Joint Assessment of Rwanda's Third Health Sector Strategic Plan (HSSP III)

June 2012

Final report

Abbreviations

CBHI	Community Based Health Insurance
CHW	Community Health Worker
CSO	Civil Society Organisation
DHIS	District Health Information System
DHS	Demographic & Health Survey
DHSST	District Health Systems Strengthening Tool
DHU	District Health Unit
DP	Development Partner (previously often called donors)
EDPRS	Economic Development and Poverty Reduction Strategy
FY	Financial Year
GoR	Government of Rwanda
HC	Health Center
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSSP III	Third Health Sector Strategic Plan
ICT	Information & Communication Technology
JANS	Joint Assessment of National Strategy & Plans
JFA	Joint Financing Arrangement
JHSR	Joint Health Sector Review
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal & Child Health
MDA	Ministries, Departments & Agencies
MDG	Millennium Development Goals
M&E	Monitoring & Evaluation
MIFOTRA	Ministry of Public Service, Skills Development & Labour
MINALOC	Ministry of Local Administration, Community Development & Social Affairs
MINECOFIN	Ministry of Economic Planning and Finance
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
PBF	Performance Based Financing
PFM	Public Fiduciary Management
PS	Permanent Secretary
RBC	Rwanda Biomedical Center
SITAN	Health Sector Situation Analysis 2011
SPIU	Single Project Implementation Unit
SWOT	Strengths-Weaknesses-Opportunities-Threats
TA	Technical Assistance

TBD	To Be Decided
TWG	Technical Working Group

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Acknowledgements

The Team wish to thank the Government of Rwanda, particularly the Ministry of Health, and its partners for all their help in preparing and conducting the JANS, for most productive and interesting discussions, and for a very friendly and constructive atmosphere throughout the JANS. A special thanks to Mr Regis Hitimane, heading the planning unit in MoH, for his great and persistent efforts to assist the JANS process.

Introduction

Background and Objective

In the first half of 2012 the MoH, supported by all its partners, have developed its draft Third Health Sector Strategic Plan (HSSP) III building on a thorough Mid Term Review of HSSP II (mid 2011), a detailed situation analysis (SITAN) in 2011 and extensive consultations. The HSSP III is supposed to start July 2012, but will be revised according to the recent Ministry of Economic Planning and Finance (MINECOFIN) Guidelines for the second Economic Development and Poverty Reduction Strategy (EDPRS II) and the findings of a JANS (Joint Assessment of National Strategy & Plans) that MoH and its stakeholders had invited to assess the quality of the draft strategic plan. The objectives of this HSSP III joint assessment was:

- To make a joint assessment using the JANS Tool and accompanying Guidelines as the guiding framework.
- To present and discuss the analysis of strengths and weaknesses of HSSPIII and possible courses of action on specific issues with senior policy makers and other stakeholders and
- Suggest recommendations for remedial steps where weaknesses exist

The JANS team examined the strengths and weaknesses of five sets of attributes considered the foundation of any 'good' and comprehensive national strategy as specified in the IHP+ JANS Tool & Guidelines:

- Situation Analysis and Programming: Clarity and relevance of strategies, based on sound situation analysis
- Process: Soundness and inclusiveness of development and endorsement processes for the national strategy
- Costs and Budgetary Framework for the Strategy: Soundness and feasibility
- Implementation and Management: Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy
- Monitoring, Evaluation and Review: Soundness of review and evaluation mechanisms and how their results are used

TORs can be found in Annex 3.1

Methodology

This JANS assessment was carried out based on IHP+ JANS Tool and Guideline. In addition it used the guidelines provided by the MINECOFIN for the preparation of the sector strategies as part of the overall EDPRS II development process.

The team undertook extensive document reviews, conducted interviews with Technical Working Groups (TWG), government officials, Civil Society Organisations (CSO), private sector and Development Partners (DP). The Team was in Rwanda from June 3 to 14[1]. It was also able to carry out field visits to 3 districts[2] during this time.

[1] Except one team member, Ties Boerma, who was only in country from June 3-6

An extensive Mid Term Review that included the use of the JANS Tool for the analysis, was conducted less than a year ago. Furthermore, the preparation of the HSSP III was preceded by a thorough Health Sector Situation Analysis (SITAN) in late 2011. Consequently the MoH and its partners decided that their needs for a JANS of the draft HSSP III would be adequately covered by a "light touch" approach in terms of the size of the team and the duration of the JANS.

JANS Team

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The Team was selected by MoH and its partners, and largely financed by IHP+.

The Draft JANS report was submitted to the MoH in June 2011. While its findings and recommendations have been used to improve the HSSP III, the MoH and its partners did not have any specific comments to the report, and this final version – correcting typos and minor shortcomings, was finally done November 2012. It does not constitute an update by this this time merely a final version of the June 24 JANS report.

[2] Gasabo, Kamoni & Kigali

1. Main Observations

1.1 Overall observations and recommendations

The HSSP III is based on a thorough situation analysis, was developed in a very participatory way under strong political leadership, and constitutes a well developed, comprehensive guidance for taking the health sector forward in the next six[3] years with coherent programming and a good balance between strategic and operational elements and a well developed results framework.

As all partners in the sector are well aware, there is still some work to be done on HSSP III for four reasons.

- First, it needs to comply with the recent MINECOFIN guidelines on EDPRS II. This will not only secure alignment with the overall government priorities for the EDPRS II period, but also improve certain aspects of the HSSP III in itself.
- Second, the fiscal space analysis and projection of a realistic funding scenario have not yet been carried out and there is no clear indication on the level of funding gap in the next six years. This makes the feasibility of the HSSP III uncertain due to the possibility of a significant underfinancing for priorities within the HSSP III and its consequences for many of the targets.
- Third, while a thorough costing has been done for the HSSP III in general, the proposed investment in tertiary care and its implications in terms of recurrent cost and for the funding of other priorities, for example primary health care, need to be assessed. This requires development of a costed tertiary care strategy.
- Finally, the JANS Team finds that the strategic approach to ensuring equity and to the role of the private sector would benefit from further elaboration.

Key Recommendations

- Strengthen analysis and overall strategic direction in relation to:
  - the EDPRS II key priorities;
  - the sector's key role, as identified in EDPRS II, as a "foundation" sector;
  - equity considerations and the desired role of the private sector.
- Develop a costed strategic section for enhancing quality of tertiary care.
- Develop a realistic resource framework, identify the funding gap, and – if needed - revise priorities and targets accordingly.
- Strengthen the overview of implementing the HSSP III, and the coherence between the different initiatives, by including annualised targets and by a road map showing policy action[4] milestones as part of the HSSP III implementation arrangements.
- Include the development of a detailed operational M&E plan.

1.2 Situation analysis and programming

The HSSP III is building on and includes the main elements of a very thorough documentation and analysis, first of all the Mid Term Review of HSSP II (mid 2011) and the Health Sector Situation Analysis (SITAN) in 2011. The document not only provides the overall strategic direction but also specifies a considerable number of policy actions needed in different areas in the form of policies, sub-sector

[3] It is assumed that the HSSP III will eventually align with the EDPRS II and end year of 2018, although the present draft still occasionally implies the year 2017 as final year.

[4] Policies, strategies, plans, and guidelines.

strategies, plans and guidelines to be developed. Nevertheless, the HSSP III may still benefit from a clearer initial section on overall strategic direction, relating to the EDPRS II thematic areas and cross-cutting issues, the crucial role of the sector as the foundation for development, and including more emphasis on improving equity, supplementing HSSP III's already strong emphasis on universal coverage (particularly due to the successful Community Based Health Insurance), and the role of the private sector. Also, it obviously needs to align with the recent guidelines for the EDPRS II. Underpinning the HSSP III are programmes based on known cost-effective interventions.

The results framework is well developed in terms of clear goals and measurable indicators, although it may need some adjustments, as described in section 2.

Finally, the excellent results achieved during the two previous strategic plan periods instil confidence in the GoR's ability to implement the HSSP III.

1.3 Process

HSSP III was developed in a very collaborative way involving all stakeholders both in terms of actors (government, CSOs, private sector and Development Partners and to a lesser degree other ministries) and levels, e.g. Districts, and with strong political leadership. Coherence with national and sub-sector strategies is deemed good.

1.4 Cost and budgetary framework

Generally the HSSP III is based on a thorough costing exercise including both a Marginal Bottleneck Budgeting costing (MBB) and an input based costing. Overall, all program areas are costed, showing their recurrent and capital investments and at what level (central or district) that these investment are required. Some issues and areas for improvement are mentioned in the section 2, including the issue of defining and costing the tertiary care component. As the sector establishes the fiscal framework for the next six year (see paragraph below), it is also necessary to validate some of the assumptions used in the two costing exercises with program managers to verity that they are indeed realistic (see annex 3.4).

Both MINECOFIN's guidelines and JANS tool require a projection of resources to know whether the strategic plan is financially feasible. The HSSP III did not include an analysis of the fiscal space and the likely funding gap. MINECOFIN is currently working on its projections for the total resources projected to be available during EDPRS II period. The health financing team has started working on projecting the resource framework and is currently looking for TA for this task.

Rwanda, like any other country faces the hard choice of matching resources with ambitions. As a resource projection is yet to be done it is not known how this will compare to the costing of the plan, and how big the resulting funding gap may be. In addition to the costing already done, the level of ambition and scope of the proposed development of tertiary care needs to be decided and costed and balanced against the needed funding for other priorities. Given the level of ambition of the HSSP III and the prospects of no or only modest increase in government allocation to the sector due to focus on emerging priorities in EDPRS II, and a possible decline in funding from DPs due to the global economic problems, there may be a substantial funding gap. If this proves to be the case the targets would have to be adjusted accordingly (also to comply with MINECOFIN guidelines) and priorities within the sector adjusted, i.e. core priorities protected and the level of ambition for other priorities downscaled. This also calls for the development of a clear resource mobilization strategy to help bridge the funding gap.

1.5 Implementation and Management

There is a well defined system for governance and planning throughout the sector including securing that overall sector priorities are translated into operational plans at the district level. Part of this is Rwanda's "imihigo" performance and accountability system. There is still scope for improving capacity particularly at the lower levels, but strategies for addressing this are planned.

One big problem in relation to implementation is that large DP resources remain off budget. The establishment of a Single Project Implementation Unit (SPIU) may alleviate some of the problems, and the HSSP III raises the possibility of establishing Joint Financing Arrangements, which could also improve the situation.

At the district level integrated planning is further impeded by the low level of discretionary funding due to much of budget transfers being earmarked. However, increased discretionary funding at the lower levels will of course have to be matched with sufficient technical and managerial capacity, which currently has weaknesses that are planned to be addressed during HSSP III. Generally, the challenges - and importantly also opportunities - facing the sector in terms of implementing its part of the Government of Rwanda (GoR) third phase of decentralisation reform are well recognised.

The JANS in itself does not constitute a sufficient fiduciary assessment. The observations of the team suggests that the system is reasonably well functioning, although with scope for substantial improvement in some areas as identified by the thorough PFM assessments done both by GoR and DPs. See Section 2.4 for more details.

1.6 Monitoring, Evaluation and Review.

HSSP III includes a well developed results framework and overall M&E system with considerations for data quality and roles of key actors. Generally, data quality is deemed to be good. Some targets still need to be defined.

The already very well functioning M&E system could be even further improved by fine tuning indicators and targets, include indicators on equity and financial protection, elaborate a more detailed M&E plan at the start of HSSP III and establish a national health observatory.

Rwanda already has a well functioning system for performance monitoring and review including all major stakeholders and translating into follow-up actions.

2. Assessment of the HSSP III

2.1 Situation Analysis and Programming

Situation Analysis & Programming Clarity and relevance of priorities and strategies selected, based on sound situation analysis
STRENGTHS
Attribute 1: Strategy based on sound analysis • The sector and its sector working groups exerted lot of time and energy to base HSSP III on good assessment in the form of a full Health Sector Situation Analysis 2011 (including SWOT analysis of main areas), presented and validated at the retreat in Musanze in February 2012. This complemented the 2011 HSSP II Mid Term Review (MTR) report. The main elements of this comprehensive and detailed sector analysis are included in the HSSP III document itself. *Attribute 2: Clear goals, policies, objectives, interventions and expected results.* • Objectives are clearly defined and linked to measurable indicators. • HSSP III includes a strong emphasis on universal health coverage and improving the quality of care. • Overall health financing strategies (but not resource projections, see later) are well articulated and included in HSSP III as well as in the underlying policies (Health Financing Policy 2009, National Health Insurance Policy 2010 & Mutual Health Insurance Policy 2010). The strategies are sound and take into account the major MTR recommendations. *Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence* • Approaches in the HSSP III, and the sub-sector strategies underpinning it, are based on known cost-effective interventions. • The programs planned for HSSP III have been based on the experience of the HSSP II which together with HSSP I achieved "outstanding results" (MTR 2011). Adjustments to strategies were made to keep this momentum, and a thorough MTR in mid 2011 strengthened this process. • Quality is a priority throughout HSSP III. • Efficiency is explicitly and implicitly a priority throughout the strategy. Various systems strengthening plans are or are planned to be put in place to enhance efficiency within the health system, not least improving district capacity. • Sustainability is adequately identified as a concern, particularly in relation to Community Based Health Insurance (CBHI). Although strategies to address this are identified, the unpredictability of future resources remains a significant threat, and it is also mentioned as a risk in relation to DP funding. • Issues relating to the regulatory framework are well identified and intended to be addressed during HSSP III. • Integrated Disease Surveillance and Response (IDSR) have clearly defined outcome with indicators and objectives. Priorities and interventions are well outlined for HSSP III. Disaster management falls under another ministry.

Attribute 4: Risk assessment and proposed mitigation strategies

- Overall the risk assessment of the HSSP III does adequately reflect the risks associated with service delivery and management. The HSSP III has outlined 11 major risk factors that HSSP III may face during its implementation. These risk factors are related to service delivery, planning and budgeting, PFM, decentralization, and funding. It also provides mitigating measures for each of the risk factors.

WEAKNESSES

Attribute 1: Strategy based on sound analysis

- MBB results will be consistent when used both as a planning and costing tool. If it had been used as a planning tool, it could have identified the major bottlenecks and consequently its major strategies. However, the MBB was used only to cost the exercise. Its bottleneck analysis was not used neither to identify bottlenecks nor as a planning tool to outline the strategies.

Attribute 2: Clear goals, policies, objectives, interventions and expected results.

- Clear, overarching strategic directions would be beneficial as an introduction to the more specific sub-sections of the HSSP III.
- The sector developed its strategic plan before the release of the MINECOFIN EDPRS II Guidelines, and consequently has some gaps:
  - Lack of a well argued case for how the health sector will contribute the four EDPRS II thematic areas and cross cutting issues.
  - Lack of annualization of target for selected outcome indicators within the HSSP III.
  - Inadequate consolidation and annualization of the policy actions identified in HSSP III to take the sector forward.
  - Lack of funding scenarios with corresponding priorities and targets based on realistic funding projections.
- Targets are ambitious, and while Rwanda has had a very good track record on achieving targets, it remains uncertain whether the HSSP III targets can be achieved as there is currently no resource projection.
- A number (36) of target values for sub-sections still need to be set.
- Despite the focus on universal health coverage, particularly in the form of the successful CBHI programme, the analysis of equity issues could be further improved and elaborated (e.g. in terms of access and health outcomes across socio-economic levels, gender and geographical location).
- Private sector (broadly understood) is not well described and the strategy for its participation could be more comprehensive and is not applied throughout (mainstreamed) HSSP III for all programmes and system interventions.

Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence

- Some targets may be based on an unrealistic funding scenario, depending on the result of the planned funding projection.
- An assessment of the capacity of enforcing regulation is missing.

Attribute 4: Risk assessment and proposed mitigation strategies

- The risks could be better elaborated and the causes of the risk better defined than they currently are.
- In addition
  - It is necessary to ensure that all risks for programs are included: for example regarding CBHI,

Performance Based Financing (PBF), Community Health Workers (CHW) and the intended expansion of tertiary care.

- The risk that government may not provide increased or sufficient proportion of its resources to finance the HSSP III should to be included.
- Capacity to develop the strategies outlined in the document is another risk to look into.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- The strong analysis underpinning the HSSP III is an important factor in achieving the substantial results indicated in the strategy.
- Although strategies do address issues concerning equity and the role of the private sector, a more comprehensive analysis of these areas may further strengthen the strategic approach of HSSP III and its implementation, including improving efficiency.

SUGGESTED ACTIONS

- Develop a chapter on the overall strategic direction that clearly shows the overall objectives of the sector and links them with emerging government priorities as outlined in the EDPRS II guidelines. With the re-definition of the core priority of government (economic transformation, rural development, productivity, and youth employment and accountable governance), the sector may need to provide a strong case for resource allocation if it is to maintain the proportion of resources allocated to it during HSSP II. Furthermore, the sector may also argue that maintaining the sector as an efficient "foundation" for reaching the EDPRS II goals cannot be achieved through a status quo approach but necessitates investments in consolidating and improving key sector services.
- Strengthen the analysis of and focus on equity.
- Including a sub section on resource scenarios (one realistic and one more aspirational as per MINECOFIN EDPRS II guidelines) in the costing and financing chapter.
- If there is a large funding gap, targets and priorities need to be revised.
- Develop annualized targets (results framework) and a roadmap with milestones for policy actions (policies, strategies, plans, regulation and guidelines) including responsible units.
- Strengthen the analysis of the private sector, develop a clearer strategic approach to its role, and mainstream the private sector's contribution throughout the document.
- Fine-tune the risk analysis, and include major risks – if any - from key programs and systems, as well as regarding government funding and capacity.

2.2 Process

Process

Soundness and inclusiveness of development and endorsement of HSSP III

STRENGTHS

Attribute 5: Multi-stakeholder involvement

- Under the guidance of the health sector-working group a Steering Committee oversaw the development of HSSP III while the planning, budgeting and M&E TWG facilitated and coordinated the process.
- Overall, its development was very participatory and inclusive of all stakeholders within the health sector (central level, program managers, district and hospitals).
- DPs and private sector (incl. CSOs) involved and confirmed that this was better than the HSSP II development, and confirmed commitment to the HSSP III.

Table 2.2.1

Stages of HSSP development process	**Composition of participation**	**Results**
Situation analysis: three workshops.	Three workshops for development of SITAN: one for the decentralized levels; one for civil society and private sector, including professional associations; and one for MOH Districts, district hospital managers, programs and development partners.	SITAN document
Validation of the SITAN document and development of initial Log frame	Government at all levels	Log Frame 1
Validation the SITAN report and Refinement of Log fame	DPs, CSO, professional associations and private sector	Refined log frame
Zero draft document	Technical Working Groups and program and system managers	Revised strategies and targets in second draft
Validation of the second draft	Health sector working group	Second draft document

Attribute 6: Political Commitment

- Political leadership in HSSP III development has been strong. The steering committee steered the process for about a year. There is strong political commitment to realise HSSP III goals if the lessons from HSSP II are to go by. This is also visible by the leadership and guidelines provided by MINECOFIN.
- The time frame of EDPRS II development process clearly shows the Cabinet will discuss and approve EDPRS II with its accompanying sector strategies in November 2012.

Attribute 7: Consistent with higher and lower level strategies and plans

- The Health Sector Strategic plan III (HSSP III) 2012-2017/18 targets have been derived from the revised targets of Vision 2020.

- HSSP III and its background documents including the Health Sector Situation Analysis (SITAN) captured well the strategies and policies within the health sector and highlight those requiring revision and development (many expires around the start of HSSP III). In this sense, HSSP III has set a very good framework for revision and update of sub sector policies and strategies in the coming years.

WEAKNESSES

Attribute 5-7 (Crosscutting)

- The participation of other Ministries (MINECOFIN, MINALOC etc.) is quite limited, however with the introduction of EDPRS II guidelines this may change, at least for MINECOFIN.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- The involvement of stakeholders in the development of HSSP III and its overall alignment to government priorities and strategies will enhance ownership and enhance commitment for its implementation.

SUGGESTED ACTIONS

- Ensure that the strategies described for decentralization and strengthening financial management within HSSP III are in line with the overall strategies now being developed as part of the EDPRS II preparation.
- Set time frames and guidelines for development and revision of subsector strategies that are coherent and consistent with HSSP III and EDPRS II

2.3 Cost and Budgetary Framework

Costs and Budgetary Framework Soundness and feasibility
STRENGTHS

Attribute 8: Expenditure Framework including comprehensive budget/costing
• Generally HSSP III is based on a thorough costing exercise, as outlined below:
  – The Strategy is costed using both MBB and input based costing and the results of the two are very close to each other.
  – All program and system strengthening areas seem to be included in the costing exercise.
  – The recurrent and capital investment requirements are identified and the recurrent implications of the investments during HSSP III are reflected.
  – The costing also shows investments required at central and district level.
  – To correct its weaknesses of only costing the MDG related intervention, the MBB costed other interventions strategies by introducing what they call 'user strategies' to ensure that non-MDG interventions are costed and included.
  – The input based costing circulated a questionnaire to program managers to get the concrete outputs and unit costs which was then used as a basis for costing.
  – The targets of HSSP III were the cost drivers of MBB costing for all MDG related programs.
 	
Attribute 9: Realistic budgetary framework and funding projections
• Funding projections yet to be done.

WEAKNESSES
Attribute 8: Expenditure Framework including comprehensive budget/costing • MBB was used only as a costing tool and was not used as a planning tool which would have helped to assist the programs to specify their strategies and targets according to identified health system bottlenecks. This could have reduced any inconsistency between planning and costing. • There are some inconsistency between the targets set in the HSSP III and the targets used in the costing exercise. • Since MBB does not directly cost non MDG interventions, it costed these interventions by using strategies like input based costing- referred to as user strategies. The costing team is not sure if all non-MDG interventions are included in this costing process. It is also uncertain how far the programs provided comprehensive inputs to the input-based costing tool in the forms of program outputs and activities. • The costing assumptions are not yet verified by the programs. • The implication of the proposed investments in tertiary care on the funding of other sector priorities, e.g. resources available for district level services, is not clear, partly because there is no specific indication of which level and coverage of tertiary care services HSSP III implies, and partly because a specific costing of tertiary care investments has not been carried out. *Attribute 9: Realistic budgetary framework and funding projections* • Funding projections, gap analysis and projections of the implications of different scenarios for funding in terms of priorities and targets are yet to be done. Likewise, there is no fiscal space analysis in the plan. • Consequently, there are no indication of priorities within HSSP III, incl. adjusted targets, in

relation to different scenarios for expected resources.

- Although the health sector has so far been one of the priority sectors regarding resource allocation, this may not continue given the re-definition of the core priority of government as indicated in the EDPRS II (economic transformation, rural development, productivity, and youth employment and accountable governance). The resources to be allocated to the sector in the coming years may largely depend on what is needed to consolidate the gains made in the health sector (making it a solid "foundation" for the new EDPRS II priorities), and the extent to which the sector also demonstrates its contributions to these new government priorities.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- Realistic estimation of costs and projections of available resources and their resulting funding gap helps to know how feasible is the implementation of the strategic plan and do a proper prioritisation within a realistic resource envelope. It also helps to develop a resource mobilization strategy when and if the gaps are bridgeable.

SUGGESTED ACTIONS

- Convene a validation workshop through the TWGs to ensure that what is costed are the targets and activities within the strategic plan and that the assumptions used are feasible and realistic.
- Develop a small briefing note on how the costing methodology and assumptions are done so that any potential partner willing to fund the program would have an understanding of the basic assumptions underpinning the costing methodology.
- Ensure that the costing and financing projections as well as categorization of programs in HSSP III are worked out in such a way that it is easy to include them in the overall government wide MTEF and annual budgeting process.
- Develop a costed strategic plan for enhancing quality of tertiary care beyond the existing service package for this level (objectives, targets, investment and recurrent cost, as well as capacity needed to implement it).
- The HSSP III needs to include an analysis of the fiscal space of the coming years and estimate the available resource projections under different scenarios and their respective funding gap. This should be projected based on MINECOFIN's overall resource projections as well as other sources of information.

2.4 Implementation and Management

Implementation and Management Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy
STRENGTHS
Attribute 10: Operational plans detail how the strategy will be achieved • Based on the overall HSSP III strategic directions a comprehensive list of subsector strategies and guidelines to be developed have been identified. • Operational plans are developed timely at community, health facilities, district and national levels and all stakeholders are involved. Each level has a defined package of services. • There is an annual MTEF process translating HSSP III into annual plans • Districts are preparing their plans based on their situation and in accordance with national priorities. • Rwanda is increasing decentralisation through the current Phase III of the GoR's decentralisation reform. HSSP III specifies very appropriately that a health sector decentralisation road map (Strategic Plan)" will be developed in consultation with MINECOFIN, MINALOC and MIFOTRA. • Roles and responsibilities of different entities and levels are reasonably clear. • There is a good correlation between priorities and targets at different levels. This is further strengthened by the Imihigo (performance contract) program for managers. *Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity* • The organisation of the health sector as well as roles and responsibilities are well defined. • Plans for strengthening the planning, budgeting and monitoring process are in place. • Drug supply is functioning well, although quality control is fairly weak. There are plans to strengthen the logistic and commodity management system in HSSP III, as well as quality control. *Attribute 12: Adequacy of institutional capacity* • A new Human Resources for Health (HRH) plan is guiding strategic directions for human resource development. • HSSP III includes the development of plans for improving district level capacity. • The plans for other systems (health infrastructure, health care financing, pharmaceuticals) are described well and are in line with the MTR and SITAN findings. • At the community level the Community Health Worker programme has been very successful. • According to HSSP III a plan for Technical Assistance will be developed. *Attribute 13: Financial management and procurement* • The GoR has a Public Fiduciary Management (PFM) strategic plan whose implementation is being reviewed by an independent team. The review revealed that that there is satisfactory or better achievement in economic and budget management, financial management and reporting and budget execution and oversight. Public procurement scored low (see table 2.4.1). The report also evidenced strengthened linkage between planning and budgeting under the MTEF framework, including the appropriate costing of programs and sub-programs of the budget

agencies.

Table 2.4.1

Pillar	Total Target outputs	Frequency of Scoring Levels				% of Satisfactory & Better Scoring (A+B)	% of Low / Unsatisfactory Scoring (C+D)
		A	B	C	D		
Economic and Budget Management	**21**	7	13	0	1	95%	5%
Financial Management & Reporting	**26**	5	14	5	2	73%	27%
Public Procurement	**6**	3	0	2	1	50%	50%
Budget Execution Oversight	**7**	4	2	0	1	86%	14%

Source: MINECOFIN, 2102, Public Financial Management Strategy, an Independent Review

- The government wide fiduciary risk assessment is carried out and the recent one documented the overall risk levels as moderate (see table 2.4.2). The overall trajectory of change since the time of the 2008 Fiduciary Risk Assessment (FRA) is also positive. General improvements in PFM performance, coupled with on-going implementation of the PFM Reform Strategy, demonstrate a serious and credible commitment to reform PFM from the GoR.

Table 2.4.2 – Summary of Overall Risk

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

DFID, 2012, Donor Fiduciary Risk Assessment of General Budget Support (GBS) in Rwanda.

- Planning and management of the on-budget resources have been according to good practice and acted as the mechanisms to safeguard public funds.
- Procurement law is generally followed, albeit most of the procurements are made at the central and facility levels, with limited involvement of districts.
- In the health sector, a PFM assessment of the health sector has documented the gaps around financial management and procurement, especially at the decentralized levels. Unlike HSSP II, HSSP III has charted out strategies to strengthen PFM in the sector.

Attribute 14: Governance, accountability, management and coordination mechanisms

- Well developed internal, institutional and multi-stakeholder governance mechanisms already exist, are functioning well and are outlined in the HSSP III.
- Recently established Rwanda Biomedical Centre (RBC), bringing together a number of departments and programmes, and the Single Project Implementation Unit (SPIU), has the potential of further improving integration and efficiency.
- The health sector complies with the national governance system. This includes the imihigo system ensuring accountability for performance.
- HSSP III contains a well described effort to improve the regulatory framework.
- The health sector is part of the overall decentralisation effort of government in phase III of the decentralisation implementation plan (2011-15). This includes further devolution as well as increased fiscal decentralisation.

WEAKNESSES

Attribute 10: Operational plans detail how the strategy will be achieved

- The decentralisation reform will result in changes and possibly challenges throughout the HSSP III period. While it is important to have coherence between the ways the different sectors implement the decentralisation reform, the specific characteristics and needs of the highly complex health sector also need to be recognised, fully assessed and incorporated into the reform plans.
- The targets and policy actions are not annualized (but will need to be according to MINECOFIN EDPRS II guidelines).

Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity

- The strategy for resource allocation criteria for programs, institutions and districts could be better described in HSSP III, and apparently there are not very clear resource allocation criteria across sub-national levels. HSSP III does, however, include the intention to revise guidelines on resource allocations in collaboration with MINECOFIN and MINALOC (Ministry of Local Administration, Community Development & Social Affairs) .
- The high level of off-budget resources from DPs complicates resource allocation as well as proper planning. The creation of the SPIU as well as the intention of MINECOFIN - and also implied by the HSSP III - to move towards Joint Financing Arrangement (JFA) could alleviate the problems, although it may not address the problems of disjointed planning of government and some DP resources at the district level.
- The role of the private sector could be better described both as an overall strategic direction as well as in relation to specific programmes or interventions.

Attribute 12: Adequacy of institutional capacity

- The linkages between the various support systems (HR and capacity building in various systems) are not very clear.
- Capacity and ability to prioritize interventions at the district level leaves a lot to be desired, however HSSP III has included district level capacity building as one of its actions.
- Some TWGs are functioning less than optimal.

Attribute 13: Financial management and procurement

- Service providing units like hospitals and health centres are currently not cost centres or MDAs, which would have ensured better accountability and relations with the district accounts. Consequently, internally generated funds are not recorded in the district accounts; not all funds that goes to facilities are recorded in the district accounts; and there is inadequate evidence that

utilization of transfers to non-budget holding institutions (hospitals, health centres), which is recorded as expensed at the time of transfer, are properly tracked and recorded.

- Because most of the resources are allocated in the form of earmarked transfers from Ministry of Health, the districts have a low level of discretionary funding making it difficult to fully base budgeting and planning on district priorities. This situation may improve during the current third phase of the decentralisation reform.
- There are delays in transfers of earmarked funding from MINECOFIN to the sector.
- The capacity for the PFM at district level remains weak.
- It is estimated that fewer than 50% of all non-budget agencies are audited every year. The internal auditors do yearly audits of hospital accounts, but do not to perform yearly audits of all Health Centers (HC) because of lack of capacity.
- Inability to fully track off-budget resources.

Attribute 14: Governance, accountability, management and coordination mechanisms

- The fact that Maternal, & Child Health (MCH) is currently not part of Rwanda Biomedical Center (RBC) seems not to fully capitalise on the potential for integration and synergy of the RBC.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- A well executed decentralisation reform is crucial for improvement in health service delivery.
- Obviously, a well functioning fiduciary system is important for transparency as well as for planning and budgeting and optimal use of resources.
- The present well functioning system of governance is clearly a great advantage for reaching health sector goals, but the implementation of an ambitious decentralisation policy will be a challenge.

SUGGESTED ACTIONS

- Annualise the targets.
- Create a road map with annual milestones and responsible entities for developing the many planned policies, strategies, plans, guidelines and other important initiatives.
- The HSSP III has outlined areas of interventions to strengthen financial management in the health sector. This PFM section could benefit if it is reviewed for its adequacy and completeness as well as for its alignment with the overall PFM reform in consultation with the relevant sector Ministries (e.g. MINECOFIN, MINALOC).
- As already outlined in the HSSP III – e.g. in form of a health sector decentralisation strategic plan/road map - focus on the implementation of the national decentralisation strategy is crucial. This should include securing that the quality of technical oversight is maintained and that implementation of key government health priorities - also beyond clinical service delivery - remain a focus also for the district councils. This work needs to be taken forward in collaboration with MINALOC.
- Develop the resource allocation criteria, for funds, drugs, HR, investments etc, as planned in HSSP III, to enhance equity and efficiency. This should take into consideration all sources of funding also DP funding that is on plan but off budget.
- Develop a comprehensive TA plan as implied in the HSSP III.
- Further develop the HSSP III intention to establish Joint Financing Arrangements (JFA).
- Strengthen auditing capability at district level to ensure that audit of non-budget holding agencies is carried out on regular basis.

2.5 Monitoring, Evaluation and Review

Monitoring, Evaluation and Review Soundness of review and evaluation mechanisms and how their results are used
STRENGTHS
Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance • HSSP III contains very useful strategic guidance for the M&E activities during 2012-2018. It has a specific and broad range of core and additional indicators and targets. • HSSP III includes 32 sector performance indicators, all with a baseline, a target for 2015 and for the end of the HSSP. The core indicators can be classified into input (6), output (7), outcome (7) and impact (12). The HSSP III also includes 94 indicators for components. • The sector performance indicators are fairly well-aligned with Vision 2020 indicators, with 7 of the 9 indicators included. The implications of aligning the HSSP III targets are shown in Annex 3.6. • The M&E sections pays due consideration to the data sources for each indicator. The timing of surveys (2014 and 2017[5]) is chosen to coincide with mid-term and final reviews of HSSP III. The role of the facility and administrative reporting systems is clearly specified for each indicator. The plan provides clarity on the required frequency of reporting for all data sources. • The Health Management Information System (HMIS) receives most attention, including a section on health information management, as part of health systems support. It also pays considerable attention to multiple innovations based on ICT solutions that have been or will be implemented as part of a national eHealth strategy. Attention is paid to the improved financial and human resource information systems. • Data quality issues are considered in the M&E component of HSSP III. Specifically, it mentions sub-national procedures that should ensure that annual data are reliable. The MTR observes: "the proximity of the national HMIS figures with the DHS figures, allowing substantial confidence in the reliability of the HMIS". • The Ministry of Health produces an annual report which presents data from all sources, including trend data focusing on the key indicators. An analytical annual health sector performance report is also produced. • The HSSP III includes plans for capacity strengthening the sub-national level, and on data use. *Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action* • The HSSP III document clearly states that multi-stakeholder sector performance reviews will continue to be carried out annually to inform strategies, plans and to reconcile plans and available budget. It also includes a mid-term review and final evaluation of HSSP III. • During HSSP II, Performance Reviews were 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. • From the review a joint health sector review summary report is produced, highlighting the main issues and recommendations on how to address these issues. The report is signed by the

[5] 2017 was the original end year for HSSP III, but most likely it will be extended to 2018 in compliance with the EDPRS II timeline.

Permanent Secretary (PS) of the MoH and the head of the Development Partners Group.

- Mutual accountability meetings were carried out by both development partners and government. The findings of these reviews with required actions are monitored and disseminated to all stakeholders.
- A second meeting for planning purposes is conducted in April of the following calendar year. This meeting aims to implement the recommendations. The focus on districts is increasing as part of the decentralization.
- Financial allocations are adjusted as part of the MTEF process.

WEAKNESSES

Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance

- The indicator and target set could benefit from a careful review to address 3 issues: (1) more attention to equity, (2) consider financial protection as an impact indicator, (3) review baseline and target setting for the core performance indicators.
- Targets must be set for the 36 indicators where targets are marked as TBD.
- The linkages with HIV/AIDS strategic plan could have been stronger.
- The nature of the sources of many of the impact indicators, i.e. surveys with several years recall period, may not allow an assessment of the results of HSSP III in terms of impact before several years after finalising the HSSP III implementation. This is not a specific weakness of HSSP III, but the case for such indicators in most countries without a vital registration system.
- There are a number of areas which could be specified better in a comprehensive M&E plan, such as specific mechanisms and reports on data quality results and data sharing; analytical issues for the assessment of progress and performance of HSSP III; a framework that guides the analysis and methods to feed into annual reviews, including assessment of performance in terms of effectiveness (progress), equity and efficiency; M&E dissemination; strengthening feedback to lower levels; and clarify the coordination mechanisms, role and responsibilities, and capacities of the different key institutions in M&E. This M&E plan could benefit from the IHP+ guidance on a single country-led M&E platform for information and accountability.

Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action

- A technical review meeting prior to the joint (backward looking) review in September is currently not conducted, but could be useful to discuss technical issues. This would allow the review itself to focus more on actual implications of the performance review results

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- The well functioning M&E system in place is a strong foundation for implementing the HSSP III and particularly for achieving the results envisaged. It could be made even stronger by adopting the few suggested actions below.

SUGGESTED ACTIONS

- Review indicators in order to further fine tune them (and include missing targets) – also in terms of targets set - and to address equity and financial protection.
- Health-related indicators in the EDPRS II could benefit from following the definitions made in the HSSP III (see also Annex 3.6).
- Include the development of a detailed M&E plan in the HSSP III activities.
- A thorough multi-stakeholder technical review with a published annual health sector performance report prior to the review would further increase the benefits of the M&E system.

- All ingredients seem to be in place for developing a highly informative web-based national health observatory with a national and sub-national dashboard of core indicators, sharing of data, key reports and other information, building upon DHIS 2.0 and other efforts.

3 Annexes

3.1 Terms of reference

Joint Assessment of Rwanda Health Sector Strategic plan III (HSSP III).

Terms of reference of the JANS mission (May-June 2012)

Background

Rwanda signed the International Health Partnership+ (IHP+) Global Compact in February 2009. At the heart of IHP+ is a commitment to get better health results by increasing support for national health strategies and plans in a well-coordinated way.
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, as part of HSSP III development a Joint assessment will be conducted using tools and guidelines proposed by IHP+.
The Joint Assessment of National health Strategies (JANS) is a shared approach to assessing the strengths and weaknesses of a national strategy, which is accepted by multiple stakeholders.
It has been developed to assist countries and their development partners to ensure and feel confident that there is an effective national health strategy in place, which partners can support. The aim is to enable achievement of health goals through:

- ensuring the health strategy is sound, relevant and achievable, and
- encouraging alignment of partners behind a single national strategy, including attracting funding for the strategy.

The main presumed added value of the Joint Assessment of HSSP III for Rwanda is to create an opportunity for strategic discussion and thus strengthen the plan. Related expectations are that the assessment will increase the quality of HSPP III and confidence in the plan by all stakeholders. The independent element is desired in order to provide a fresh, systematic perspective on the plan.

HSSPIII process and current status

After the HSSP II Midterm review in July - August 2011, which recommended to go for a new strategy by June 2012, an extensive Situational Analysis (December 2011) conducted over a period of three months, provided the information for a four days prioritization retreat in Musanze attended by MoH senior staff and all stakeholders in the sector, such as representatives of the Development Partners (DP), Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs), Private sector, professional associations and regulatory bodies.

From the retreat a full Log Frame was developed that provided the essential inputs and ideas for the elaboration of a 'Zero draft', being the first version of HSSP III, submitted to MOH in the first week of March. In an intensive short period this 'Zero Draft' was enriched through detailed discussions between the writing team and the chair, co-chair and members of the Technical Working Groups (TWG), under

the guidance of the Steering Committee. The subsequent 'First Draft' was discussed by the Health Sector Working Group (HSWG). The meeting with some 90 participants provided important additional comments that were included in the second draft, submitted to MOH at the end of March. This draft is the one that will be assessed using JANS tools and will be submitted to Cabinet for final approval.

Joint assessment mission objectives

The joint assessment of HSSP III will meet the following objectives:

- To make a joint assessment of HSSP III using the JANS Tool and accompanying Guidelines as the guiding framework.
- To present and discuss the analysis of strengths and weaknesses of HSSPIII with senior policy makers and other stakeholders, and possible courses of action on specific issues.
- Suggest recommendations for remedial steps where weaknesses exist

Scope of the assessment:

The assessment team will examine the strengths and weaknesses of five sets of attributes considered the foundation of any 'good' and comprehensive national strategy as proposed by IHP+:

- Situation analysis and programming: clarity and relevance of strategies, based on sound situation analysis
- The process through which national plans and strategies have been developed
- Costs and financing of the strategy
- Implementation and management arrangements
- Results, monitoring, review mechanisms

Findings on strengths and weaknesses and proposed recommendations will be addressed to the Health Sector Working group.

Methodology/Main tasks of JANS team

- Prior to the mission,
    - the JANS team will undertake a 'desk review' work, and review HSSPIII and associated relevant documents, such as HSSPII midterm review, health sector situation analysis, sector performance report, various SWAp documents, Resource tracking reports, Joint Health Sector review reports, sector performance reports, disease specific strategies pertaining to diseases of major importance, e.g. HIV/AIDS, malaria, TB as well as other key public health areas such as maternal and child health,…
    - To agree on a preliminary set of key issues to be discussed in greater depth during the in-country mission and discuss with the JANS steering committee.
- When in country,

- to conduct interviews with key informants, including some at district level
- To produce a profile of the strengths and weaknesses of HSSPIII
- To discuss findings with stakeholders in Rwanda, and subsequent recommendations
- To agree how to capture lessons learned, on the process and the tool, in collaboration with the IHP+ consultant responsible for documenting lessons across countries

Reporting arrangements:

The team leader of the joint assessment team will prepare and present the inception report to the HSSP III steering committee the first working day of in Country mission. After the mission, the team leader, with the help of team members, will present a power point presentation on HSSP III strengths and weaknesses to the Health Sector Working group meeting the team's profile of to HPAC, and share with IHP+ core team at the end of the mission. Afterwards the Team Leader in collaboration with the whole team will prepare a full report.
The HSSP III steering committee will be responsible for deciding on follow up actions and communicating these to all interested parties.

Management of JANS process

The oversight of JANS process will be in hands of HSSP III steering committee composed by representatives of Government, Development Partners and Civil society. The role of the steering committee will be to facilitate the process and not to dictate to the JANS team about what to report,. It will also decide on what actions to take in response to recommendations

Team composition

The assessment team consists of a mix of international and national experts, whose collective skill-mix addresses the main dimensions of the strategic plan and the JANS attributes and includes people with substantial knowledge of the Rwandan health system.

National team members will be composed by:

- General public health expert
- Health systems expert
- Rwanda decentralization expert

International team members will be composed by:

- A team leader with extensive knowledge on health policies and strategies
- Health systems expert
- Expert on Monitoring and Evaluation of health strategies
- Expert on health strategy costing

Timeframe:

The JANS process will have 3 main phases:

1st phase (2 last weeks of April and 2 first weeks of May): preparatory phase during which there will be discussion and approval of ToR by the steering committee, recruitment of National and international consultants, collection of all necessary documents, preparation of financial and logistical arrangements, among other,…

2nd phase (third week of May-first week of June) : Assessment phase: during this phase, there will be one week of desk review of all relevant documents prior to in-country mission, 7 days of interviews with key informants and 3 days for the preliminary reporting to the HSWG.

3rd phase (1st to 2nd week of June) reporting phase: The time of drafting and discussing on the JANS full report.

3.2 List of Persons Met

N0.	Names	Institution	Function
1	Jennifer Slotnick	USAID	Health service delivery team leader
2	Marie Ahmed	USAID	HSS Team leader
3	Patrick Condo	USAID	Malaria proj. other is specialist
4	Koama Jean Baptiste	CDC	HMIS Advisor
5	Michael Karangwa	USAID	HSS specialist
6	Chuck Pill	USAID	HIV/AIDS Advisor
7	Carrie Whitlock	USAID	PEPFAR Coordinator
8	Kelly Hamblin	USAID	Supply chain advisor
9	Rugwabiza Minega Leonard	MINECOFIN	Director general of national development , planning and Research
10	Sekamondo Francois	MINECOFIN	Social sector and population policies and program expert
11	Gatete Michel	MOH	Parteners coordinator
12	Karema Corine	RBC	Head of division MOPDD
13	Nina Stochhniol	MINECOFIN	Advisor
14	Diane Muhongerwa	WHO	Health Financing
15	Aline Niyonkuru	MOH	Planning, M&E
16	Vincent Tihon	Minisante 4-BTC	Technical advisor
17	Uzziel Ndagijimana	MOH	Permanent Secretary (PS)
18	Djordje Gikic	CHAI	CD
19	Girrbach Elisabeth	GIZ	Health coordinator
20	Randy Wilson	MSH	HMIS advisor
21	Dela Dovlo	WHO	Rep
22	Pratima Raghunathan	CDC	Director
23	Gaetane SCAVEE	Belgian embassy	1st secretary
24	Dukit Innocent	MOH	DF
25	Kabera Michee	MOH	Data analyst
26	Regis Hitimana	MOH	Planning, M&E
27	Jean Louis Lambeau	Lux –Development	Technical advisor
28	Umutesi Viviane	Kibagabaga Hospital	Community Health supervisor
29	Niyonizeye Maurice	Kibagabaga Hospital	Data manager
30	Uwimana Nathalie	Kibagabaga Hospital	M&E officer
31	Nkurunziza David	Kibagabaga Hospital	Supervisor
32	Rutaganira Ildephonse	Kibagabaga Hospital	Supervisor maternal health
33	Claire Karemera	Kibagabaga Hospital	In charge of HMIS

34	Stella Matutina Tuyisenge	NPD EDM	HMIS
35	Munyakazi Alphonse	UNFPA	Assistant representative
36	Mwihaki Muraguri	Rockefeller Foundation	Associate Director
37	Michel Hereus	Belgium cooperation	BTC
38	Dela Dovlo	WHO	WR
39	Banv Lippens	Belgian Embassy	Assistant cooperation officer
40	Francoise Ukulikiyabandi	Suiss Development Cooperation	Health Program Officer
41	Friday A. Nwaignie	UNICEF	Chief Health and Nutrition
42	Mamadou Malifa Balde	WHO	Medical officer EPI/CSR
43	Zinda Victor	Faith Victory Association	Fundrising officer
44	Bishop Joseph Kamanza	Victory churches of Rwanda	R. Legal
45	Karangwa F. Xav	UPHLS	ED
46	Aimable Mwananawe	AIMR	National coordinator
47	Prince Bosco Kanani	Rwanda NGO's forum on AIDS & HP	Chairman
48	Canut Dufitumukiza	Rwanda NGO's forum on AIDS & HP	Executive secretary
49	Bena Fadya	AMUR	AMURISSA HIV/GF
50	Ingabire Laure	Rwanda NGO's forum on AIDS & HP	District coordinator
51	Mukiza N.Joas	Civil society /RCLS	Pastor
52	Ignace Singirankabo	RCLS	Executive secretary
53	Mgr Dusingizimana Enoch	CECA&AER	President
54	Philomene Cyulinyana	FRSL+/RW	Executive secretary
55	Michel Herens	BTC-SHSS	Conseill
56	Sabine Furere Musange	NURSPH	Lecturer
57	Mwanafunzi Willy	FVA/RNGOFO&HP	Executive Dir.
58	Gumuyire Joseph	RRP+	Executive secretary
59	Willy Jaussen	BTC-PAPSDSK	JA
60	Jeanette Kayirangwa	WFP	Nutritionist
61	Pado Ruggio d'Au	CHAI	Technical advisor
62	Nyirasafari Odette	MOH	Acting Director Adj.
63	K. Mwari Assumpta	Lux Development	Neonatology
64	Alphonse Nkusi	USAID	HSWP Team leader
65	Tito Turatsinze	GIZ	CTD

66	Didier Mukama	GIZ /Health	TA
67	Canisius Musoni	USAID	Health specialist
68	Bob de Wolfe	MSH/IHSSP	Techn Dir.
68	Uwayitu Appoline	MSH/IHSSP	CoP
69	Franklina Mantilla	REACH-UNICEF/UNFPA/WHO/FAO	REACH Facilitator
70	Fidele Ngabo	MOH	MCH Director
71	Gashumba Diane	EGPAF	Technical director
72	Nizeyimana Maurice	HPA-Rwanda	Project Manager
73	Aimable Mbituyumuremyi	RBC/HIV	Director OBBI Unit
74	Mary Murebwayire	MOH	Director of Nursing
75	Birori Innocent	MOH	e-learning coordinator
76	Joseph Kabatende	MOH	Pharmacy expert
77	Jean Nkurunziza	MOH	M&E / Report expert
78	Adolphe Karenzi	MOH	NCDs
79	Habimana Mucyo Yves	MOH/RBC	TB & ORD Division
80	Ndabamenye Protais	FHI360	Associate Director
81	Viktor SIEBERT	GIZ	Young professional
82	NIEVERAS Olivia	GIZ	Health Financing advisor
83	Rusanganwa Vincent	MOH	Medical Education and Research
84	Nyinawankusi Jeane d'Arc	MOH	Ag coordinator SAMU
85	Lazare Ndataro	MOH/Swap	Expert
86	Ruturwa Dieudonne	UNAIDS	SMA
87	Mwesigye John Patrick	MOH/PTF	Coordinator PTF
88	Twagirumukiza E	MOH	HRD
89	Beatha Mukarugwiro	MCHIP	MNH/FP
90	Paul Dielemans	EGPAF	Snn advisor MCH/FP/RH
91	Rose Luz	Concern W	H. Team leader
92	Andre H. Mbayiha	GIZ	SRH Advisor
93	Emmanuel Manzi	UNICEF	Health specialist
94	Mugabo Maria	WHO	FHP Advisor
95	Mukakabanda Suham	Intrahealth	Program manager
96	Eric Kagame	USAID	RH/FP/ specialist
97	Thomas Nsengiyumva	MOH	In charge of FP
98	Yvonne Umurungi	Lux-Development	National coordinator
99	Alphonsine Nyirahabineza	MOH	Nutrition expert
100	Anicet Nzabonimpa	MCH/MOH	FP-HIV integration
101	K. Mwali Assumpta	Lux Development	Neonatal program
102	Katabarwa Joseph	MOH	Head of Environmental Health

			Department
103	Samuel Ndagijimana	Remera-rukoma district hospital	Medical director
104	Uramutse Jean Pierre	Remera-rukoma district hospital	Administrator
105	Felix Gafurumba	Kamonyi District	Director
106	Muhayimpundu Ribakare	RBC	HIV care and treatment director
107	Sabin Nsanzimana	RBC	HIV division
108	Josefin Wiklund	UNAIDS	HIV Advisor
109	Kate Doyle	UNAIDS	Gender & HIV Advisor
110	Yvonne Kayiteshonga	RBC	IHDPC- mental Health Head of division
111	Iyamuremye Jean Damascene	RBC	Mental Health care specialist

3.3 HSSP III targets compared to Vision 2020

Table 3.3.1

Indicator	Status in 2000	Current status	Vision 2020 target	Proposed new Vision 2020Target	HSSP III targets for 2017
Access to improved sanitation facilities (% of population.)	20	74.5	60	**100**	**This may be mandated to sector. It is not reflected**
Access to clean water (% of population.)	52	74.2	100	**100**	**This may be mandated to sector. It is not reflected**
Life expectancy (years)	49	54.5	55	**66**	**68**
Population Growth rate (%)	2.9	2.9	2.2	**2.2**	
Women fertility rate	5.8	4.6	4.5	**3**	**2.5**
Infant mortality rate per 1,000	107	50	50	**27**	**42**
Maternal mortality rate per 100,000	1071	476	200	**200**	**230**
Acute malnutrition (wasted) %	None	3	None	**0.5**	**2**
Underweight (%)	None	11	None	**8**	**TBD**
Chronic malnutrition (%)	None	44	None	**15**	**24.5**
Rate of mortality for malaria cases (%)	51	13	25	**5**	**Not targeted**
Doctors per 100,000 inhabitants	1.5	6	10	**10**	**10**
Nurses per 100,000 inhabitants	16	77	20	**100**	**100**

3.4 Costing issues

MBB costing: The MBB costing model was adjusted through user strategies [6]to include and cost non-MDG interventions. The costing exercise of the plan included three scenarios based on the different levels of ambitions (low, medium and high) and scaled outcome and impact indicators targets accordingly. Some of identified weaknesses in using MBB in the HSSP 3 process are:

- The bottleneck analysis, the basis of MBB, was not carried out. As a result it is not easy to ensure consistency of intervention included in the strategic plan and in those in the costing model
- There are some inconsistency between the targets set in the HSSP III and the targets in costing-results targets (See separate section). The costing team identified some of these discrepancies, but unable to correct it at the time of the finalization due to the fact that the revising these targets require technical support from the international MBB support team and re-entering the data set afresh which was not possible at that time.
- Although user strategies helped to include non- MDG targets, the costing team is not sure if all non-MDG interventions are included understandable.

Input based costing:
Since the HSSP III has not defined clear outputs and activities to generate the inputs required for costing, the IBC team distributed a questionnaire to programs to submit their generic outputs for delivering results. It used DHSST tool outcomes as evidence for unit costing and formulate the assumption of costing. Some of the issues are:

- There is lack of clarity on whether HSSP III is fully costed when there is no output and activity plan that guides the required inputs in the next six years. The team stated that they did not have the full information they wanted.
- The assumptions used are mainly based DHSST 2 outputs and some of them may not be in line with the HSSP III targets.

[6] MBB is designed to cost MDG interventions using proven interventions. However, it also provides user strategies to cost non MDG interventions.

3.5 Financial management and Procurement Arrangements

The review of the implementation of the PFM strategic actions revealed that there is satisfactory or better achievement in "economic and budget management", "financial management and reporting" and "budget execution and oversight". Public procurement scored low (see table 3.5.1). The report also highlighted that there is strengthened linkage between planning and budgeting under the MTEF framework, including the appropriate costing of programs and sub-programs of the budget agencies (MDAs).

Table 3.5.1: Summary of Indicative Scoring of Implementation Results for each of the Pillars in FY2010/11

Pillar	Total Target outputs	Frequency of Scoring Levels				% of Satisfactory & Better Scoring (A+B)	% of Low / Unsatisfactory Scoring (C+D)
		A	B	C	D		
Economic and Budget Management	**21**	7	13	0	1	95%	5%
Financial Management & Reporting	**26**	5	14	5	2	73%	27%
Public Procurement	**6**	3	0	2	1	50%	50%
Budget Execution Oversight	**7**	4	2	0	1	86%	14%

Source: MINECOFIN, 2102, Public Financial Management Strategy, an Independent Review

In the health sector, a PFM assessment of the health sector carried out documenting the gaps around financial management and procurement, especially at the decentralized levels. According to the 2010 MOH audit report, generally, the money is spent according to approved budget and it uses government laws and procedures and there were no reportable issues. Learning from this, and unlike HSSP II, HSSP III has charted out strategies to strengthen PFM in the sector.

The government wide fiduciary risk assessment documented the overall risk levels as moderate (see table 3.5.2). The overall trajectory of change since time of the 2008 Fiduciary Risk Assessment (FRA) is also positive. General improvements in PFM performance, coupled with ongoing implementation of the PFM Reform Strategy, demonstrate a serious and credible commitment to reform PFM from the GoR

Table 3.5.2 – Summary of Overall Risk

PEFA dimension	Risk level 2008	Risk level 2011	Trajectory of change
Credibility of the budget (Indicators 1- 4)	Moderate	Moderate	↔
Comprehensiveness and transparency (Indicators 5-10)	Moderate	Moderate	↑
Policy based budgeting	Moderate	Moderate	↑

(Indicators 11-12)			
Predictability and control in budget execution (Indicators 13-21)	Moderate	Low	↑
Accounting recording and reporting (Indicators 22-25)	Substantial	Substantial	↑
External scrutiny and audit (Indicators 26-28)	Substantial	Substantial	↑

DFID, 2012, Donor Fiduciary Risk Assessment of General Budget Support (GBS) in Rwanda.

This overall government wide risk assessment also highlighted that the health sector is doing better in terms of having costed strategy that links reasonably robustly with annual budget plans for the health. The Health sector

Procurement law is generally followed, albeit that most of the procurements are made at the central and facility levels, with limited involvement of districts

However, there are also some weaknesses within the PFM system:

- Gaps in the legal framework necessary to ensure that service providing units like hospitals and health centers becomes cost centers to ensure better relations with the district accounts. This has created a number of challenges:
  - Internally Generated Funds are not recorded in the district accounts.
  - Not all funds that go to facilities within districts are recorded in the district accounts.
  - Inadequate evidence that utilization of transfers to non budget agencies (hospitals, health centers), which were expensed at the time of transfers, are tracked.
  - Misalignment of district prioritization and government earmarked funding
- Delays in transfers of earmarked funding from MINNICOFIN.
- Capacity for the PFM at district level remains weak.
- The 2010 audit report also highlighted the following major issues in Ministry of Health at the central level: lack of monthly procurement reports to Rwandan Public Procurement Authority, lack of regular physical count of assets; lack of verification of stock count either by supervisor or independent person; lack of full compliance (only 89%) in implementing previous year's audit recommendations.

3.6 Monitoring, Evaluation and Review

Preamble

A JANS mid-term review (MTR) of HSSP II (2009-12) was conducted in 2011. It concluded that M&E process indicators and joint decision-making structures were working well. The MTR recommended strengthening of the analytical feedback and use of data and identified the need to scale up the good practices and invest in improving the quality of information and strengthen information collection and utilization capacity at all levels. The MTR also highlighted the strengths of review mechanisms and recommended that the HSSP III should sustain the existing modality by deepening trust among development partners and government as well as enriching the content and openness of the policy dialogue.

A JANS type exercise focusing on M&E was also conducted by a small team from WHO in February 2011. The study aimed to inform the work of the Commission on Information & Accountability for Women's and Children's Health, as part of a three country case study. The study reviewed current practices in the context of HSSP II and showed the importance of building what is going on in countries in terms of accountability. The country case studies strongly influenced the recommendations of the Commission which were translated into a country accountability framework. The opportunities provided by the implementation of the accountability framework in Rwanda should be directed towards support for the M&E component of HSSP III, with special attention for women's and children's health.

Attribute 15
The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance

- ▲ HSSP III contains very useful strategic guidance for the M&E activities during 2012-2018. It has a broad range of core and additional indicators and targets and provides specifics on the data sources for those indicators.
- ▲ The M&E plan is well-aligned with the strategy and the overall HSSP III framework forms a good basis for a comprehensive M&E plan.
- ▲ The plan provides substantial information on the use of eHealth/ICT to strengthen facility reporting system, the HMIS, and the administrative data sources, such as human resources.
- ► There are a number of areas which could be specified better to assist the M&E of the HSSP III. This could be addressed in a more comprehensive M&E plan which can benefit from the IHP+ guidance on a single country-led M&E platform for information and accountability. This could for instance include more details on a technical framework to guide reviews, data sources, analysis and synthesis, data quality mechanisms, M&E dissemination and feed-back and specific products and institutional roles and responsibilities.

There is a comprehensive framework that guides the M&E work which reflects the goals and objectives of the national health strategy (characteristic 5.1)

- ▲ The M&E plan is focused on the major components of the HSSP III 2012-18 (programs, health support systems, service delivery, governance) with due consideration for the specific M&E issues in each area.
- ▲ The general strategic framework of HSSP III is a logical framework oriented towards impact. It identifies three major areas – leadership & governance, health support systems, programs – that influence service delivery systems, resulting in outputs, outcomes and eventually a healthy and productive population. This framework also serves as the basis for a hierarchy of indicators along the results chain from input to impact.
- ▲ The M&E plans of the main disease programs have been taken into account in the HSSP III, although the linkages with the HIV/AIDS strategic plan, for instance, could have been stronger.
- ▲ The M&E component is described in a chapter in the HSSP III. Monitoring is also included in all sections of HSSP III, focusing on indicators and targets, and there is a five page section to describe the M&E arrangements.
- ► There is no specific M&E plan or specific link with a health information strategic plan, but there are multiple references to eHealth / ICT strategies. There is no technical framework that would help guide the analysis of progress and performance towards the goals and targets of HSSP III.

There is a balanced and core set of indicators and targets to measure progress, equity and performance (characteristic 5.2)

- ▲ HSSP III includes 32 sector performance indicators, all with a baseline, a target for 2015 and for the end of the HSSP. The core indicators can be classified into input (6), output (7), outcome (7) and impact (12). The HSSP III also includes 94 indicators as part of the log frames for each of the three components of the plan (45 input, 32 output, 12 outcome, and 5 impact indicators).
- ▲ The sector performance indicators are fairly well-aligned with Vision 2020 indicators, with 7 of the 9 indicators included. Malaria case fatality rate (which appears to have unlikely high baseline and target values) and lab technicians' density are additional indicators in Vision 2020. A revision to the 2020 targets was made in May 2012. The implications of aligning the HSSP III targets are shown in Table 3.6.1.
- ▲ There are 12 health-related indicators and targets in the EDPRS 2008-2012. This includes 7 outcome indicators (including infant mortality in the poorest quintile) and five intermediate progress indicators. The EDPRS implementation report for 2009-2010 however included 6 additional indicators and replaced 2 of the 5 intermediate indicators with proxies. Basically, the majority of EDPRS indicators are included in the HSSP III, except for the more specific attention for the poorest and for proximity of health services. Health-related indicators in the next EDPRS could benefit from following the definitions made in the HSSP III.
- ► The indicator and target set could benefit from a careful review to address 3 issues: (1) more attention for equity (2) consider financial protection indicator as impact (3) review baseline and target setting for the core performance indicators.

The M&E plan specifies data sources and collection methods, identifies and addresses gaps and identifies information flows (characteristic 5.3)

- ▲ The M&E plan pays due consideration to the data sources for each indicator. The timing of surveys (2014 and 2017) is chosen to coincide with mid-term and final reviews of HSSP III. The role of the facility and administrative reporting systems is clearly specified for each indicator. The plan provides clarity on the required frequency of reporting for all data sources.
- ▲ The plan provides specifics on several data sources, enhancing confidence in the ability to generate timely and accurate information to guide the plan implementation. The HMIS receives most

attention, including a section on health information management, as part of health systems support. This section shows the progress and plans made in strengthening the HMIS, including the development of a web based reporting system from the district level and up (DHIS 2.0, from Jan 2012). It also pays considerable attention to multiple innovations based on ICT solutions that have been or will be implemented as part of a national eHealth strategy. Attention is paid to the improved financial and human resource information systems.

► The plan is partially clear on other data sources. Birth and death registration, with a reliable cause of death, receive no attention. This is important for long run progress. Facility assessments, both for the regular verification of data and service delivery, are not specified, perhaps because of potential reliance on the District Health Systems Strengthening Tool (DHSST).

Data analysis and synthesis are specified and data quality issues are anticipated and addressed (characteristic 5.4)

▲ Data quality issues are considered in the M&E component of HSSP III. Specifically, it mentions subnational procedures that should ensure that annual data are reliable. With the increasing volume and quality of data from almost all sources there is an opportunity to produce strong national and subnational progress and performance reports.

► There are a few gaps that could be addressed in a comprehensive M&E plan such as specific mechanisms and reports on data quality results and data sharing; analytical issues for the assessment of progress and performance of HSSP III; a framework that guides the analysis and methods to feed into annual reviews, including assessment of performance in terms of effectiveness (progress) of HSSP III, equity and efficiency.

Data dissemination and communication is effective and regular, including analytical reports for performance reviews and data sharing (characteristic 5.5)

▲ The Ministry of Health produces an annual report which presents data from all sources, including trend data focusing on the key indicators. An analytical annual health sector performance report is also produced but not readily available on the web.

- All ingredients seem to be in place for a highly informative web-based national health observatory with a national and subnational dashboard of core indicators, sharing of data, key reports and other information, building upon DHIS 2.0 and other efforts.

Roles and responsibilities are clearly defined, with a mechanism for coordination and plans for capacity strengthening (characteristic 5.6)

▲ The HSSP III includes plans for capacity strengthening the subnational level, and on data use.

► HSSP III provides an opportunity to better clarify the coordination mechanism, role and responsibilities, capacities of the different key institution in M&E. This would include the different units and sections of the Ministry of Health, including disease programs, the Rwanda Biomedical Centre and its Programme Planning and M&E Coordination Division (M&E unit), the General Directorate of Health Information System of the Ministry of Health, the National Bureau of Statistics, the School of Public Health of the University of Rwanda, and others.

Attribute 16

There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action (Attribute 16)

- ▲ Rwanda has a clear mechanism in plan for joint periodic reviews (in September) to assess progress and performance, which leads to a high level summary report with recommendations that are taken into account in the annual operational planning meeting which is conducted in April of the following year.
- ▲ A technical review meeting prior to the joint (backward) review in September is currently not conducted, but would be useful to discuss technical issues. This would allow the review itself to focus more on actual implications of the performance review results.

There is a multi-partner review mechanism that inputs systematically into assessing sector or programme performance against annual and long term goals (characteristic 5.7)

- ▲ The HSSP III document clearly states that sector performance reviews will be carried out annually to inform strategies, plans and to reconcile plans and available budget. It also includes a mid-term review and final evaluation of HSSP III. During HSSP II Performance Reviews were 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 were 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 the Ministry of Finance and Economic Planning on M&E and review mechanisms to follow EDPRS.
- ▲ The TWGs are operational entities of the health sector working group. The responsibility for the preparation of the annual health sector performance report lies with the Department of Policy, Planning and M&E, supported by its TWG.

Regular assessments of progress and performance are used as a basis for policy dialogue and performance review (characteristic 5.8)

- ▲ The annual health sector review, based on an assessment of progress and performance in the preceding year, is usually held in September. There is no technical review of the data prior to the health sector review. From the review a joint health sector review summary report is produced, highlighting the main issues and recommendations on how to address these issues. The report is signed by the PS of the Ministry and the head of the Development Partners Group. It forms the basis for the next annual plan aiming to address the issues identified.

There are processes for identifying corrective measures and translating these into action, including mechanisms to provide feedback to sub-national levels and to adjust financial allocations

- ▲ The September meeting is followed by a second meeting for planning purposes, which is conducted in April of the following calendar year. This meeting aims to implement the recommendations of the preceding review of progress and performance. The focus on districts is increasing as part of the decentralization. Financial allocations are adjusted as part of the MTEF process.

Table 3.6.1
HSSP III indicators and targets

Implications of the new targets of Vision 2020 for a potential revision of the HSSP III targets.

	2000	2010	2017	2020	2020	2014	2017	2014	2017
	Baseline	Current status	7YGP	Vision 2020 target	Vision 2020 new	Current HSSP III	Current HSSP III	Proposed revisions	Proposed revisions
Life expectancy	49	54.5	58	55	66	58	68	59	63
Population growth rate	2.9	2.9		2.2	2.2				
Fertility rate	5.8	4.6		4.5	3	4.5	2.5	4.0	3.5
Infant mortality rate	107	50	30	50	27		42	41	34
Maternal mort. ratio	1071	487	200	200	200	287	230	372	286
Wasting, under 5		3			0.5	2.5	2	2	1
Underweight, under 5		11			8	6		10	9
Stunting, under 5		44			15	27	24.5	32	24
Malaria mortality	51	13	5	25	5			10	7
Doctors per 100k	1.5	6	10	10	10	6.7	10	8	9
Nurses per 100k	16	77	100	20	100	91	100	86	93
Under 5 mortality		76					57	54	45

- The indicator of malaria mortality in the Vision 2020 is a case fatality rate. The baseline and targets seem however very high and do not align with the HSSP indicator.
- Note that some of the indicators refer to "recall" period prior to the year of the survey. Notably, the infant (and under 5) mortality rates refer to 2006-2010 and the maternal mortality ratio to 2005-2010, implying for example that some indicators pertaining to the end of HSSP III will only be available a few years later.
- The EDPRS indicators include equity which is not prominent in HSSP III. Definitions of some indicators vary. The new EDPRS should use exactly the same indicators, with the correct definition provided by the HSSP III.
- The table below summarizes the indicators in Vision 2020, EDPRS I, HSSP III core performance indicators, and HSSP III component indicators (1=programmes; 2= support systems; 3= service delivery; 4= governance). There are some overlaps and there is scope for reduction in the number of input and output indicators.

	Vision 2020	EDPRS I	HSSP III core	HSSP III components
IMPACT	**9**	**6**	**12**	**5**
Life expectancy	*		*	
Population growth rate	*			
Fertility rate	*	*	*	
Teenage pregnancy rate				1
Infant mortality rate	*	*	*	
Under 5 mortality			*	
Neonatal mortality				*
Maternal mort. ratio	*	*	*	
Wasting, under 5	*		*	
Underweight, under 5	*		*	
Stunting, under 5	*		*	
Infant mortality in poorest quintile		*		
HIV prevalence 15-49			*	
HIV incidence 15-24		*		
HIV prevalence in ANC			*	
Malaria mortality (case fatality rate)	*	*		
Malaria proportional mortality				1
Malaria prevalence women /children			*	
Malaria slide positivity rate				1
Diarrhea cases, new			*	
% satisfied clients in the PH and RH				3
OUTCOME		2	7	12
Contraceptive prevalence rate		*	*	
CPR by wealth quintile				1
Contraceptive utilization rate			*	
Unmet need for family planning				*
Births in facilities		*	*	
BIrths in facilities by wealth quintile				1
ANC 4+ visits			*	
Postnatal care, at least one visit				1
Measles immunization			*	
Full immunization by age 1				1
DIstricts with >80% pentavalent vaccine				1
Drop out rate pentavalent 1-3				1
Households with at least one LLITN			*	
ITN: children sleeping under LLITN				1
TB/HIV patients receiving ART			*	
Malnourished children in rehab programme				1
Households with improved non shared latrines				1
Household with access to improved water source				1
Households drinking home treated water				1
OUTPUT		**3**	**7**	**32**
ITN distributed		*		

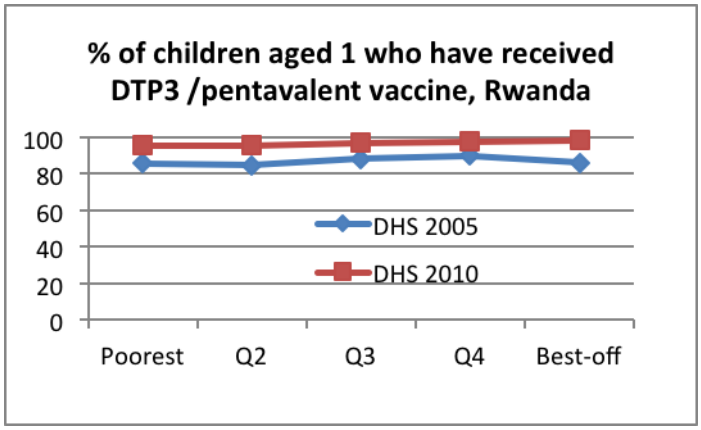
Districts with one stop centre (GBV)		*	
Health centre with youth friendly services (ado)		*	
Health facilities with VCT / PMTCT		*	
TB treatment success		*	
TB smear conversion rate 6 mo after MDR			1
Trained env health officers		*	
OPD attendance /pp/yr		*	
Population coverage CBHI	*	*	
% Population covered by 'mutuelles'.			2
Health facility within 5 km	*		
CHW providing MNH package			1
Facility with functional B/C Emoc			1
IMCI: treatment visits per under five			1
DIstricts conducting quarterly surveillance			1
IMCI: treatment visits per under five			1
CHW : mean children seen per month			1
CHW: children screened in CBNP			1
TB laboratory with quality assurance			1
Health centres with mental health services			1
Health facility/communities implementing IDS			1
Mass media channels used			1
Community hygiene clubs functioning			1
Health facilities with effective waste management			1
% HF with NO stock outs of tracer drugs			2
% prescription with antibiotics in DH / HC			2
% of DH/DHU using computerized iHRIS for staff census			2
% HF with online tracking system for all procuring entities (LMIS)			2
% reported stock-outs of Lab/Rx tracer items			2
% Lab samples with 100% concordance			2
% CHWs providing C-IMCI services			3
# HC accredited			2
# HC eligible for accreditation			2
# Nat, Referral Hosp accredited			3
# Prov Hospital eligible for accreditation (>70%)			3
% of HC and District Hospitals using OpenEMR or other individual medical records system			2
% of registered private clinics and dispensaries reporting routinely to HMIS			2
# registered CHW tracking PW using RapidSMS			2
% of HF receiving at least one formal feedback report from HMIS each quarter			2
# CHW cooperatives functioning (financially)			3
% HCs using Clinical protocols			3
INPUT /PROCESS	**2**	**6**	**45**
Financing			
% gov budget allocated to health		*	
Health expenditure per capita		*	
PBF allocation per capita		*	
% on-budget / off-budget resources increased			4
Donor expenditure as % of donor commitments			4
% on-budget funds disbursed as % total DP fund			4
% of ODA delivered in the year for which it was scheduled			4

% DP provide resource information				4
% of MOH expenditure going to District level and below (NHA)				2
% GOR funds disbursed to districts (grants)				4
% HC with functional QA team				2
Human resources				
Doctor / Pop ratio	*		*	
Nurse /Pop ratio	*		*	
Midwives / pop ratio			*	
Environmental health officers N				2
Lab tech / Pop Ratio				2
# Traditional Practitioner with legal status				2
# of A2 nurses who have completed eLearning course to upgrade their skills				2
# trained hospital managers increased				3
% HF trained in PFM and fiduciary issues				4
Infrastructure				
National Reference Laboratory constructed				2
% adequate infrastructure in HF based on norms				2
% DH with effective maintenance workshops				2
% HF with functional IT infrastructure (Internet & computer)				2
% HCs with functional electricity and water				3
% Sectors without a HC				2
% Sectors without a functional HC				2
Medicines / diagnostics /equipment				
% generic drugs locally produced				2
% Hosp with Drug Therapeutic Ctees				2
% GOR financial contribution to medicines				2
Governance / management				
Districts with comprehensive plan				2
Districts timely submitting annual plan and budget				2
PLans and budget reviewed quarterly				2
Link Accreditation with PBF established				2
% functional DHMT in all 30 districts				3
# Referrals from HCs to DH by year				3
% DH eligible for accreditation (> 70%)				3
% of DH supervised quarterly by Prov / Nat Referral Hosp				3
# referrals from DH to ProvH / NatRHosp				3
% of HF with referral guidelines used				3
Criteria ambulance distribution reviewed				3
# DHU operational (comprehensive district annual planning, budgeting, reporting timely)				4
% of districts that hold quarterly DHMT meetings with stakeholders				4
# districts having quarterly health commission meetings.				4
% districts that implement the SWAp roadmap				4
% DPs, private sector, civil society, professional bodies participate in HSWG meetings				4
# stakeholders participating in district planning				4
% of DH with clean (internal / external) audits annually				4
# reviews / evaluations of subsector programmes/strategies completed (annually)				4
% of targets met from HSSP III				4
% of HCs that receive supportive supervisions from district hospitals.				4
TOTAL	**11**	**11**	**32**	**94**

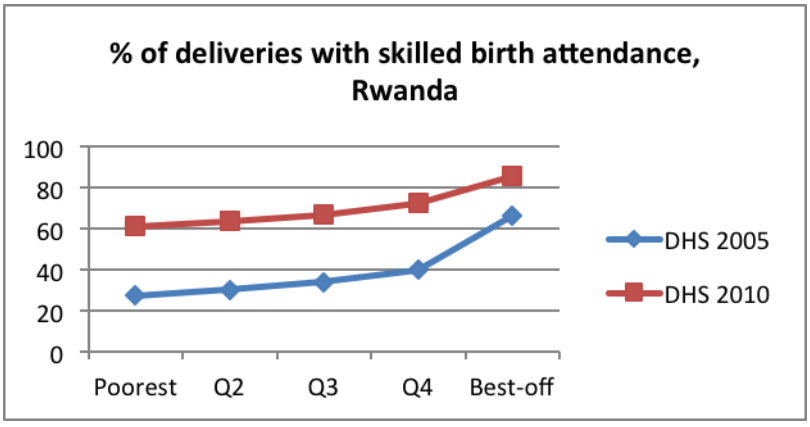
Annex 3.6 B Equity in health – a brief situation analysis

The DHS surveys in 2005 and 2010 provide extensive data on equity in coverage of interventions and health status. This considers differences by sex/gender, place of residence (urban-rural), mother's education, and wealth quintile. The differences by sex of the child tend to be small for all coverage indicators. For the other three stratifiers there are major differences for some indicators and small differences for others.

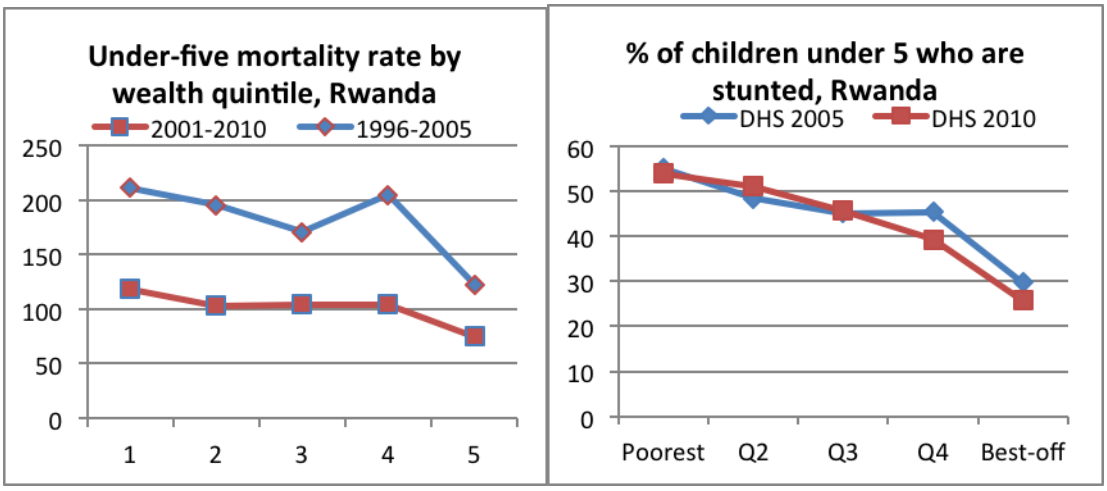
There are several interventions which already have very high national levels of coverage (over 85%) where the differences by socio-economic stratifiers tend to be small. The differences were already small in 2005 and remained small in the 2010. Examples are antenatal care (first visit) and immunization coverage (all vaccines, see Figure with DTP3 example). Remarkably, differences in ITN use by wealth quintile were large in 2005 but almost completely disappeared by 2010, as part of a spectacular increase in coverage to over 75%.



For other interventions, such as skilled birth attendance, very large inequities in coverage existed in 2005, and have been reduced in subsequent years. There are however still substantial gaps between the poorest and best off quintiles in skilled birth attendance coverage that need to be addressed.



Other areas such as nutritional status have persistent large inequities between the poorest and best off. Child stunting, which is influenced by multiple factors, continued to be much more prevalent among the poorest quintile, with little change between 2005 and 2010. Stunting is occurring in over half of the children in the poorest two quintiles in Rwanda, while those in the best off quintile have less than 30% prevalence of stunting. This is in sharp contrast with child mortality inequities which sharply reduced between the two DHS surveys in 2005 and 2010 – the rates refer to the ten year periods prior to each survey, 1996-2005 and 2001-2010 respectively. Most progress was made in the two poorest wealth quintiles.



Comparing the main socio-economic stratifiers shows that differences for coverage and health outcomes are largest by wealth quintile (between the poorest and best-off) and mother's level of education (no education versus secondary education). Urban rural differences are also present but smaller than by wealth and education. Differences between the North, West, South, and East regions were relatively small for the health indicators; only Kigali city had much better statistics for most indicators by 2010 than the four regions.