (allied health sciences), e.g.: A1 laboratory technicians, nutritionists and environmental health specialists.	

3. Ensure financial accessibility and equitable financing

3.1. Financial accessibility

Ensuring financial accessibility to health services for all in sustainable and equitable manner is one of the programme areas of the HSSP II. Not only the HSSP II set out clear strategic objectives and targets, but since then three detailed financing policies have been issued: the overall Health Financing Policy, and National Health Insurance Policy and the Community-Based Health Insurance policy. A closer look at these polices revealed that the challenges indicated in the HSSP II and the overall strategies are now translated into concrete policy actions. A health finance unit has been established in 2010 to guide and steer the implementation of these health financing agenda. Progress towards achieving some of the set targets is presented in table 39.

Table 39. Findings in financing the sector (Logical framework. p. 40)

Strategic Area	Outcomes	Indicators	Baseline	target 2012	Achievements MTR 2011	
					Achievements	% target
Financial Access to services	Budget and alignment	Public expenditure (including GBS and SBS) as % of GOR total expenditure	6.5	12	11.5 (2011/12 budget finance Law data)	96
		% of external assistance in total health expenditure	38.2		32.9 [11] (BTC)	86
		% of external assistance to health channeled through budget and sector support mechanism	NA	NA	48% (2011/2012 Finance Law data)	
		% of external assistance allocated through performance based financing mechanisms	NA	NA	29%	
		% of external assistance allocated to the provision of health insurance coverage for poor and vulnerable groups	NA	NA	37%	
		Per capita RWF allocated to community health workers through PBF (RWF)	NA	NA	293 (2010/11 budget)	
		Per capita RWF allocated to health centers and district hospitals through PBF (RWF)	NA	NA	1079 (2011/12 budget law)	
		Resource allocation formula developed in 2012	NA	NA	Not carried out	

Achievements (Qualitative Information)

According to the finance law of 2011/12 (excluding off-budget, public parastatal expenditures and health related expenditures from other ministries), public health expenditure (Including GBS AND SBS) as % of GOR total expenditure increased to 11.5%, slightly lower than the 12% set in the HSSP II and much lower than the Abuja Declaration of 15%. On the other hand, the financing by external assistance (both on- and off-budget) remains significant, in terms of financing the health sector. The preliminary (not yet validated finding) of the resource tracking tool show that about 83% of institutional health spending ,which includes spending by government and development partners, but excludes spending by households or the private sector ,is financed by external assistance. Other HSSP II financing targets and their level of achievement are shown in table 40.

[11] The data for the current status was taken from the report from Sven Baeten, 2011, Health Financing Mechanisms at Districts in Rwanda, study on financial resources made available by the MOH at district level.

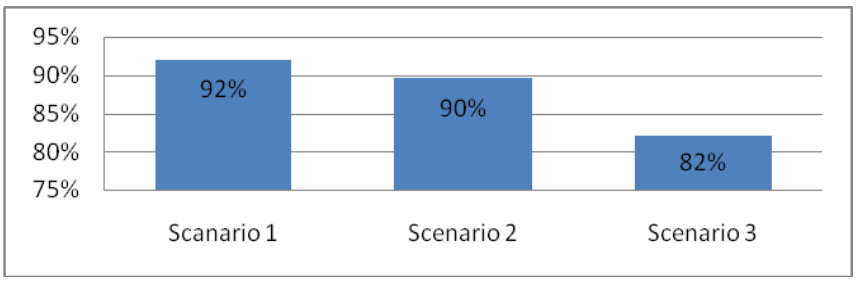
Table 40. Estimated PH expenditure (by GOR + DPs, in millions USD)

	2009/10 Expenditure	2010/11 Budget	Total
Government	25.6	69.9	95.5
External financing	161.6	328.8	490.4
Estimated resources	187.2	398.7	585.9

Source: Resource tracking tool result as provided by MOH. Please note that this figure does not include internally generated funds by facilities. Spending and allocation from other government institutions is also not included.

If we assess the financing situation as compared the projected financing scenario in the HSSP II, the current status seems close to scenario one, the lowest financing scenario. The main omission is the internally generated funds at HF level and the payment from CBHI. If the per capita contribution of community members is included as additional internally generated funds, the total is estimated only to fill the gap of scenario one.

Figure 3. Expenditure 2009/10 and Budget 2010/11 as % of resource projections



Challenges (Qualitative Information)

The SWAp roadmap clearly stated that alignment and harmonization through SWAP has been hampered, among others due to lack of agreement on common procedures. It is therefore high time to implement its recommendation to find jointly common ground and bring all (or most) off-budget support under one single joint management framework'. It may also be helpful to revisit the MOU, signed in 2007.

Aid alignment and harmonization is progressing but below the target set (40% and the targets set to be achieved for 2010 is now rescheduled for 2012/13). Use of county planning, budgeting, procurement and auditing systems has not progressed as planned either. This is also reflected in the health sector. The MINECOFIN report stated "it has been pointed out in various reports on the health sector that spending by the Government represents only a portion of total expenditure of the health sector in Rwanda. The other portion is spent by various external donors and these expenditures are not included in Government's expenditures".

The major sector aligned support comes from SBS donors (German (via KfW), Belgium Cooperation, and DFID). The other one is the Capacity Development Pooled Fund (CDPF) which again is funded by these three DPs (for German Cooperation including GIZ and KfW) and Swiss Cooperation. On the other hand, the fact that the new big USG support package (33 million USD) for harmonization and system development, is not part of pooled funding, is a sorry example of non-harmonized aid (SWAp Road Map). The number of sector budget support DPs has remained the same since its start, while one of the partners is about to exit from the health sector. The fact that other partners are not aligning themselves is, according to government, due to some DPs' countries weak political will and legislative constraints.

It is evident that not enough effort is made by DPs to work through and strengthen government systems (see aid harmonization). The current division of labor as defined by GOR[12] has resulted in the more aligned donors moving out of the health sector and the others and new partners with stringent procedures remain within.
There is a need to review the constraints faced by DPs to use government systems (planning, budgeting, PFM, procurement and M&E) and explore (i) what DPs can do more to be on budget, (or if not, on 'shadow' budget known only to sector partners) and (ii) what the government can do in strengthening its systems and – if possible - bringing them closer to the DPs requirements.

Table 41. Recommendations for financing the sector

Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Produce health finance performance report to be presented in the JHSR.	Enhance the implementation of the health SWAP by agreeing on a strategy to bring more DPs' contribution on plan, on budget and on report.
Action 2	Strengthen the health Financing Unit of the MOH	Become predictable after a thorough review of bottlenecks and constraints
Action 3	Re-orient TOR for HF WG and strengthen leadership of HF WG as the main coordinating and oversight body for the implementation of HF Strategic Plan covering the 5 strategic areas.	

[12] GOR requires that DPs can only operate in three sectors.

3.2. Community Based Health Insurance (CBHI)

Table 42. Findings in CBHI (Logical framework. p. 40)

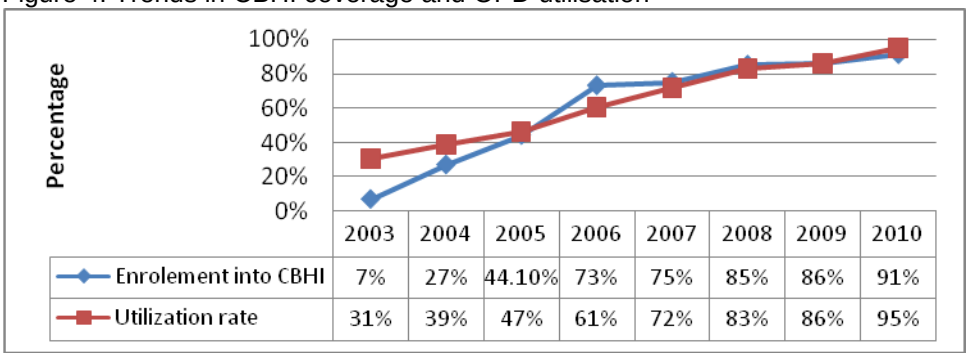
Strategic Area	Outcomes	Indicators	Baseline	target 2012	Achievements MTR 2011	
					Achievements	% target
	Universal coverage and risk equalization achieved	% of population covered by health insurance	91 (*)	100	97 (91 CBHI only) + 6% (others)	(97%)
		% of hospital bills reimbursed by district pooling risk	66	100	79	79

(*) The percentage includes RAMA, MMI and Private: 86% for CBHI and 5% for other insurance schemes.

Achievements (Qualitative Information)

There is a new CBHI policy outlining the strategies to be carried out to implement the emerging challenges of CBHI: institutional capacity building, financial sustainability and equitable access to CBHI. Challenges remain to translate these actions into practice. Rwanda is advancing well in achieving universal coverage. According to the latest information provided by the MOH, about 97% of population is covered by some sort of health insurance (91% for mutuelle scheme and an estimated 6% through other insurance schemes). As a result of this there is increased utilization of services as evidenced by Figure 4.

Figure 4. Trends in CBHI coverage and OPD utilisation



	2003	2004	2005	2006	2007	2008	2009	2010
Enrolement into CBHI	7%	27%	44.10%	73%	75%	85%	86%	91%
Utilization rate	31%	39%	47%	61%	72%	83%	86%	95%

The various studies carried out show that there is reduced unmet needs, increased consumption of health care, decreased incidence (risk) of catastrophic expenditures and decreased inequality in consumption of health care.

This has been facilitated by two major factors:

- High political commitment: there is continued strong political commitment from the government for universal coverage. This is evidenced, among others, by the issuance of a legal framework which makes health insurance compulsory for all Rwandans and including mutuelle coverage as one of the indicators in the annual contracts between local governments and the President (imihigo). Other evidences include the introduction of stratified premiums to make it more progressive and more equitable, the continued commitment to subsidize the indigent; and the will to introduce 'sin tax' to ensure sustainability. MINECOFIN has allocated 15% of the premium to cover the costs of the indigents. There is also strong development partners' support to ensure that this program succeeds. For instance the Global Fund subsidizes about 1 million indigent members of CBHI.
- Social satisfaction and will to be members: increased enrolments with low drop out because of high mobilization efforts by the community. Villages, with 30-50 HHs, elect committees among themselves to go house to house for mobilization meet as a group every month to pay

premiums and talk about challenges and success. This is now supported by village community health workers.

Challenges (Qualitative Information)

Given the numerous challenges in the rapid scaling up of CBHI coverage in the country, the new CBHI policy outlines the strategies to meet the emerging challenges of CBHI: institutional capacity building, financial sustainability and equitable access to CBHI. These remain to be translated into concrete guidelines, actions and practice. In the process, it requires a lot of mobilization, communication and sensitization to ensure compliance with the new contribution rates and increase coverage under the new scheme

Given the numerous challenges in the rapid scaling up of CBHI coverage in the country, the new CBHI policy outlines the strategies to meet the emerging challenges of CBHI: institutional capacity building, financial sustainability and equitable access to CBHI. These remain to be translated into concrete guidelines, actions and practice. In the process, it requires a lot of mobilization, communication and sensitization to ensure compliance with the new contribution rates and increase coverage under the new scheme.

Financial sustainability: Although there is an estimated unit cost for the benefit package to set the premiums (2900 RWF), the exact cost of care provided by the CBHI package will be known when the results of the ongoing costing exercise is released.. The costing exercise will indicate whether the stratified premiums will sustainably finance the cost of care provided. What is important is to be prudent and either revise the premiums if there is significant variation in the unit cost or come up with additional subsidy to cover the gap between the unit cost and the premium. There are insufficient funds at both district and national risk pooling level and weak pooling mechanisms. As can be seen in table 42, the district pool is not able to reimburse the bills of about 21 % of hospitals. From the field visits, it is reported that pools with small number of members do have difficulty in paying their hospital bills. Cross district reimbursement is an issue that still needs to be addressed given that the new policy also allows roaming services for members in certain cases.

As the CBHI reforms imply premium contributions based on socio-economic strata, the inequities that may result from disparities between poor and rich districts/sections need to be appropriately managed in order to ensure financial sustainability across districts; hence, the equalization mechanism stated in the new CBHI policy need to be strongly supported. Moreover, the distribution mechanism of CBHI revenues between section, district and national pool will be revised to prevent cash flow problems in the different levels appropriately implemented.

Institutional sustainability: the new CBHI policy clearly outlined the challenges associated with the management of the CBHI, including but not limited to insufficient staff and limited management capabilities, possible abuse at different levels in the system (beneficiaries and providers); and moral hazards. Clear strategies are stipulated in the new policy for building management capacity both at the central and decentralized levels. The There is a weakness in capacity of districts and sections; given that fee-for-services provider payment mechanism encourages health facilities to induce over use and provides incentive for over treatment , spot checks of facility bills is necessary. But this capacity remains weak and not carried out in a regular manner; there are logistics and transport capacity limitations for effective supervision of sections by districts. The capacity at district and section levels management of risk pools needs strengthening. This is also true for negotiating with providers regarding quality of services.

The country is about to reach universal coverage but there is fragmentation of the health insurance system (CBHI, RAMA, and MMI) although there is a vision is to put all these schemes under one umbrella that coordinates the various agencies; as stated in the Health insurance policy. The consolidation of these makes it easier to realize economies of scale and economies of

scope, and build one unified capacity and also ensure sustainability and for this to happen the Rwanda Health Insurance Council should be established and take its defined leadership.

Equitable access to CBHI: The new CBHI reforms are expected to deal with the regressive aspects of the CBHI (same flat fee of FRW 1000 for all socio-economic categories of the population) that was implemented up to June 2011. However, Safety nets for the poor are already assured through the policy for the poorest category. Its implementation calls for effective targeting of the poor through accurate identification and updating of the Ubudehe database and to ear mark resources for subsidizing their premium contribution, mainly increasing government resources to fund their premium that is mainly covered by Global Funds at the moment. There could be households in the second category (expected to pay 3000) who might not be able to pay and the safety net program should be flexible to consider paying for some of them as well appropriate safety nets need to be designed in order to insure poorest categories are identified and subsidized.

Table 43. Recommendations for CBHI

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Enhance the implementation of the new health financing and health insurance policies, through the development and implementation of a subsequent HF strategic plan. Strengthen the monitoring of the progress in health financing in general and implementation of the reforms in particular Undertake necessary revisions (norms, laws) and institutional arrangements in order to harmonize and strengthen the HF systems, including reviewing the current CBHI provider payment mechanism to improve quality and cost-effectiveness	Consider Consolidating and integrating the different social health insurance schemes into one financial sustainable national pool. Fast track the introduction of earmarked taxation (Sin tax) for ensuring predictability and partly sustainability of the CBHIs
Action 2	Strengthen the quality assurance by working with the Quality Improvement WG on developing a mechanism to integrate demand and supply mechanisms within the context of National policy on Quality	Strengthen the linkage of supply and demand side financing channels.
Action 3	Enhance the skills and number of the health care financing unit in the MOH (system and HR), and in the districts CBHI and sections CBHI. Strengthen the HF systems and CBHI systems in order to timely assess and make necessary adjustments in this learning process of reforms.	Reviewing feasibility of the premiums set in the new policy (stratified contributions) against the findings of the new costing exercise
Action 4	Operationalizing the equalization mechanisms at national level to compensate poor districts and sections. Financial distribution mechanism between levels implemented	Develop CBHI Information system

3.3. Performance Based Financing (PBF)

Table 44. Findings in PBF (Logical framework. p. 40)

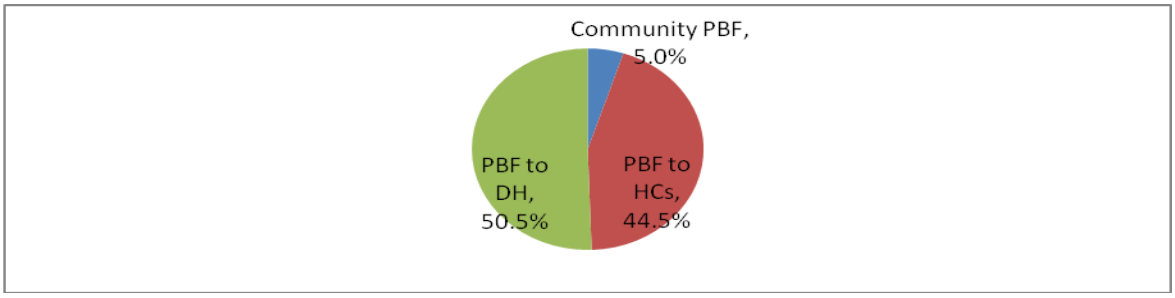
Strategic Area	Outcomes	Indicators	Baseline	target 2012	Achievements MTR 2011	
					Achievements	% target
	Extending PBF for HFs and CHW cooperatives	% of health facilities covered by whole package of PBF	70	100	93	93
		% of CHW cooperatives covered by PBF package	0	100	100% of 429 cooperatives	100

Achievements (Qualitative Information)

The % of health facilities covered by whole package of PBF during HSSP II varies from service to service. It is reported that all health facilities have been covered for TB, PMA and PCA and only 72% for HIV Aids indicators, giving an overall average of 93%. The performance based financing has transformed the health sector performance at all levels of the system. It has encouraged health facilities to become innovative and result driven to get the prices for each of the indicators. It has also encouraged performance on the part of the health workers and contributed to limit the mobility of human resources in their work. The PBF has also strengthened the reporting systems, improved timeliness, quality and comprehensiveness of reports. The reporting requirements have also ensured 100 percent compliance from each of the health facilities. There are regular quality assurance mechanisms for data (national and district data audit, monthly meeting etc) to ensure it followed guidelines. The penalties for incorrect reporting (reduction of PBF funding to the unit-twice as much as the % errors found by audit, 10 % reduction for 5 % of error) has helped as a stick to ensure quality of data. It has now extended it coverage to community health workers. The investment of Community PBF into income generating activities is likely to sustain the service as cooperatives will generate their income. This has provided discretionary funding (25%) to health facilities (in one visited health centre about $ 2500 per quarter), although not always respected, to invest on quality improving investments. There are some good investments seen during field visits. The development and financing of the CHW cooperatives for Income Generating schemes seem to respond to some of the sustainability challenges at the community level.

Figure 5 compares the achievements of the PBF in terms of indicators set for the HSSP

Figure 5. Share of Community, HC and DH in PBF funding



Challenges (Qualitative Information)

There are concerns raised about PBF: shifting the mentality of the staff to incentives, introduce gaming and increase hidden costs. However, strong quantity and quality control measures have been instituted to check gaming and reduce hidden costs. The challenge is how this Pay for Performance (P4P) will reward priority services. Although some of health sector outcomes are difficult to measure, the tariff applied by PBF needs to be dynamic and readjusted to reward services that are showing poor results. PBF needs to be flexible enough to readjust list of indicator so that new indicators might be introduced (depending new health challenges) at least through instituting annual PBF indicators list review seminar. Given the results of DHS 2010, it

will be a challenge to balance paying less for services that have shown good achievements and pay more to those with lower achievements in order to get better results. PBF should also consider providing differential incentives among geographic areas: it can improve equity by introducing higher prices for services delivered in remote areas to help to attract staff. Another area is reducing the fragmentation of rewards provided by different vertical programs (HIV/AIDS, TB and Malaria is part of other diseases we do not provide vertical funds for PBF) vis- a vis other services areas and come out with one comprehensive indicator list.

PBF contributed to stabilize human resources but does not solve inequality among facilities with different levels of human resources, as payment is made based on volume outputs. This favors facilities with large catchment populations which already tend to have the highest number of health workers. However, PBF introduces an incentive for facilities to maintain an optimum staffing level in order to maximize financial income and incentives for staff. Furthermore, PBF does not directly deal with shortage and mal-distribution of health workers. It is therefore not a long term strategy to overcome the current shortage in qualified health professionals.

PBF is working and changing the performance environment in the country, However, PBF in the health sector is highly subsidized, especially by donors for HIV/AIDS and TB. This might have led to a biased incentive structure for these programs as compared to other PHC services. Last but not least, PBF is functioning as a vertical funding mechanism. It is therefore necessary to look into mechanisms to integrate it with other demand and supply side financing modalities.

Table 45. Recommendations for PBF

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Harmonize the PBF systems with the Health Financing Policy directions.	Review the indicator tariffs (basis for costing the rewards) and balance incentives given the evolving and changing priorities (more to under achieved areas)
Action 2	Develop PBF Strategic Plan for the implementation of HF policy.	Consolidate with other supply and demand side financing mechanisms
Action 3	Develop criteria and legal framework to reward Provincial Hospitals through the PBF (incl. those district hospitals playing the role of Provincial Hospitals.	

4. Ensure geographical accessibility to services

4.1. Infrastructure, maintenance and the referral system

Table 46. Findings in geographical accessibility (Logical framework. p. 40/41)

Strategic area	Outcomes	Indicators	Baseline	target 2012	Achievements MTR 2011	
					Achievements	% target
Geographic access to services		Utilization of primary curative services			95% (HMIS 2009)	
	Functional unit of SAMU in all districts	Average number of ambulances per district	5	5	5 ambulances functioning	100
		Less than one Kilometer	NA	NA	77%	
	All HF have electricity and water	% of HF with electricity	17	100	NA	
		% of HF with water			NA	
		% of HF with a maintenance tracking system	0	100	100	100
		% of districts with operational SAMU		100	100	100

Achievements (Qualitative Information)

Three policy documents are now in place (policy on engineering and maintenance, strategic plan for the same and norms and standards for health facilities, equipment and infrastructure).

During HSSP II, geographic access to health care has improved through the construction and equipment of 1 DH and 1 health center (HC). Currently 11 HCs have been constructed but are not yet equipped. Another 4 DHs and 3 HCs are under construction. The initiation and implementation of community services has also taken the health service closer to the community. This is further enhanced by bringing the qualified health staff from district hospitals to health centers at least once a month on pre-arranged and notified visits.

Another area of focus was to ensure that all health facilities have access to electricity and water during HSSP II. Almost all facilities have access to these facilities respectively.

This geographic access is further enhanced through SAMU. This service is now fully operational in all districts with 168 (five ambulances per district as per standard, all fitted with a tracking system) and a call center managing the flow. SAMU staff together with DHs staff working in A&E departments underwent periodic advanced life support trainings in various emergency fields; Some SAMU staff went for international emergency management course.

Community level Smart SMS by CHW has helped to link the demand (community emergencies) with supply side (the health centers and ambulatory services). A training program is being developed to ensure that all health workers are skilled in pre-hospital (emergency) care during their pre-service training.

Furthermore, a curriculum for biomedical technicians has been developed (training has already started) to reduce the skills gap in the maintenance area. Efforts are on-going to strengthen the move-ability of the technicians from district hospitals to health centers. Although inadequate, the initiation of a ‘maintenance fund’ is a good start. The challenge of replacing laboratory equipment is now addressed through this fund. This experience needs to be replicated for other types of equipment. Moreover, there is a lack of specialized training on equipment that needs special skills such as radiographic units. Efforts are therefore necessary to train biomedical engineers on selected specialized equipments. Lack of procurement of standardized medical equipment is at the origin of disparate medical equipment brands within hospitals. This makes training of technicians very difficult and the purchase of spare parts a complicated task.

Challenges (Qualitative Information)

In spite of the impressive achievements as described above, there are areas that require further work in the remaining period of the HSSP II and beyond. These challenges include:

- Around 51/416 sectors (12%) are still without a HC. People will go to other sectors to access health based services, while neighbouring HCs will undertake outreach services.
- The minimum package of services provided at different levels have been expanded from time to time without a concomitant infrastructural expansion.
- Inadequate number of staff (call operators, paramedical staff for SAMU) and biomedical engineers (for the maintenance unit) and limited skills of the biomedical technicians
- Lack of adherence to national equipment donation policy and standards by DP, NGOs, other actors as well as health facilities when donations are made and received (not going through the maintenance unit).
- Inadequate funding for equipment maintenance at facility levels exacerbated by the lack of a separate budget line for this activity.
- Inadequate attention to ambulance maintenance by district hospitals.
- Concentration of policy, regulation, control and operational functions in the maintenance unit; lack of a legal framework for SAMU.

Table 47. Recommendations for maintenance and accessibility

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Continue training the technicians and review their effectiveness, once the graduates have started working Develop national Pre-hospital care curriculum Train SAMU staff and emergency care providers	Consider separation of the policy and regulation function from operation function in the maintenance unit. Develop emergency and disaster contingency plans in SAMU Strengthen SAMU staff skills through local, regional and international emergency care courses
Action 2	Consider developing equipment replacement policy. Review ambulance maintenance system	Establish the legal framework for SAMU Consider the option of having autonomous institution with its own infrastructure
Action 3	Ensure adherence to medical equipment policy (standards as well as spare parts for few years)	Strengthen the unit with Biomedical engineers. Continue the skill training of technicians; start pre-hospital care training
Action 4	Continue upgrading SAMU 912 call center (912 call center to acquire new communication equipments and Radio base. Ambulances in field to be equipped with radios for communication	Encourage the role of the private sector in equipment maintenance
Action 5	Implement computerized maintenance management system for central and decentralized levels.	Decentralise maintenance budgets to DH in order to encourage hospitals to have budget lines for medical equipments

5. Ensure availability and rational use of pharmaceuticals

Table 48. Findings in pharmaceutical sector (Logical framework. p. 41)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Provision of drugs	% HF / stock outs down from ?? to 0%	Data not available
2. Rational Drug Use (RDU)	% District Hospital adhering to EDL, STG	Data not available
3. Quality of drugs	% HF with pharmaco vigilance reports	Data in process by the MOH/PTF

Achievements (Qualitative Information)

Since the overview on the pharmaceutical sector provided in the HSS Framework and Consolidated Strategic Plan (August 2010, pages 24-31), several important strategic documents have been produced: the pharmaceutical quality assurance plan (2011-2014) in May 2011 and the guidelines for medicines safety surveillance in Rwanda (February 2011). The status of the 4 Laws awaiting approval has been summarised in the footnote below[13].
For rational use of medicines there is a National list of essential medicines (2010).

Structurally, CAMERWA performance in procurement appears satisfactory, as procurement procedures have been standardised and audits by USG and GFATM gave the green light for direct procurement with USG funds.

Training on pharmaceutical management and pharmaco vigilance has been conducted almost at all levels of the health system. Training curricula are being revised to integrate pharmaco vigilance along with logistics, rational use of medicines (RDU) and resistance. Drug Therapeutic Committees have been established in some hospitals to discourage self-medication. RDU is beginning to be promoted through the media and professional forums. The revised Essential Drug List and Standard Treatment Guidelines facilitate the prescription of appropriate treatment for common illnesses, including HIV/AIDS, Malaria, and TB (incl. multidrug-resistant TB).
For traditional and complementary medicines, a plan has been developed to identify and register traditional healers (TH) in the country; there is also a draft policy and ethical code of conduct to regulate the practice of traditional healers.

From our interviews, the team noted that (i) all 30 District Pharmacies are operational; (ii) stock-outs of drugs occur at all levels, but are rare and can often be compensated by other similar drugs; (iii) the timeline between request–arrival has been reduced (iv) drug consumption is closely monitored at district and national levels and (v) registration of traditional healers is taking place at health centre level.

Challenges (Qualitative Information)

Quality control: In general, the capacity for quality control is still weak; Drug Therapeutic Committees are not yet established in all hospitals; even where they exist, there is often a lack of human resources qualified to ensure that they function effectively. With the apparent increase in the prescription of antibiotics, a study in Rational Drug Use appears timely and relevant.

[13] 1. The **Pharmacy Law** was enacted by Parliament in 1999, Law No 12/99 of 02/07/1999
2. **Law establishing regulations on food, medicines**, medical devices, poisons, cosmetics, herbal medicines and other related health commodities was approved by Cabinet on the 23/06/2010. It has been tabled for Parliament in the second week of July 2011. It still has to go through the Parliamentary Commissions before being enacted.
3. **Law establishing the RFMA** (=Rwanda Food and Medicines Authority) is still at the Prime Minister's Office level. It is expected to be tabled in the Cabinet for approval any time soon (perhaps even before end of Aug 2011).
4. Law **related to the organization, functioning and powers of the Pharmacy Council**. There is a ministerial instruction No 20/50 of 14th Jan 2011, that establishes registration of pharmacy professionals which is one function of the council.

LMIS: Most of the information system in use at district and sector levels is still paper-based, but an LMIS office will be established within CAMERWA.

Procurement: While there is collaboration, there appears a need to further coordinate the procurement of essential medicines between the public and private sector. CAMERWA works with different procurement agencies, each having its own requirements (USG through SCMS-FDA approved; for GFATM / WHO approved suppliers). Harmonisation by DPs is required.

Required standards for quality assurance of medicines systems and institutions need to be put in place (Pharmaceutical inspection; Registration of medicines; and Quality control Laboratory, whose implementation is in progress).

There are no guidelines on how to dispose expired drugs at the District Pharmacies (since 2006). The Standards Treatment Guidelines (2007) and National therapeutic formulary (2007) need to be revised.

CAMERWA is providing about 85% of the requests of health facilities, while the remaining supply is covered by other supply agencies. The lack of quantification capacity at facility levels is partly responsible for CAMERWA's inability to predict and procure adequate supplies timely.

Currently, the Pharmacy Task Force (PTF) combines the responsibilities of implementing and regulating agency (on behalf of MOH). It licenses imports of medicines and health products, develops quality regulation for medicines, inspects pharmacies and medical stores, monitors adverse drug reactions, and provides pharmaceutical information. It is expected that these two functions will be separated in the near future with the establishment of a National Pharmaceutical Regulatory Authority.

Table 49. Recommendations for the pharmaceutical sector

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Initiate study in Rational Drug Use in HCs and DHs	Establish a fully equipped LMIS system within CAMERWA
Action 2	Institutionalize Traditional medicine by adoption of basic documents	Develop a pharmaceutical / drug pricing policy (together with the Health Financing TWG
Action 3	Develop a plan for the production and regulation of relevant traditional medicines (herbs etc).	Implement the Pharmaceutical Regulatory Authority, once endorsed, and separate regulatory from control functions
Action 4	Develop guidelines and regulation on how to dispose of the expired drugs	Strengthen quantification of drugs and medical supplies by health facilities
Action 5	Develop plan for strengthening the medicine quality assurance	Put in place the medicine quality assurance system and institutions.
Action 6	Review the Standard Treatment Guidelines and National Therapeutic Formulary	Strengthen pharmaceutical information system

6. Quality Assurance of health services (QA)

Table 50. Findings in Quality Assurance (Logical framework. p. 41/42)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. Quality teams	All HF have quality improvement teams	Initial phase of implementation
2. Accreditation / Certification	% of fully accredited HF up from ? to 100%	Two referral hospitals are in the process
3. Regulation	Policies, norms are updated	Norms updated for DH and HCs

The institutionalisation of services Quality Assurance (QA) has started in the sector. A cell within the MOH has been created and receives some support from the DPs. Several initiatives have been undertaken by the team in charge of quality assurance within the MOH. The process is still at its infancy. Some major results can already be mentioned:

Achievements

- Quality assurance policy and strategy defined
- Essential health care package (EHCP) defined for the different levels: community, HC, DH, Prov. hosp, Tertiary hospitals together with their standards and norms
- Health Facility accreditation process: initiated in two national reference hospital (2007) and in two remaining in 2011
- Quality assurance activities have started in some district hospitals and Health Centres. These early stage activities include
    - Elaboration of customer care norms for health care and service providers at all levels (to improve quality care at facility level, reduce waiting times, improve the diagnosis and treatment for better outcomes, emphasizing the need for positive attitude towards clients, getting their adherence…)
    - Creating health care and services quality assurance committees in some hospitals and health centres with sub-committees
    - "Opinion boxes" to collect the opinions and views of customers and users opinions
    - Customer care service with a staff to follow up quality assurance and customer satisfaction in crucial services in some hospitals

Challenges

- Community opinions are not taken on board through regular surveys
- HMIS at all levels in the pyramid of health care delivery does not capture QA
- Weak institutionalisation of quality assurance as cross cutting activity
- Shortage of required HRH for all levels
- Shortage of formative supervision vehicles in most of district hospitals
- Budget constraints to accelerate roll-out
- Existing equipment and infrastructure does not match the new norms
- Poor integration of private health facility activities

Table 51. Recommendations for Quality Assurance

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Develop and implement a comprehensive plan for the improvement of Quality Assurance policy in all Provincial & District hospitals.	Review implementation through PBF with the perspective of accreditation of Provincial and District Hospitals
Action 2	Enhance the linkages between PBF and CBHI programme and the quality assurance initiative	Integrate QA activities in all health services (cross cutting) and private sector

7. Strengthen Specialised Services

7.1. Research

Until recently the structures in charge of research activities were under the authority of MOH and the Ministry of Education (for the Faculty of Medicine, the School of Public Health). This situation made coordination difficult to define research priorities and use of the results. The creation of the department of medical education and research within the MOH will allow researchers and practitioners (field workers, public health, clinicians, etc.) to better collaborate in:

- Defining the collaboration and coordination mechanisms
- Identifying needs and priorities for research and
- Improving management, effectiveness and efficiency in the health sector

The MOH has provided strategic orientation in deciding to prioritize operational and behaviour research.

Achievements

Department of "Medical Education and Research" within the MOH with a strong institutional mission facilitates the coordination. This department will take charge of

- formulating research policy and strategies for the sector
- regulation research activities and set up the research ethic committee
- defining and assuring the M&E for research activities and
- defining the HRH capacity development policy for research

The School of Public Health (SPH) under the authority of the MOH has developed a research programme based on the MOH needs. Its collaborative work is instrumental to:

- Support the Community Health Insurance Performance-Based Financing, Marginal Budgeting for Bottlenecks and District Health System Strengthening programs
- Work directly with the former National Aids Commission (CNLS), the Treatment and Research Centre on HIV/AIDS, Malaria, Tuberculosis
- Use the findings of various research and programme evaluation activities in guiding the development of evidence-based policies

Constraints

- Institutional weakness; department very new
- Insufficient qualification of health professionals

Table 52. Recommendations for Research Capacity

Summary Actions to be undertaken	**Next Year, before start HSSP III July 2011 – June 2012**	**After start HSSP III July 2012 and beyond**
Action 1	Enhance collaboration between the MOH operational structures and researchers	Build HRH capacity in research and use of findings to improve quality of health care

7.2. National Reference Hospitals

Rwanda has four National Reference Hospitals. King Faysal Hospital (KFH) is the top end of the referral mechanism, followed by the two academic hospitals CHUK (in Kigali) and CHUB (in Huye / Butare). The Neuro Psychiatric Hospital (HNP) in Ndera is fourth specialised referral hospital. The Kanombe Military Hospital in Kigali is also a referral hospital, but mainly used by the military.

HSSP II mentions (p. 31) the capacity and utilisation of the three Reference Hospitals, but they are not part of the annual planning and monitoring process. The MTR team can therefore not assess their performance over the last two years. We can only provide a few observations / comments on the current situation:

1. King Feysal Hospital (KFH) is a private hospital that receives those patients that cannot be properly treated in the other two referral hospitals. It has recently been formally accredited by COHSASA (South Africa) and therefore is considered at the top of clinical care in the country.

Achievements (Qualitative Information)
With a limited number of specialists and many tasks in patient care, the staff in the two academic hospitals manage to train medical doctors and at the same time specialists. For example CHUK with some 40 specialists for 500 beds is training 50 graduated doctors to become “general specialists”.
The country has established a well functional referral and counter referral system (with ambulances in all districts). This is reinforced by the non-reimbursement of costs by the CBHI system, if patients do not respect the rules. The referral hospitals therefore do receive mainly serious (referred) cases that cannot be treated elsewhere. This triage system appears effective, even in the capital Kigali.
Finally, both CHUK and CHUB have initiated a few years ago the process to receive accreditation from COHSASA. CHUK is now at 55% and CHUB around 35% to get accreditation. One of the constraints to move faster was the absence of qualified (and expensive) facilitation. This has now been solved.

Challenges (Qualitative Information)
CHUK has not enough sub-specialists (quantity and quality) within these broad specialisations to provide the quality of care it aims for. For example, the hospital does not have pathologists, neurologists or oncologists, and has only a limited number of specialized surgeons (8), gynecologist (9) and anesthesiologists (3).
.
Recommendations:
Involve all four referral hospitals from the start in the planning process of HSSP III, providing them with the format to plan, allocate resources and provide timely, accurate reports (link with HMIS).

7.3. Blood Transfusion Services (NCBT)

Table 53. Findings in Blood Transfusion Services (Logical Framework. P. 42)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1.# Blood units collected	# Blood Units in 2000: 23.000	# Blood units collected in 2010: 41.000
2. Quality Assurance	% Blood screened according to the guidelines	All samples are screened at each collection for HIV, Hepatitis B+C, Syphilis (100%)
3. New blood donors	# New blood donors / year	Not available

Achievements

The one National and 5 Regional Centres for Blood Transfusion (NCBT / RCBT) now provide blood products in total to 47 Hospitals and 5 other health facilities (total 52 HF)

Specific software has been installed, all required tests for screening are done (HIV, Hepatitis B and C, Syphilis and Malaria) and when needed traceability is guaranteed. A short- and long-term training programme has been developed and is being implemented. Most importantly, NCBT accreditation by the 'American Association of Blood Banks Standards' has been requested and the process for its attainment has been initiated.

A blood donor recruitment programme is in place (voluntary, non-remunerated) and 3 mobilisation officers have been trained together with local blood donor committees.

Challenges

The provision of blood by the NCBT to the health facilities is free of charge and not included in the CBHI scheme. This means that this service provided by NCBT is not being paid for. The staff is concerned about the financial sustainability of their services

The NCBT (Kigali) is housed in the premises of the RBC (being a division as part of the Medical Production and Procurement Department /MPPD[14]). The available space is quite limited, as there is little room for expansion.

Table 54. Recommendations for NCBT

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Emergency preparedness plan for NCBT	Kigali RCBT Accredited by US Association
Action 2	Prepare Strategic Plan as part of HSSP III	Expand waste management system (Incinerators) in all 5 Centres
Action 3	Initiate a Value for Money study to decide on the need for (partial) cost recovery	Extension of RCBT in Karongi & Rwamagana districts
Action 4		Strengthen activities related to clinical use of blood (needs and risk assessment, response)

[14] Organisational Chart for Rwanda Biomedical Centre (Annex I, undated).

7.4. National Reference Laboratories (NRL)

The National Reference Laboratory (NRL) is addressing its key functions in many ways. The NRL benefits support from various Development Partners to meet the different objectives in creating a sound performing laboratory network through out of the country and conducting specialized biomedical testing at the central (referral) level. Several activities have been developed in that purpose. Some achievements

Achievements

- Policy and technical standards defined for all levels (post centres, health centres, district, provincial and central hospitals)
- Laboratory routine activities decentralized at peripheral level
- 2 professionals per district trained and supervised for better laboratory performances
- Quality control with the support of the National Reference Laboratory
- Epidemiologic surveillance with a "response rapid team"
- Weekly analysis and feedback to health centres and district hospitals
- The NRL is in the process of accreditation together with the laboratories of the Kigali Teaching Hospital, the Kanombe Military Hospital and the King Faysal Hospital

Constraints

The institutional capacity for implementation was not sufficiently assessed during HSSP II preparation. The human resource issue at service delivery level is well addressed in the human resource section of the HSSP II and is being implemented. PBF is providing incentives for health workers to deliver results. On the other hand strengthening management capacity at the central and district levels was not prioritized and hence implementation is weak (see decentralization section of this MTR). Strengthening the planning, budgeting and supportive supervision could be more prioritized than it is now. Maintenance capacity remains weak and investment in its capacity (biomedical engineers and technicians) remains limited. HSSP III should refocus on building these necessary capacities.

Table 55. Reference Laboratory (NRL)

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Strengthen and expand the laboratory network	Improve quality control at all levels

7.5. Mental Health (MH)

Table 56. Findings in Mental Health (Logical framework. p. 42)

EXPECTED OUTPUTS / OUTCOMES HSSP II	TARGETS / BASELINE	PROGRESS BETWEEN July 2009- June 2011
1. # HF with mental health	% HF providing the mental health package up from ? to 100%	27/30 DH; HCs unknown
2. # Consultations	# Cons HNP Ndera 17,149 in 2005 # Cons SCPS Kigali 10,167 in 2005	# Cons. 34,951 in 2009. # Cons. 17,162 in 2009

Achievements (Qualitative Information)

A national study in 2009 showed a prevalence of 28.5% of post traumatic stress, often in combination with depressions (54% of those with ESPT). There also appears to be a high level of depression among the general population (15.5%)

In 2011, the National Mental Health Programme (PNSM) has updated both its policy and its strategic documents against the background of the recent developments in the health delivery system (PBF, CBHI, referral systems). The documents provide 10 interventions for the PNSM[15], each with its objectives and indicators over a period of 5 years (2011-2015).

Mental health is provided at the Hospital Neuro Psychiatric (HNP) in Ndera, the ambulatory services (SCPS in Kigali) and to a lesser extent in the DHs. A C-Mental Health Programme is being developed, even though Mental Health (MH) services are not yet regularly provided in the HCs.

The PNSM programme has developed training materials specific for doctors, nurses and recently for CHW. It has also trained already 10.000 CHW in all 30 districts. Psychotropic drugs are available in all DH. The Kigali Health Institute (KHI) has started the training of mental health nurses.
Clearly, the programme has now being rolled out nationwide compared with 3 years ago (when it was very Kigali based).

Constraints / Challenges (Qualitative Information)

While Mental Health (MH) is quite prevalent in the country (perhaps even more than many of the other diseases), it is generally not given the attention and priority it deserves, as apparent from:

- There appear to be substantial numbers of unemployed Clinical Psychologists in the country.
- The role of the MH services in relation with Traditional Medicine and the Traditional Healers remains to be defined.

Table 57. Recommendations for Mental Health

Summary Actions to be undertaken	Next Year, before start HSSP III July 2011 – June 2012	After start HSSP III July 2012 and beyond
Action 1	Finalise MH package for HCs and CHW	Include MH in work of CHUK / CHUB
Action 2	Define operational indicators to monitor PNSM	Expand training in MH at DH and Nat. level
Action 3	Collaborate with the Pharmacy Task Force (PTF) in registering the TH in the country	Initiate the development of a Mental Health Law

[15] These interventions are: curative services, community mental health, HR development, IEC, legislation, research, treatment and prevention of epilepsy, psychotropic drugs, drug abuse and mental health in children and adolescents.

PART C. FINDINGS FROM JANS ATTRIBUTES

The objective of the JANS[16] is to support stakeholders to review national strategies through a series of attributes and characteristics that are related to assessing national strategy documents. The revised version of the JANS is based on 5 sets of attributes, 16 attributes (summarised below) and 44 'characteristics of the attributes' (not specified here).

1. Situational analysis and coherence

1. National strategy is based on a sound situational analysis

Overall the participants in the HSSP II process were satisfied with the situation and response analysis and found that the overall data provided for the assessment was adequate. The situation analysis reviewed the political, demographic and socio-economic situation, the institutional overview of the health sector, the international and national policies and targets. It presented the health sector performance in terms of meeting the MDGs, human resource for health, geographic access, and burden of diseases. Universal coverage, improve health equity and analysis of past and current health sector responses and health financing arrangements have been well assessed and included in the HSSP II. The CBHI and the PBF are used to drive achievements of health outcomes. These have achieved their objectives as evidenced by the 2010 DHS results. There is a well elaborated assessment of the financing plan and there are policies and strategies to address the challenges of identified health financing issues. What is required for HSSP III is to replicate this.

However, there seem to be some areas of potential improvement. These are:
Areas where reforms are on-going, such as decentralization (both administrative and fiscal);
Capturing the multi-sectoral interventions that require other sectors where other Line-ministries are involved (Ministry of Youth, Ministry of Education, Ministry of Local Government)
Strengthening institutional capacity at district level including the district health team / unit and the HF in view of the current decentralization and the weaknesses in the PFM system.

2. Priorities, policies, objectives, interventions and results are defined

Overall the priorities and goals and main objectives are clearly defined, but the lack of clear linkages between the 3 strategic objectives and the 7 programme areas are reported to create challenges for the monitoring of implementation. They should be re-assessed as part of the HSSP III preparations. Some health service interventions find themselves into two strategic objectives, which make programming, including budgeting and reporting, difficult. Furthermore, there are gaps in setting the targets between the main actions in the programme descriptions and the log frame. There are important sector performance indicators that are included in the main text of the HSSP II but not in the log frame. Consistency between the strategic actions and the log frame needs to be improved in HSSP III.

HSSP II is also silent on some of the overall countrywide strategies, which are necessary to achieve the health outcomes, including but not limited to governance, decentralization, sector management and multi-sectoral issues (nutrition, gender-based violence etc). Such multi-sectoral issues need to be looked into and targeted in the HSSP III.

The HSSP II does not include fully the areas of interventions that need to be assessed together with the 7 programme strategies. These, however, have been developed separately with different timelines, something which makes the overall SWAp management and monitoring complex and, we believe, also somewhat fragmented. The lack of clarity and predictability on the resource envelope also represent a challenge. The potential for improving aid flow predictability should be

[16] For this assignment a revised version (version 2, 17th June 2011) of the JANS has been used.

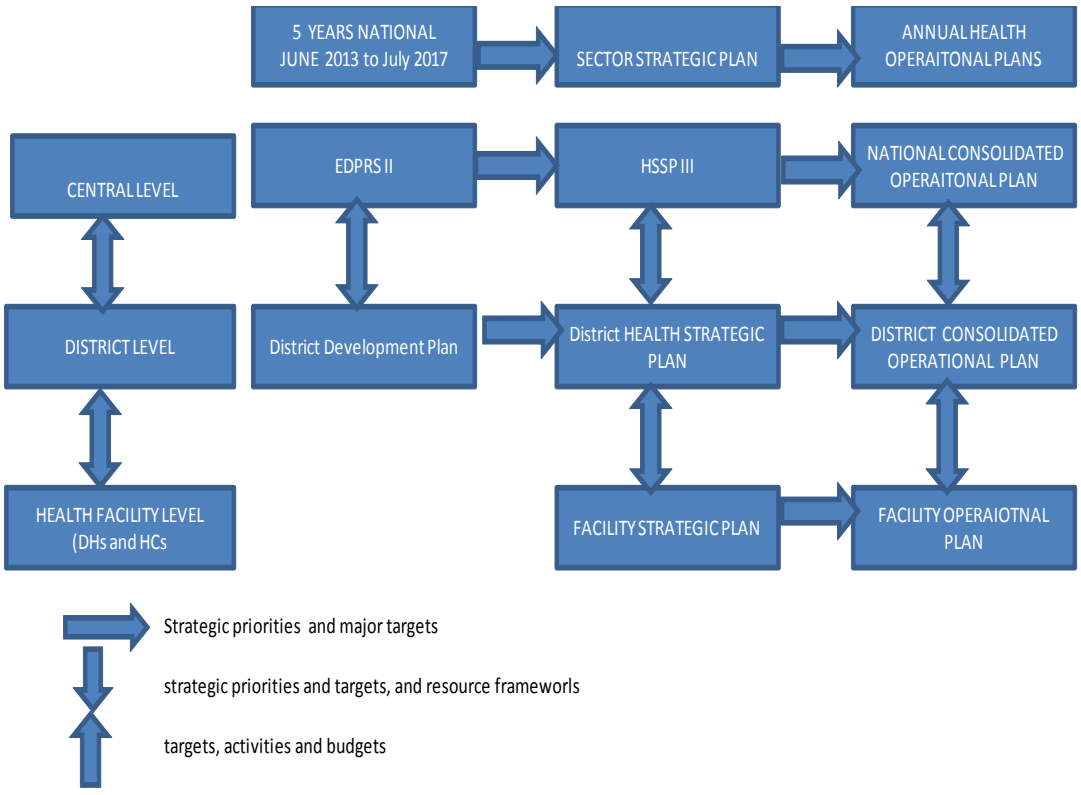
addressed in the context of the HSSP III process (see recommendations on aid effectiveness in Part B, section 1.3). HSSP III and the various programme strategies should become aligned in the next phase. This will even become complicated as the alignment of the HSSP III time frame, its objectives and strategies may not be the same as EDPRS II.

MINECOFIN plans to develop EDPRS II by July 2013, one year after the expiry of the HSSP II. Once this EDPRS II is place, sectors are going to be given time to develop an aligned sector strategic plan within a certain period of time. The health sector therefore will have difficulty to wait until then since their strategic plan should accompany global health initiative proposals (GAVI, GFATM). For instance Rwanda is one of the few countries that received Global Fund assistance based on their national health strategic plan application. The sector shouldn't miss these kinds of opportunities because of not having a strategic plan. It therefore has three options:

- *Develop a six year plan (one additional year as a bridging plan from EDPRS) in consultation with MINECOFIN or;*
- *Develop a one year bridging plan and wait for the EDPRS II to guide its development.*
- *Develop a five year sector plan, which may follow overall government priorities but will later be adjusted if changes need to be made; or*

This decision is more of political than technical in nature and MOH and its partners needs to examine the political environment to decide, and after consulting MINECOFIN, which route to follow in the development of the HSSP III.

Figure 6. Overview of Strategic and Operational Planning by Level



3. Planned interventions are feasible and equitable.

The HSSP II interventions at all levels of the system are consistent with the internationally agreed high impact interventions to achieve the MDGs, hence, they are appropriate and cost effective interventions. Some of the interventions has been piloted and experimented in the country (CBHI, PBF, community health etc) before scaling up to the national level. The plan has clear targets and strategies to address financial and geographic equity within the country. However, the capacity requirement at the lower levels does not seem to be appreciated enough. Several important public health problems, such as Eye care, ENT, Rabies have not been addressed in HSSP II. The inclusion of contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases) also is not apparent. HSSP III needs to correct these weaknesses / omissions.

4. Risk assessment and mitigations measures are presented

The risk assessment is limited to four risks as are also the mitigations measures. More attention should be given to the risk assessment, the mitigation measures and the monitoring procedures for the risk. The latter seem not to have been present in HSSP II programme implementation. HSSP III need to build from this experience and clearly spell out risk mitigation measures for identified risks. The sustainability of the PBF and CBHI remains an issue that is addressed in the health care financing section of the MTR (Part B, sections 3.2 and 3.3)

2. Process and inclusiveness of development and endorsement

5. Multi stakeholder involvement in the drafting and endorsement

The stakeholder involvement seems to have been satisfactory, as the the involvement of DPs and umbrella NGOs is well documented; but district level (District Administration, Hospitals and Health Centres) and some other ministries or sectors could have been included more in the process. The development process of HSSP III is suggested to become more inclusive of districts and other sector ministries. To help this achieve, it may be necessary to consider developing a broad road map for the development of HSSP III (contributions by TWG and MOH units / departments, consultation with CSOs and districts, as well as in-country and out-of the country DPs).

6. High level of political commitment

The political leadership and commitment is strong. HSSP II is discussed and approved by the cabinet. Leadership in implementing the HSSP II is also very much appreciated. This needs to continue during the HSSP III. It is necessary to make sure that the HSSP III draft document is well discussed and agreed (perhaps through a JANS in mid 2012?) by all stakeholders before it becomes a political document.

7. Consistent with relevant other level strategies and plans

The HSSP II has been aligned to the EDPRS, Vision 2020 and other relevant high level policies, strategies and plans. The decentralization process could have been reflected, but this might have been premature at the time of the HSSP II. However this should be strengthened in the HSSP III process.

3. Cost and financing of the strategy

8. The strategy has an expenditure framework and budget

HSSP II used two costing methodologies (bottom up input based costing and marginal budgeting for bottlenecks (MBB). In other countries these tools are used in combination to cost MDG and non MDG services. In Rwanda they were used independently to compare results and did produce

more or less similar results (table 58). The use of MBB has also an added value in defining health system bottlenecks, as it estimates the results of investments in terms of health impact and outcome targets. The MBB used three costing scenarios based on different levels of ambitions while the input based costing had only one costing scenario. This MTR found that the input based costing falls within the range of the three costing scenarios of MBB. This shows the costing of the HSSP II was given due consideration during HSSP II and needs to be replicated in HSSP III.

Table 58. Estimated costs of HSSP II by type of costing (in B-RWF)

Costing tool	Year 1	Year 2	Year 3	Total	Comment
Input based costing	425.9	476.4	516.0	1445.2	One scenario
Marginal Budgeting for Bottlenecks (MBB)	410 to 443	416 to 475	430 to 522	1256 to1440	MBB estimates using three scenarios

Given that the two costing methods provide similar results, HSSP III needs to consider using only one method to reduce the transaction cost of costing. The choice of the method should depend on skills available and the capacity of the MOH to undertake it without any constraint. With a declining trend of USG budget and one donor leaving the health sector, the costing and financing of HSSP III need to also consider these declining resource envelope – not just the status quo.

One of the issues in costing is lack of clarity in linkage between the costing of the three strategic objectives and the seven programme areas. While total cost of both two sets of strategic objectives / programs adds up, it is not apparent which programme objectives are subsets of the overall strategic objectives. This is a reflection of un-clarity on the linkages between the three and the seven objectives. Ensuring exclusive linkages between each strategic objective with some of the 7 programme objectives in HSSP III could help the development of subsequent costing of sub strategic and operational plans for service delivery and systems strengthening that can be used for implementation. The HSSP III costing therefore needs to be more functional to allow linkage with operational planning at sub programme level (see the HIV/AIDS Strategic Plan development and costing).

9. There is a realistic financing framework

HSSP used clear assumptions and scenarios in projecting resources to be available during the planning period. It started with a conservative estimate of 'as is' and moved on to higher scenarios. Projections are made on government allocation and resources to be mobilized from external assistance. The crude information collected in this MTR shows that the sector is probably in about scenario one. HSSP III need to review the achievements made so far and put more realistic assumptions on its fiscal space analysis. It is also important to consider internally generated funds as source of funding for the sector.

Table 59. Fiscal space and gap analysis in HSSP II

Fiscal space projections	**Input based costing method**	**MMB costing method**
Scenario 1	• Government share of spending from the total GOR spending to remain the same • Facility based revenue to grow at 2% per annum • External support to remain at the current level	• Use EDPRs growth projections (4.4%) • Allocation to health remains at 10.6% • Earmarked aid to health remains $US 19/pp
Scenario 2	• Share of health sector budget to reach to 12% as per EDPRS • Facility based revenue to grow at 5% per annum • External support to increase by 5%	• Use EDPRs growth projections (4.4%) • Allocation to health remains at 12% • Earmarked aid to health remains $US 19/pp
Scenario 3	• Share of health sector budget to reach 15% as per EDPRS • Facility based revenue to grow at 10%/yr • External support to increase by 30%	• Use EDPRs growth projections (4.4%) • Allocation to health remains at 15% • Aid to close to Gleneagles commitment

4. Implementation and management

10. Operational plans are developed in a participative manner

Operational plans are prepared on annual basis at facility (HC and DH) and national levels. Most of the programme and facility based plans are well aligned to HSSP II. There are few programs with different timeframe but working towards amending it. The district health annual plans on the other hand are yet to be fully aligned and made operational in all districts. Operational plans are relatively fragmented at district level, but for programme implementation there is a Joint Action Plan. The operational planning process should be reassessed and redesigned in view of the decentralization process and the changed role of the districts.The link to the financial resources should be strengthened. The existence of a large off-budget support which is not captured is a major gap in the current HSSP II and its implementation. The sector can consider the development of 'shadow budget' that brings both on- and off-budget resources collected from the tracking tool (assuming that the tracking tools is also going to collect commitments) to show the overall sector resources available in a year.

11. How resources will be used for outcomes is described

HSSP II clearly classified service delivery interventions into three modes: family oriented community health services, population oriented health services and individual oriented health services. However, it does not show how these three delivery services are linked to the health service delivery structure shown in figure 7 below. Even though, it is not shown in HSSP II document itself, Rwanda has defined service packages to be provided by the various levels of the health system. The packages are structured by level of care as follows:

- at cell (community and dispensary) level: le paquet commmunautaire (PC);
- at health centre (sector) level: le paquet minimum d'activités (PMA);
- at district hospital level: le paquet complementaire d'activités (PCA);
- at referral hospital (central) level: le paquet tertiaire d'activités (PTA).

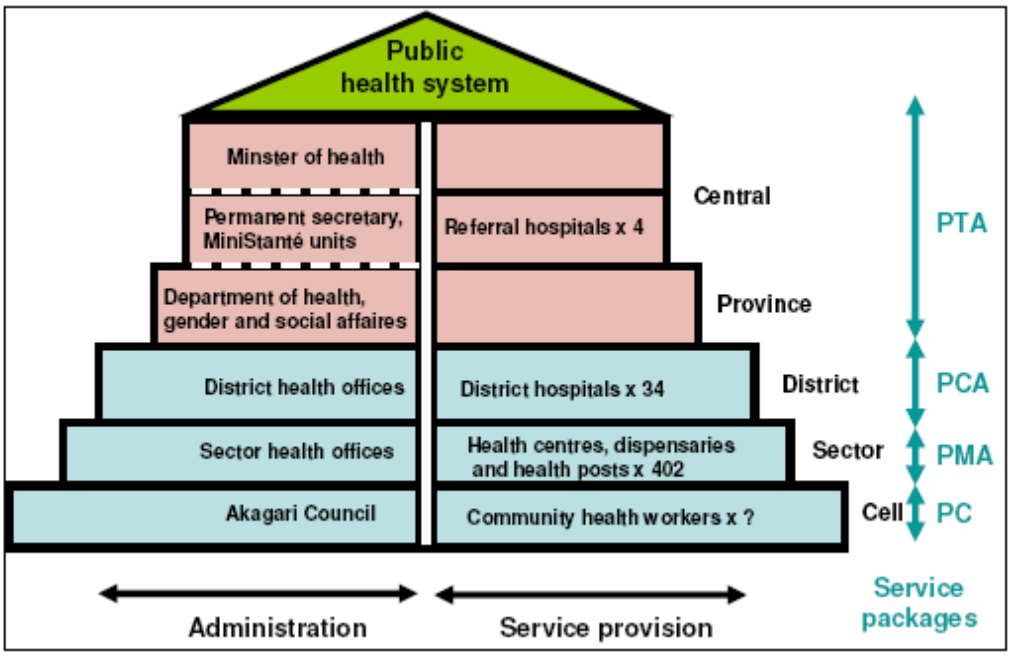
The costing only showed the breakdown according to the above three intervention modes and did not go down to estimate cost by levels of service providers. The financing projections do not show where the money goes. It is therefore necessary to show this more explicitly in HSSP III.

The sector has also demand and supply side resource allocation mechanisms with criteria associated with each one of them. However this is not reflected in the HSSP II as this level of detail can only be found in the separate health financing policy document. This also applies to other areas as well. This is due to the present hierarchical structure of documents. The HSSP II document is very good in terms of its size and readability. Including more issues into it will make it bulky and less readable. It is therefore suggested to annex some of the overall service delivery and systems related processes, procedures and guidelines. The main document then remains with objectives, interventions, indicators and targets, governance and resource allocations.

12. Institutional capacity for implementation has been assessed

The institutional capacity for implementation was not sufficiently assessed during HSSP II preparation. The human resource issue at service delivery level is well addressed in the human resource section of the HSSP II and is being implemented. PBF is providing incentives for health workers to deliver results. On the other hand strengthening management capacity at the central and district levels was not prioritized and hence implementation is weak (see decentralization section of this MTR). Strengthening the planning, budgeting and supportive supervision could be more prioritized than it is now. Maintenance capacity remains weak and investment in its capacity (biomedical engineers and technicians) remains limited. HSSP III should refocus on building these necessary capacities.

Figure 7. Service packages by level of service provision.



Source: WHO 2008.

13. Financial management and procurement is appropriate

There is a clear gap in the area of financial management and procurement. More attention should be given to strengthen the capacity, harmonize the procedures and ensure further alignment by the DPs. Safeguard measures to mitigate fiduciary risk should also be considered. Reference is made to previous PFM sections in the MTR report (Part B, sections 1.2 and 1.3).

14. Governance, accountability and coordination specified

There is clear governance and coordination structures in the health sector (see governance section), both at the central and district levels. These governance structures are conducting forward and backward reviews each year. Joint health sector review is carried out regularly. There is mutual accountability as both government and development partners present their activity and financial reports to these meetings. These are not specified in HSSP II but there are other documents that spell out how they are functioning. However, an assessment of their functioning and strategies for their improvement should be considered as part of the HSSP III.

5. Monitoring, Evaluation and Review

15. M&E Plan is sound and includes core indicators

The HSSP II has clear baselines and targets for each of the strategic areas, although there are gaps between the main text and the log-frame. It has also defined health related indicators and targets specifically mentioned in vision 2020, the MDGs, the EDRS, the CPAF and SBS agreements. Although it is not clearly presented in the HSSP II document, there is an M&E policy strategic plan document with an elaborated implementing strategy and plan. There is core list of indicators described well with their definition and sources of information. A ‘minimum set of indicators for the health sector’ has been developed and is part of the HMIS.

There is currently a full compliance in reporting by health service providers which makes monitoring easier. The current information systems are trying to put a data dashboard to create an interface among different information sub systems (human resources, logistics etc). Regular non-routine information systems (DHS, I-DHS, Annual Statistical bulletin) are being collected.
HSSP III need to scale up the current good practice and invest in improving the quality of information and strengthen information collection and utilisation capacity at all levels. However the use and analytical feedback needs improvement. Training for national staff to address that weakness is scheduled in September / October this year. That training will help to develop the standard feedback reporting module for the new HMIS.

16. There is a plan for periodic Joint Performance Reviews

The HSSP II document clearly states that sector performance reviews will be carried out annually as part of joint sector review to inform strategies, plans and to reconcile plans and available budget. It also foresees mid-term reviews and final evaluations of HSSP II. As this MTR report shows, HSSP II Performance Reviews are undertaken annually as part of the Joint Health Sector Reviews (JHSR), based on annual and periodic performance and process indicators as well as MTEF monitoring. Mutual accountability meetings (CPAF, DPAF) are carried out by both development partners and government. The findings of these reviews with required actions are monitored and disseminated to all stakeholders.
There is clear guidance from MINECOFIN on M&E and review mechanisms to follow EDPRS.
For DPs (DPAF following the Paris Declaration / Accra Indicators) while CPAF (budget support) is based on Joint Budget Support Reviews. Sector specific indicators of the sector strategies are monitored through the Joint Sector Reviews.
HSSP III is to sustain the existing modality by deepening trust among development partners and government as well as enriching the content and openness of the policy dialogue.

ANNEXES

Annex 1: TOR of the MTR and JANS of HSSP II (2009-2012)

TERMS OF REFERENCE FOR THE MIDTERM REVIEW AND JOINT ASSESSMENT OF HEALTH SECTOR STRATEGIC PLAN II (2009-2012)

Background

The Ministry of Health in collaboration with its health sector development partners is dedicated to joint implementation of the National Health Sector Strategic Plan (HSSP II 2009- 2012) and the National Strategy (EDPRS 2008 – 2012). The purpose of the Health sector strategic plan is to provide an overarching framework and clear direction to the development of the health sector over a medium timeframe. Programme areas in the HSSP-II focuses on **3 strategic objectives** which are;

- To improve accessibility to , quality of and demand for MCH/FP/RH/Nutrition services
- To consolidate expand and improve services for the prevention of disease and promotion of health
- To consolidate, expand and improve services for the treatment and control of disease

To ensure that the 3 strategic objectives of the HSSP-II are met, **7** cross-cutting **strategic programmes** provide an enabling environment for service delivery to be optimally effective and efficient.

1. To strengthen the sector's **institutional capacity**
2. To increase the **availability and quality of human resources** (including basic and in-service training)
3. To ensure **financial accessibility to health services for all** and sustainable and equitable financing of the health sector
4. To ensure **geographical accessibility** to health services for all
5. To **ensure the (universal) availability** and rational use at all levels of quality drugs, vaccines and consumables
6. To ensure the highest attainable **quality of health services** at all levels
7. To **strengthen specialised services,** National Referral Hospitals and Research capacity

Purpose of the Mid-Term Review (MTR) and Joint Assessment of National Strategy (JANS).

The Ministry of Health has recognized that much progress has been made within the sector and in effect a large proportion of the targeted plans have been completed in the two and a half years of its implementation. To accurately identify the progress made over the last 18 months against the set targets the MOH proposes to conduct a midterm review of the HSSP II (2009-2012) Additionally and in order to help Rwanda to meet its global responsibilities as an International Health Partnership (IHP+) signatory, it was agreed by Ministry of Health and its development partners that this midterm review will be conducted together with the Joint Assessment of Health sector strategy proposed by IHP+.

Both reviews will be undertaken to establish the comprehensiveness of the plan and to document the progress made so far with regard to its implementation. It is therefore expected that the two separate but interrelated processes will contribute immensely to the information required in the planning process for the next sector plan

Scope and focus

(i) **The Mid Term Review of the Health Sector Strategic Plan (HSSP II**)

The overall objective of the MTR of the HSSP is to review progress made in the implementation of the HSSP against what was initially planned and to provide recommendations which can be implemented in the last phase of HSSPII. Guided primarily by the performance framework of the HSSP II (including its indicators, targets and milestones) and using the standard evaluation criteria (relevance; effectiveness, efficiency; sustainability) the MTR will specifically look at;

a. Assess progress towards the achievement of HSSPII targets
b. Management arrangements and systems for managing the programmes related to the national strategy at national and decentralized levels.
c. Assess new interventions applied in the implementation of the current HSSPII.

What are the challenges and constrains in implementation of the HSSP II policies and strategies and for realizing set objectives and targets including the appropriateness and relevance, of the policies and strategies in reversing the health trends
Identify best practices lessons leant and recommendations for next steps for sustaining and improving

(ii) **The Joint Assessment of the Health Sector Strategic Plan:**

The objectives of the joint assessment of the HSSP II using IHP+ attributes is to examine the strengths and weaknesses of five sets of attributes considered the foundation of any 'good' national strategy:

- The situation analysis, and coherence of strategies and plan with this analysis ('programming'); for example, whether priority health needs and issues of equity and access are adequately addressed;
- The process through which the plan or strategy has been developed;
- Adequacy of financing projections and strategies; and of arrangements for financial management and auditing;
- Implementation and management arrangements, including for procurement; and
- Plans for monitoring and evaluation, and processes for using the findings.

Existing Information Sources

Both reviews will take advantage of the wealth of material available to support the exercises. The review will be expected to refer to and not limited to the documents listed in the Annex C.

Review Process and Methods

1. METHODOLOGY

The Midterm review and the Joint assessment of the HSSP II will be integrated and conducted jointly with a same team that will deliver one report. However, the consultants must ensure that the needs of each of the two exercises are responded to in enough detail.

a. Mid Term Review (MTR)

The mid-term review will be conducted as an in-depth evaluation using a participatory approach, whereby the Ministry of Health, other relevant Government of Rwanda institutions, civil society and development partners are consulted throughout the Review. The review team will also discuss with the MTR TWG on any methodological issues to properly conduct the review.
The findings of the evaluation will be based on:

- Meetings with Government of Rwanda institutions (MOH and agencies (including RBC) , MINECOFIN, MINEDUC, MINALOC, and Prime minister's office, and other relevant GoR's institutions),
- Meetings with members of the Health Sector Working Group;
- Meeting with Civil society organizations.
- Meeting with all Technical working groups in the health sector;
- Field visits to selected Districts, Referral Hospitals, district hospitals; health centers; and community
- Desk review of the Health sector documents and reports.

b. Joint assessment of the HSSP II (JANS)

The joint assessment of HSSP II will also be conducted in a participatory approach. The assessment is expected to include reviews of documents such as evaluations, mid-term reviews of previous strategies, reports on performance, budgets, expenditure frameworks, actual expenditure records and audits, existing assessments of procurement and financial management systems; notes from multi-stakeholder meetings and forums; interviews with key informants, and possibly field visits. The assessment team will involve multiple stakeholders including government, civil society and development partners/donors. The JANS will be conducted using the IHP+ Combined Joint Assessment Tool and Guidelines covering attributes listed in Appendix B which is part of these ToRs. More information about the tool and guidelines is available at http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_guidelines_EN.pdf

Proposed implementation arrangements and accountabilities

In line with well-accepted processes in Rwanda, and to balance the principles of being country-led but having an independent element, implementation arrangements are as follows: The exercise will be guided by a

a) **Steering Committee** chaired by the MOH and rather than creating a new structure, makes use of the existing Health Sector Working Group chaired by the PS Ministry of Health. The role of the steering committee will be to provide overall strategic guidance to

the MTR and JANS processes. Specifically the steering committee will be responsible for:

a. Validating and approving the Terms of Reference for the MTE
b. Approving the members (international as well as local) of the Joint assessment Technical Team
c. Monitoring the implementation plan, review methodology and work schedules
d. supporting the organization of the stakeholders meetings
e. Reviewing and approving the quality and standards of MTE reports

b) **A MTR technical working group** chaired by the MOH M&E specialist will oversee the day to day implementation of the review exercise. The technical working group will be comprised of the members of the MOH M&E technical working group.
The specific responsibilities of the TWG will be to;

- Develop TORs for the MTR and JANS exercises and seek approval from the steering committee
- Develop criteria for the selection of the consultants and review team that will undertake the review
- Provide technical guidance to the team of consultants undertaking the exercise
- Develop An monitor timeline for the activity
- Review the methodology proposed for the exercise by the lead consultant
- Collect all documents for the review

I. Steps and deliverables

- Steering Committee reviews dates; TORs and evaluator criteria; a **and propose to MOH for approval (24 March 24th – April 1st)**

- In consultation with DPs an IHP+, MoH to identify and select consultants core team and contracting process **(5 weeks) (2nd April- May 6th)**

- Development and submission of consultants' **inception report** (should contain feedback on TOR; proposed methodology and timeline for the review; draft desk review documentation and outline of the report)

- Phase 1 (preparation): team orientation; review of key documents, preliminary outline of questions for the in-country assessment; Team also develops specific objectives and methods (terms of reference) for the in-country visit including the district field visits; to be approved by the Technical Committee **(1 week June 1st – June 7th**

- Assessment phase 2 (in-country assessment) field visits to selected districts, Key informant interviews with various departments and technical working groups, involving interviews at central and district level, and document review**. (2 weeks: 8th June-22nd June)**

- Organize a debriefing meeting to present the MTR and JANS major findings to the Technical Team first and the Steering Committee (at the end of the phase 2) **(3 days : 23th June- 27th June)**

- Write up and disseminate the results to the Ministry of Health and the Health Sector Working Group (HSWG) Rwanda, HSSP II MTR draft report **(1 week: 28th - 3th July)**

- Sharing the draft report with MOH and stakeholders for comments (1 week 4th July-11th)

- Final validation of the report by the Health Sector Working group. **(1 day: 12th)**

- Approval of the report by MOH (1 day)

- Dissemination meeting (1 day)

Expected Outputs/ Deliverables

The main output of the review shall be:
a) An executive summary of not more than 10 pages
b) A final report with:

- Findings on the progress of implementation of each strategic objective and strategic programme area;
- Successes, challenges and lessons learnt during the mid-term period documented;
- Lessons learnt for consideration in remaining period and in the design of HSSP III;
- Strengths and weaknesses of the HSSP II taking into consideration the JANS attributes.
- Evidence based recommendations.

Stakeholder participation

The Ministry of Health will be the primary stakeholder and beneficiary of the review processes. Other stakeholders will include the national health sector working group members and development partners in health the SWAP partners ..civil society and NGO partners involved in health

Review team roles and responsibilities

An independently selected team of *3 to 4 international and 3 national consultants* will be hired to undertake the activities that are part of this combined assessment. Considering the different levels of technical and managerial expertise it is proposed that the review process be led by an overall senior consultant team leader with expertise in the management of large scale evaluations who will oversee the implementation of both reviews. Details on required competencies of the consultants are provided in the Appendix A.

The Team-Leader is responsible for preparing the final report to be validated by the MoH.

Timeframe:

The MTR & JANS will take place in the month of May 2011. It will be preceded by a small preparatory mission from IHP+ the 3rd week of March, assisting the MoH and its partners with preparing the MTR & JANS. Specific schedule for each step will be determined by Joint steering committee.

Approved by:

The Permanent Secretary **The lead of development partners**

Annex 2: Work programme of the MTR/JANS Team (July-August 2011)

There will be two teams, but for several assignments the composition can change
Team A = Public Health: (Jarl, Drame, Vincent Rusanganwa and Manasse Nzayirambaho)
Team B = Finance: (Torun, Abebe, Diana Muhongerwa)

DAY	MORNING	AFTERNOON
Sunday 17.07.10	13.35 Arrival Jarl and Abebe ET 19.00 Arrival Drame and Torun KL 535	20.00 Team Meeting in Chez Lando with international team members (if possible)
Monday 18-07	08.30 Meet WR and WHO Programme Team 10.00 Meet national colleagues /MOH (Technical Team)	14.00 Internal team meeting 16.30 Meeting Steering Committee (SC) (ALL)
Tuesday 19.07	08.00 Planning, M&E TWG / HMIS, e-Health, ICT (A+B) 10.00 Decentralisation TWG (A+B)	13.00 HRH TWG (A) 15.00 Commodities and supplies (A)
Wednesday 20.07	07.00 Field Visit Northern Province / Western Province With Musanze / Karongi Districts.	In each district 2 HCs / CHW
Thursday 21.07	07.00 Field Visit Eastern Province / Southern Province With Ngoma and Muhanga Districts.	In each district 2 HCs / CHW
Friday 22.07	08.00 Meeting with DPG / HSWG (A+B) (at GIZ) 10.00 Health Financing TWG (A+B)	13.00 MINECOFIN (A+B) 15.00 Prevention & Care/Treatment TWG (A) 17.00 CHAI (A+B in Chez Lando)
Saturday 23.07	*Team meeting*	*Writing first draft chapters*
Sunday 24.07	*Writing first chapters*	*Writing first draft chapters*
Monday 25.07	08.00 USAID (A+B) 10.00 MCH TWG (ARH, GBV, Community health) (A) (SM, FP , EPI not present)	13.00 Mental Health Division (A) 13.00 Resource Tracking technical team (B) 15.00 Nutrition and IMCI (A) 15.00 Local civil society (Umbrellas) (B)
Tuesday, 26.07	08.00 Governance (A+B) (at DFID) 10.00 SBS donors: German, Belgian and British (A+B) 11.30 Lunch with Elisabeth	13.00 Environmental health (A) 13.00 Maintenance (B) 15.00 Health Communication Centre 15.00 CCM Secretariat (B)
Wednesday 27.07	07.00 Quality Assurance Unit 08.30 Heads TB, Malaria Programme (TRAC+) (A) 08.00 Single Project Implementation Unit (B) 10.00 Partner Coordination (SWAp) (B) 10.00 Blood Transfusion (CNTS) (A1)	10.00 National Ref Laboratory (A2) 11.00 Director of Finance, Budget, Procurement and accounting officer (B) 13.00 UN Agencies (A+B) 15.00 Faculty of Medicine, School of PH, KHI (A) 17.30 Meeting with Hon Minister
Thursday 28.07	08.00 NCD and NTD TWG (A) 11.00 CHU Kigali (A1) 11.00 Camerwa (B)	14.00 Prepare power point for debriefing SC
Friday, 29.07	10.00 Prepare debriefing SC (ALL) at WHO Office	14.00 Debriefing Steering Committee (SC) (A+B)
Saturday,	Writing first draft chapters	19.00 Departure Torun
Sunday	Writing first draft chapters	Writing first draft chapters
Monday 01.08	Writing first draft chapters	15.00 Meetings with MCH and FP Heads TWG (A)
Tuesday 02-08	Prepare the debriefing meeting for all stakeholders Meeting Community Health, EPI, FP and MCH	Finalise the writing and discuss internally
Wednesday 03.08	Team to finalise a first draft for internal check	Debriefing Workshop with all stakeholders (HSWG) 19.00 Departure Drame and Torun, KL
Thursday		16.00 Departure Abebe and Jarl ET 806

Annex 3: Persons interviewed during the MTR/JANS

NAMES	RESPONSIBLE FOR
MINISTRY OF HEALTH (MOH)	
Hon Minister of Health	Dr. Agnès Binagwaho
Permanent Secretary, MOH	Dr. Uzziel Ndagijimana
Michel GATETE	SWAP Coordinator
Dr Ida Kanindi	Coordinator of Decentralization department
Aline Niyonkuru	EDPRS facilitator
Oscar IYAMUREMYE	Procurement officer
KIGALI University Teaching Hospital	
Dr Theobald Hategekimana	Director General of the University Teaching Hospital in Kigali (UTHK)
MINISTRY OF FINANCE AND ECONOMIC PLANNING	
Naphtal Nyandwi	MOH Focal person in the Planning Directorate
William RUKUNDO	MOH Focal person in the Budget Directorate
Leonard RUGWABIZA	Director General Economic planning and Research
General Directorate of Planning and Health Information Systems	
Regis HITIMANA	Professional in charge of Planning and M&E), < hifreg@yahoo.fr > +250788 528 533
Daniel MURENZI	ICT Head
Dr Richard GAKUBA	e-Health Coordinator
Directorate of Finance	
Duka Innocent	MOH / Director of Finance (SC)
Fidele KARANGWA	Budget Officer
Remyi Yamin	Procurement Officer
Directorate of Administration	
Daphy Mukakigeri	MOH / Director Administration (SC)
Francine NKURUNZIZA	Human resource officer
Directorate of Health Dinancing	
Jean-Luis Mukunzi	MOH / Ag Director of Health Financing (SC)
Joseph Shema	MOH / Acting coordinator of CBHI and PBF (SC)
Josephine Mashavu	MOH / Coordinator of National CBHI Pooling Risk (SC)
Karangwa Francois	Executive Director of Civil Society Umbrellas
Odette Mukabayire	Head of NRL
Emmanuel Twagirumukiza	MOH / Human Resource Development officer
Camille Kayihura	RBC / KFH Head of training Unit
Joseph Kabatende	MOH / Pharmacy Dept, Ag Coordinator
Deogratias Leopold	Logistic advisor SCMS
General Directorate of Clinical Services	
Dr Bonaventure NZEYIMANA	In charge of Public Health Facilities
Dr Eugene RUBERANZIZA	In charge of Non Communicable Disease

NAMES	RESPONSIBLE FOR
Maternal and Child health	
Fidele Ngabo	MCH Coordinator
Dr Lizet Boerstra	HSS / M&E advisor in MCH
Caroline MUKASINE	GBV M&E
Diane MUTAMBA	Adolescent and Reproductive Health
Dr Tacien BUCYANE	IMCI
Alphonsine NYIRABEMERA	Head of Nutrition desk
Dr Felix SAYINZOGA	Maternal health
Dr. Corine Karema	**RBC/IHDPC / Malaria Unit, Director (SC)**
Francois Uwinkindi	RBC/IHDPC
Leonard Kayonde	RBC/IHDPC
Anitha Irakozange	RBC/IHDPC
Monique Ruyange	RBC/IHDPC/Malaria/GFATM
Alphonse Rukundo	RBC/IHDPC/Malaria/M&E
Sebaziza Gakumzi	RBC/IHDPC/HIV
Emanuel Hakizimana	RBC/IHDPC/Malaria
Dr Placidie MUGWANEZA	RBC/IHDPC/HIV/ Clinical Prevention Unit
Dr Ribakare MPUNDU	RBC/IHDPC/HIV/ Care and Treatment Unit
Dr Michel C\Gasana	**RBC/IHDPC / TB Unit, Director**
Evaristo Gasana	TB Division
Claude Bernard Uwizeye	TB Division
Charles	RBC/ Drug Production and Procurement
MANZI Martin	RBC/ Maintenance
Arthur ASIIMWE	RBC/ Health Communication Centre
Jean Damascene IYAMUREMYE	RBC/Mental Health
Placide MWITENDE	SPIU Head of Planning, M&E
Ida HAKIZINKA	CCM Permanent Secretary
Thierry NYATANYI	**RBC/IHDPC / Other infectious Diseases**
Peter Kimenyii	**RBC/CNTS, Interim Head CRTS of Kigali**
Jean-Pierre Munana	CNTS / M&E
Marechal Gasana	CNTS / Data manager
Xavier Rwandamuriye	CNTS / Quality Assurance
Emmanuel Makuni	CNTS / Finance and Administration (Acting Director General)
Arthur Asiimwe	**RBC / Health Communication Centre (RHCC)**
Joseph Theodomily Katabarwa	Environmental Health Department (EHD) and Community health
Zachary Bigirimana	Kigali Health Institute (Head Environmental Health Sciences Department)
Geoffry Ndayishimiye	KHI, Director Planning and Development
Dr Paulin BASINGA	Deputy Director (Research and consultancy)
Laetitia Nyirazinyoye	SPH, Deputy Director (Academic Affairs)
Cyprian Munyanshongone	SPH, HOD Lecturer
	Umbrella of Civil Society

NAMES	RESPONSIBLE FOR
Canut Dufitumukiza	Rwanda NGO Forum
Joseph Gumuyire	Rwanda Network of PLWH
Ignace Singirankabo	Rwanda Interfaith Network
Francois-Xavier Karangwa	UPHLS
Innocent Bahati	ABASIRWA (Umbrella of Journalist)
Development Partners	
Elisabeth Girrbach	Health Coordinator GDC and Head of GIZ Health Programme (SC)
Dr Olivia Nieveras	GIZ, Health Programme (Health Care Financing WG)
Marie Florence Pruemm	GIZ, Adolescent Reproductive Health and Gender Based Violence (TWG MCH)
Dr Remo Meloni	BTC, Health Sector Advisor (SC)
Vincent Tihon	BTC, Technical Advisor
Francoise Ukulikiyabandi	Swiss Agency for Development and Cooperation (SDC), Health Programme Officer
Michael Karangwa	USAID, Health System Specialist (SC)
Barnabe Mpfizi	USAID Deliver / SCMS
Jennifer Slotnick	USAID Health Services Delivery Officer (Environmental Health)
Kelly Hamblir, Tara Reichenbach,	USAID Advisor
Yogesh Rajkotia	USAID advisor
Eugenic Kayuangwa	CDC
Zara Ahmed	CDC
Dr Boureima Hama Sambo	WHO / WR interim
Jean-Pierre Ruhira	WHO / Environmental Health
Mamadou Malifa Balde	WHO / HSP
Dr Friday Nwaigwe	UNICEF, Chief Health and Nutrition programme (SC)
Guy Mbayo	UNICEF, Chief Water, Sanitation and Hygiene
Dr Djordje Gikic	CHAI, Country Director (SC)
Erik Josephson	CHAI, DCD
Fulgence Afrika	Access Project
Randy Wilson	MSH, HMIS Advisor
Alex Hakuzimana	MSH, Logistics specialist
Steve Musau	Abt Associates
Muhuza Imelda	PSI, Programme Manager
Ms Laura Haas	Director Tulane University / Rwanda
Mr Calvin Wilson	Director Dept Family Medicine, University of Colorado, Denver
Northern Province / Musanze District (20.07)	
Vincent Ndayambaje	Vice Maire Musanze
Francine Uwamungu	District Council (Social Commission)
Celestin Lasana	In Charge of Health and Hygiene Musanze District
Justin Mutuyidana	Coordinator CDLS
Kamana Damascene	Directeur Mutuelle de Sante
Dr John Kalach	Medical Director Ruhengeri District Hospital
	HC Kirigi
	HC Busogo

NAMES	RESPONSIBLE FOR
Eastern Province / Ngoma District (21.07)	
Angelique Uwamahoro	In Charge of Health and Hygiene in Ngoma District
Dr. William Nambaiya	Medical Director Kibungo District Hospital
Fiacre Rutaganda	Pharmacist District Pharmacy
Aimable Gakunzi	Comptable Mutuelles Kibungo Hospital
Felicite Muhayimana	Nutritionist
Valentin Ndamage	HC Mutenderi, Titulaire
Genevieve Muhimpundu	Mental Health Nurse (i/c Gender Based Violence)
Augustin Gakwaya	HC Rukira, Titulaire
Suzane Mukarugambwa	Nurse
Fortunee Murekatete	Nurse
Western Province / Karongi District (21.07)	
Liberty Mukama	Director Administration
Eric MUNEZERO	Budget responsible
Phlippe TURATIMANA	Dir Mutuelles Karongi District
Marie HAKUZWIMANA	Dir District Pharmacy
Donatille NISHIMWE	Head of Social commission of Karongi District council
Leocadi Mukampara	Rubengera Health Centre
Dr Frida	Kibuye Hospital Director
SEVUMBA Innocent	Kibuye Hospital Administrator
Southern Province / Muhanga District (20.07)	
Sosthene Kamana	Charge de Sante in the District
Marie Gikundiro	Coordinator CDLS
Aimable HARERIMANA	Mutuelle officer
Janvier Ndicunguye	Dir District Pharmacy
Dr Ose SEBATUNZI	Kabgayi Hospital, Director
MUKABADEGE Soline	Nyarusange Health Centre
NSABIMANA Longin	Rutobwe Health Centre

Annex 4: Documents consulted by the team

Author, Year	Title
Background documents	
GOR/MOH, Oct. 2004	Health Sector Strategic Plan (HSSP I, 2005 - 2009)
GOR, Febr 2005	Health Sector Policy
GOR, July 2006	Rwanda Aid Policy (French)
GOR/MOFEP, Sept 2007	Economic Development and Poverty Reduction Strategy (EDPRS 2008-2012, English).
GOR – DP, Oct. 2007	MOU between MOH and Health Sector Development Partners (DPs)
External Evaluation team, July 2008	Mid Term Review of the HSSP I (2005-2009), final evaluation report
MOH, Dec 2008	Health Sector Performance Report 2008
MOH, Dec 2008	Health Sector Performance Report 2009
MOH, April 2009	Annual Report 2008 final
GOR/MOH, July 2009	Health Sector Strategic Plan (HSSP II, July 2005 – June 2009)
WB, Sept. 2009	Rwanda, a Country Status Report (CSR) on health and poverty
MINALOC, Dec 2009	The Rwanda Citizen Report and community score cards 2009 (final)
GOR/MOH, July 2009	Health Sector Strategic Plan (HSSP II, July 2009 – June 2012)
MOH, Oct. 2009	Joint Health Sector Performance Report (mini budget Jan-June) 2009
MOH, February 2010	Health Sector Action Plan (excel file)
MOH, Oct 2010	Annual Report July 2009 – June 2010 final
Terwindt, Frank, July 2010	Roadmap for further development of the Rwanda Health SWAp
MOH, Oct 2010	SWAp Procedures Manual (28 pages)
MOH, Sept 2010	SWAP Procedures Manual (power point presentation)
GOR, Oct 2010 with MOH, 2010	Economic Development and Poverty Reduction Strategy (EDPRS) Implementation report (June 2009 – July 2010), WITH: Health Sector Performance Report July 2009 – June 2010
MOH, NISR, ICF-Macro, April 2007	Interim Demographic and Health Survey, (I-DHS 2007-2008)
MOH, NISR, ICF-Macro, 2010	Demographic and Health Survey, (DHS 2010-2011), Preliminary results (power point presentation)
WB, Claude Sekabaraga, 2010	Rwanda on the way towards health MDGs, DHS 2010, preliminary results, WB, Nairobi, HSS Hub.
DHS, 2010	Preliminary report (34 pages). Received July 2011
MOH website, undated	Rwanda Indicators
MOH, undated	Annual Statistical booklet 2008
MOH, Oct 2010	Annual Statistical Booklet 2009
Service Delivery and Programmes	
MOH, July 2003	National Reproductive Health Policy
MOH, July 2005	National Medical Laboratory Policy (draft)
CNLS, Dec 2005	Politique Nationale de Lutte contre le HIV/SIDA (finale) (French)
MOH/PNILT, August 2005	Policy Statement on TB/HIV Collaborative Activities
MOH, 2006	Family Planning Policy and Strategy 2006-2010 (in Kinyarwanda)
GOR/MOH, Dec 2006	National Behaviour Change Communication Policy for health sector
MOH/NCBT, May 2006	National Policy for Blood Transfusion

Author, Year	Title
MOH, 2008	National Community Health Policy
GOR/MOH, July 2008	Environmental Health Policy (French)
MOH, April 2009	Politique Nationale de Sante de l'Enfant (French)
MOH, Dec. 2009	Health Financing Policy
MOH, June 2009	HRH Strategic Plan 2009 - 2012
MOH, 2010	National Policy on Traditional Medicine (NPTM)
MOH, July 2010	National Palliative Care Policy
MOH, April 2010	Community-Based Health Insurance Policy
GOR/MOH, 2010	National Health Promotion Policy
GOR/MO Trade and Industry, June 2010	Rwanda draft Quality Policy
MOH, Jan 2011	Community Health Strategic Plan 2009-2012 (draft)
MOH, June 2011	Rwanda National Mental Health Policy (in french, 40 pages)
MOH, July 2011	Adolescent Sexual Reproductive Health policy and Rights Policy (ASRH&R Policy, 42 pages)
District Development Plans DDP 2008-2012	Huye District (June 2007), Muhanga District (July 2007) Nyagatara District (June 2007) Bugesera, District HSS Framework, Implementation Plan, June 2008
Kibuye Hospital, 2011-12	Kibuye Hospital Action Plan (example)
MOH, March 2011	Draft Malaria Programme Performance Review (101 pages)
CNTS, 2011	Blood Transfusion Centre: achievements 2000-2010
NTLCP, 2009	National TB Control Strategic Plan 2009-2011 (PNILT, 85 pages)
Health Systems Strengthening	
MOH, Dec. 2004	Mutual Health Insurance Policy
MOH, 2005	Politique Pharmaceutique Nationale (draft)
MOH/WHO, 2008	Health Financing Systems Review, options for universal coverage
MOH, July 2008	National Health Accounts Rwanda 2006 (with AIDS, Malaria and RH sub-accounts)
MOH, December 2009	Rwanda Health Finance Policy
MOH, April 2010	Rwanda Community Based Insurance Policy
MOH, Oct 2009	Health Sector Monitoring and Evaluation Policy (24 pages)
MOH, Oct 2009	Health Sector M&E Strategy, 2009/10-2012/13 (30 pages)
MOH, 2009	National Pharmacy Policy (23 pages)
GOR/MOH, 2009 Pharm	Various formal docs on food regulation (zip file)
GOR/MOH, 2009 Pharm (Zip files 2x)	Guidelines: Formal documents for pharmaceutical sector (Zip file with EDL, STG, National Formulary, Pharmaco vigilance guidelines, etc)
MOH, April 2010	National Health Insurance Policy
MOH, August 2010	HSS Framework and Consolidated Strategic Plan 2009 – 2012 (vs 1.c)
Calvin Wilson, June 2010	Defining Family and Community Medicine in Rwanda (FAMCO)
Mieke Visser, undated	Concept Note HRH FAMCO training
MOH, February 2011	SIP – MTEF July 2011/June 2012, statement of priorities
MOH, March 2011	HRH Strategic Plan, 2011 – 2016
MOH July 2011	Health Financing TWG Overview Presentation

Author, Year	Title
MINECOFIN, various years	Budget and expenditure Report
MOH, June 2011 (2x)	SOP for the management of routine health information (District Hospital and Health Centres-Posts)
Governance and Financial Management	
MINECOFIN, July 20007	Managing the risks associated with AID increased in Rwanda (by Mick Foster and Peter Heller)
GOR, November 2007	Strengthening Partnerships for Economic Development and Poverty Reduction, Annual Report (32 pages)
GOR, June 2008	Public Expenditure and Financial Accountability Assessment (PEFA), PFM Performance Report (final) (by Martin Johnson et al)
MINECOFIN, June 2008	National Planning, Budgeting and MTEF Guidelines
GoR November 2010	Public Financial management Performance Report
JAWP, March 2009	JAWP (excel file) 2009/10
JAWP, 2010	JAWP, Karongi district 2010/11
TWG various presentations, August 2010	New TWG structure with responsible chairs and co-chairs. Power point presentations by TWG of: Care and Prevention, SWAp Manual, Health Resource Management, e-Health, HSS and Single project implementation unit (SPIU)
TWG MCH – GBV, July 2011 TWG MCH-ASRH, July 2011	Presentations for the MTR
HSCG – HSWG Minutes	Health Sector Consultative – Working Group Minutes 2009 – 2011.
MOH-DPs, Sept 2010	TOR Health Sector Working Group (HSWG)
MOH-DPs, Sept 2010	TOR Technical Working Groups (TWG)
MOH-DPs, Sept 2010	List of TWG with chairs and co-chairs (2 docs)
MOH, October 2010	Joint Sector Review Report
MOH, Febr 2011.	Health Sector Action Plan 2011-12 (excell sheet)
GIZ, July 2011	Rwanda SWAp: milestones and architecture (power point)
MINALOC, January 2011	Decentralisation Implementation Plan (DIP, 2011-2015)
MOH, May 2011	District Health System Reorganization Guidelines (from a managerial perspective)
DP Group, March 2011	Development Partners Recommendations on SWAp (power point)
MTEF 2010-2011	MTEF Consolidated Action Plan 2010-2011.
MTEF 2011-2012	MTEF Action Plan for all components of the HSSP II (2 versions)
MINECOFIN, April 2011	Budget Framework Paper, 2011/12 – 2012/13 with 9 Annexes
MINECOFIN, undated	Budget execution by Ministry & Programme 2009-2010 (budget vs actual)
MINECOFIN, undated	Actual by sector and category, 2009-2010.
BTC / CHAI, March 2011	Health financial mechanisms at districts in Rwanda (28 pages)
MINECOFIN, May 2011	Revised Fiscal and Financial Decentralization Policy, Adopted by the Cabinet, 11th May 2011 (22 pages)
MINECOFIN, March 2011	2011 Survey on Monitoring of the Paris Declaration Rwanda and DCF Survey on Mutual Accountability: Preliminary Results
MINECOFIN, June 2011	Roadmap to EDPRS II.
MOH, July 2011 (2x)	Options for the development of HSSP III (with answers from all DPs)

Annex 5: Questions and tools for interviews and field visits

Part A: The "Strategic Objectives" for MNCH and Disease Control merit questions both on the supply and demand side. Some HSSPII expected outputs/outcomes with related indicators have been selected to assess the progress made from July 2009 up to now.
Q1: How far these outputs/outcomes and indicators represent the progress made so far?
Q2. Where progress has been made over the last 2.5 years against the targets, what are the factors that contributed to such a success?
Q3. Where progress was not achieved against targets and/or baseline, what are the main constraints and challenges that hindered achievements?
Q4. Main recommendations (i) from now to the end of the HSSPII (June 2012) and (ii) after 2012

Part B: The "Strategic Programme and Systems Strengthening Areas" of HSSP II address the various support systems. Suggested questions for the most important systems are:

1. Planning: Questions for the District Offices
Q1. What types of plans (strategic, operational, capital, HRH, etc) and for who are they done at District Levels? (i.e. MOH, CPs, vertical programmes, PEPFAR, GFATM, etc)
Q2. How is this planning supported and coordinated? (clear policy guidelines communicated, support from higher levels, technical guidelines, feedback, timely budgets, etc).
Q3.How is the linkage between strategic and operational plans established? How strong is the linkage between the plan and resource envelopes?
Q4. Comprehensiveness of the annual district plans (government, CSOs, Internally generated funds and DPs contribution in one plan and budget at district level)?
Q5. What are your main challenges for effective planning?

2. Questions for Management and Organisation
Q1. Is the Ministry of Health management and organisational structures at all levels clearly understood and functioning, including roles and responsibilities and how do they relate to each other?
Q2. What is the current capacity to fulfill these management and organisation functions, if capacity is weak what is needed to strengthen it?
Q3: What are the major challenges the sector is facing with the new health district system organization put in place in line with the whole country decentralization frame?
Q4: What are the major constraints and challenges the district health management teams are facing in providing health care (promotional, preventive and curative)?
Q5. How the reference and counter reference system is organized?
Q6. What are the challenges for effective management at District Levels? (explore stewardship functions, supervision and relations with district councils)

3. Questions for Human Resources
Decentralisation: which HR functions are decentralised from MOH HQ to district level? What would be the benefits and what are the challenges involved?
HR information: how is HR information collected and used? Are monthly or quarterly staff returns produced and send to higher levels? Does MOH communicate staff postings or transfers to district management? Is there any incentive systems? And what are the strategies to attract et retain HR in rural areas?

Public Private Partnerships: are there private (for-profit or not-for-profit) health facilities in the district and how is the collaboration and communication with these facilities organised (i.e. health centres, hospitals, training institutions)? Do they receive any supports from the public sector structures and institutions (training, supervision)? Do their statistics included in the district health information system?
Community Health Workers: how many Community Health Volunteers (all types) are working in your district and how is their contribution to service delivery assessed? Do they have any job description? Do they have a standard training and supervision package according to their job description? Is there any motivation, incentive systems for the CHWs? What are recommendations for strengthening the CHW's contribution?

4. Questions in Financial Management
Budget planning and preparation
How involved are district and health centre staff in preparing budget submissions?
How promptly after approval are budget holders notified of their allocated budget?
To what extent are CP funds incorporated in overall planning and budgeting?
Budget Releases
How are budget releases to Districts and onwards to Heath Facilities made?
How frequently are budget releases processed? Are funds released on time?
Spending
To what extent is expenditure authorization delegated? To whom?
Are payments made locally by cash/bank or through District offices?
Monitoring
Is there a Financial and Administration Management System implemented at District and Health Centres? Have there been any recent developments regarding this?
What reports are received showing expenditure against budget? How often are these received? Who receives them? What action is taken on them?
Are any reports prepared which combine financial and performance information?

7. Questions in M&E, HMIS and Research
7.1. Health Facility (HF)
- Has the HF analysed monthly statistics from the HMIS and acted upon them?
- How does health facility staff appreciate the HMIS forms?
- What constraints does HF staff encounter in terms of the quality and coverage of the data they collect?
- To what extent have staff been trained in the use of the HMIS system?
- *Quality of data:* what mechanisms are in place to guarantee data quality?

7.2. District Health Office (DHO)
- To what extent
    - have DHO programme staff updated information from health facilities
    - have DHOs analysed data/ have DHOs reviewed action plans using information from HMIS and other sources?
    - have DHOs shared information with stakeholders (e.g. DHO reporting recent HMIS info to DDCC)?
    - Is there any retro-information systems between different levels of the system
- What have been the main constraints for using/not using/ analysing data?
- What are practical things to follow-up on in the near and more distant future?

8. Geographic Access:

What are the achievements and challenges in:

- Constructing, extending and rehabilitating HF according to norms and standards?
    - Health centers
    - District hospitals
    - Referral hospitals
- Equip all HFs according norms and standards?
- Referral system and ambulatory services?
- Develop and implement a procurement and maintenance framework for all medical equipment and energy for health sector?
- Coordinate ambulance system management through SAMU?

What do you think should be done to overcome the barriers and challenges in the short and medium term?

Part C: The Tools for the JANS assessment are already given in the attributes and characteristics and do not need repetition here.

Annex 6: Summary of JANS attributes (revised version)

ATTRIBUTES	CHARACTERISTICS
SITUATIONAL ANALYSIS AND COHERENCE	
1. National strategy is based on sound situational analysis	3
2. Priority areas, goals and objectives clearly defined	2
3. Planned interventions are feasible and equitable	3
4. Risk assessment and mitigations measures are included	1
PROCESS AND ITS INCLUSIVENESS	
5. Multi-stakeholder involvement in the drafting and endorsement of the final strategy	1
6. High level of political commitment	4
7. Consistent with higher level strategies	2
ADEQUACY OF FINANCE AND AUDITING	
8. Expenditure framework and costing is included	2
9. There are realistic funding projections on the funding gaps	3
IMPLEMENTATION AND MANAGEMENT	
10. Operational Plans are regularly produced	2
11. Description of how resources will be used for outcomes	3
12. Institutional capacity to implement the strategy has been assessed and there are plans to develop this if required	3
13. FM and Procurement are appropriate and accountable	4
14. Governance, accountability, management and coordination for implementation are specified	2
MONITORING, EVALUATION AND REVIEW	
15. M&E Plan is sound and includes core indicators, sources and responsibilities for data collection	6
16. There is a plan for Joint Performance Reviews and feedback of findings into decision-making and action	3