SCALING UP TO ACHIEVE THE HEALTH MDGS IN RWANDA: A BACKGROUND STUDY FOR THE HIGH-LEVEL FORUM MEETING IN TUNIS JUNE 12TH-13TH 2006

The paper was prepared by the Government of Rwanda with the assistance of the World Bank.

Global Forum on Development: Pre-meeting on Aid Effectiveness in Health
4 December 2006

This paper provides a vivid example of the challenges faced by individual countries as a result of lack of donor harmonization and alignment at country level. It provides both conceptual and empirical information concerning the significant management problems and the distortions resulting from donor behaviors in a country with strong donor support. These distortions may be sufficient to severely constrain a country from implementing its PRSP and the health plan within it.

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SCALING UP TO ACHIEVE THE HEALTH MDGS IN RWANDA

A BACKGROUND STUDY FOR THE HIGH-LEVEL FORUM MEETING

IN TUNIS JUNE 12\textsuperscript{TH}-13\textsuperscript{TH} 2006
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ARV</td>
<td>Anti Retroviral</td>
</tr>
<tr>
<td>ACT</td>
<td>Artemisin Combination Therapy</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control (US)</td>
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<tr>
<td>CBO</td>
<td>Community based organisation</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society organisation</td>
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<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EDPRS</td>
<td>Economic Development and Poverty Reduction Strategy</td>
</tr>
<tr>
<td>EFU</td>
<td>External Finance Unit (MINECOFIN)</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, TB and Malaria</td>
</tr>
<tr>
<td>GOR</td>
<td>Government of Rwanda</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly Active Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>HIPC</td>
<td>Highly Indebted Poor Country</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>HLF</td>
<td>High Level Forum</td>
</tr>
<tr>
<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<tr>
<td>IFF</td>
<td>International Financing Facility</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>MBB</td>
<td>Marginal Budgeting for Bottlenecks</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MINISANTE</td>
<td>Ministry of Health</td>
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<tr>
<td>MINECOFIN</td>
<td>Ministry of Finance and Economic Planning</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President's Emergency Program for AIDS Relief (US)</td>
</tr>
<tr>
<td>PER</td>
<td>Public Expenditure Review</td>
</tr>
<tr>
<td>PRSG</td>
<td>Poverty Reduction Support grant</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>SPA</td>
<td>Strategic Partnership with Africa</td>
</tr>
<tr>
<td>SWAP</td>
<td>Sector Wide Approach</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>U5MR</td>
<td>Under 5 Mortality Rate</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

1.1 Background

1. The High-Level Forum on the Health MDGs (HLF) recognised that the failure of current approaches to strengthening the health sector reflects fundamental problems with the ways in which aid for health is delivered. To address them, the World Bank tabled a proposal for a brokering service that would facilitate action by donors and Governments to provide coherent support for more effective Government strategies and expenditure plans. The ultimate objective is to support a process whereby Government and development partners will develop and implement a ‘compact’, a form of agreement setting out how both will work together to achieve faster progress towards the Millennium Development Goals (MDGs).

2. This is one of a number of case studies intended to test the viability and value added of the approach.

1.2 Prospects for Achieving the Health-Related MDGs in Rwanda

3. Rwanda has achieved a great deal since the 1994 genocide. Peace has been restored, the institutions of Government have been re-established, and the economy has bounced back from the steep decline that followed the genocide. The Government has managed the economy effectively, and has continuously improved public financial management and the institutions of planning and budgeting. Rwanda has also made significant progress on health indicators since 1994, achieving one of the highest immunization coverages in SSA, reversing the HIV trend and scaling up micro-insurance and performance based programs. Nevertheless, Rwanda will not reach the MDG goals on present trends.

4. In 2005, the public sector, including donor aid, spent about $12-$14 per head on health1. In addition to public sector spending (Government and donor), the private sector in 2003 accounted for 25% of total health expenditure, an additional expenditure of $3.47 per head of which $2.75 came from households2. Total health expenditure by 2005 may therefore have been of the order of $15-$17 per head.

5. According to analysis using the Marginal Budgeting for Bottlenecks (MBB) approach, Rwanda could come close to achieving the child mortality target if it increased health spending in order to finance a package of additional expenditures in health expected to cost $20 per head when fully scaled up in 2015. This would reduce under five mortality

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1 2005 health public expenditure review. Page 18 gives a figure of $8.5 per head, based on external aid of $4.7 or $45mn. However, the same document quotes health aid as $75mn in 2005, $7.8 per head, which would give total Government plus donor spending of $11.6 per head. Coverage of health aid statistics is incomplete, and health aid is believed to be over $100mn, giving per capita spending of nearly $13 if ‘recettes formations sanitaire’ are excluded, over $14 if included.

2 NHA Table 24 and Table A-1. Table 25 in the same source quotes a much higher private sector share of 47%, presumably because off-budget spending by donors is included with the private sector.
by about 60%, maternal mortality by about 40%. The remaining reduction in mortality required to achieve the child mortality target is likely to be met as a consequence of the contribution from faster economic growth and investments in water and sanitation. A more limited package, which covers health interventions up to and including the district hospital but excluding additional expenditures in tertiary hospitals and the further roll-out of ARV treatment for HIV/AIDS, would cost $9.35 per head on top of current spending levels. Although costing less than half as much, it is estimated that this would ‘buy’ three quarters of the reduction in child mortality, and 63% of the reduction in maternal mortality expected from the $20 package.

1.3 Financing Additional Health Sector Spending

6. There is limited scope for financing the additional health spending from the private sector. The HSSP acknowledges that financial barriers to access are already a major reason for low utilisation of health services. Although there is scope for making better use of existing private expenditures on health, the bulk of additional finance will need to come from Government revenues or from development assistance.

7. Government has increased health sector spending dramatically to about 9% of the budget, and now spends a share of resources on the health sector that is comparable to other countries in the region, having until recently been one of the low spenders. Aid donors spend over 16% of aid to Rwanda on the health sector, giving health a 15% share in total Government plus donor resources. However, economic growth has slowed to 5% per annum over the last five years. Growth needs to accelerate if Rwanda is to achieve the income poverty reduction target, or be able to sustain improved social services. To achieve this, Rwanda will need to devote an increased share of the budget to spending that directly supports higher economic growth, particularly infrastructure investment. It will be a challenge to balance these priorities with the need to sustain the recent dramatic increase in the health share in total expenditure.

8. A combination of optimistic assumptions (doubling of aid from the existing already high 20% of GDP, double digit economic growth, and health receiving the 15% Abuja share of all additional resources) would yield just $8 per head extra for health by 2015. A lower-case scenario (5% per annum growth of the economy, a 50% increase in aid, and a 10% health share of additional resources) results in only an extra $2 per capita in public resources for health by 2015 (Table E1). This is less than 10% of the incremental cost of the scaling up package. Fully implementing the health package using public sector financing would require some combination of significantly higher economic growth, and a very substantial increase in aid. On most scenarios, aid to health would need to increase by more than $200mn p.a. by 2015, on top of the existing $100mn, with most of the increase needing to be sustained to 2020 and beyond. This would imply health taking between 35% and 100% of the additional money becoming available from aid plus domestic revenues.

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3 Spending is quoted as a share of tax revenues plus concessional aid. This simplification is reasonable when looking forward, as there is very little scope for increasing funding from other sources without risks to macroeconomic stability and debt sustainability.
### Table E.1: What Additional Resources are Available for Health? (2005 US $ Per Capita)

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V. High GDP Growth With Doubling of Aid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Revenue p.c.</td>
<td>32</td>
<td>40</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Aid p.c.</td>
<td>47</td>
<td>83</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Total Resources p.c.</td>
<td>79</td>
<td>123</td>
<td>135</td>
<td>56</td>
</tr>
<tr>
<td>Health @ 15% of the increase</td>
<td>12</td>
<td>18</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Health @ 10% of the increase</td>
<td>12</td>
<td>16</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td><strong>5% p.a. GDP Growth With Moderate Aid Increase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Revenue p.c.</td>
<td>32</td>
<td>36</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Aid p.c.</td>
<td>47</td>
<td>49</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Total Resources p.c.</td>
<td>79</td>
<td>85</td>
<td>96</td>
<td>17</td>
</tr>
<tr>
<td>Health @ 15% of the increase</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Health @ 10% of the increase</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>2</td>
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</table>

Source: Authors’ calculations from data and projections provided by macroeconomics department of MINCOFIN.

### 1.4 Making Better Use of Existing Resources

9. In addition to the contribution of new resources, there is very substantial scope for improving the allocation and management of existing health expenditure.

10. The main problem is the development partners. Central Government manages only 14% of donor support to the health sector. Donor support pays for services delivered from public sector facilities, but it is channelled via NGOs or direct to local Government or donor projects. The NGOs as financing agents manage a larger share of total health expenditure (27%) than does Government (20%)\(^4\).

11. The predictable consequence has been gross misallocation of resources, with per capita aid for health in 2005 varying from $1.86 per capita in the least funded province to $11.84 in the highest funded. Similar inequalities afflict the distribution of donor funding by strategic objective, with $18mn earmarked for malaria (the biggest cause of mortality and morbidity) and just $1mn for the integrated management of childhood illnesses, compared to $47mn for HIV/AIDS, grossly disproportionate in a country with a 3% infection rate. Some 27% of total Government and donor expenditure is absorbed in administration. This partly reflects the proliferation of actors (21 donors and over 40 NGOs), the large number of discrete projects, and the perpetual need to re-negotiate in a situation of very short donor pipelines, with 55% of donor projects due to end within a year.

12. Despite relatively high total spending compared to other Eastern and Southern African countries\(^5\), the service still achieves insufficient coverage, particularly for maternal and child health. According to the 2005 MNCH study, only 2 from 12 life-saving maternal, neo-natal and child health interventions reached more than half of potential users, with most achieving less than 20% coverage\(^6\). One of the problems of vertical...

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\(^5\) NHA, 2005.

\(^6\) Paul Smithson and Javier Martinez, Addressing health MDGs in Rwanda, Progress, Gaps, Challenges and Opportunities, DFID Resource Centre, February 2006.
funding is that contacts with users tend to deal with a specific issue, rather than taking the opportunity to deliver all relevant aspects of the minimum package.

13. Government, through the Health Sector Strategic Plan, has a clear strategy for scaling up effective, evidence-based interventions. It is based on:-

i. Expanding decentralised approaches to performance contracting with service providers at community, health centre, and district hospital level. By linking payments to output rather than supply of inputs, pilot programmes have achieved significant success in scaling up the most effective interventions.

ii. Expanding community insurance to guarantee access to a basic package of services delivered at health centre level. Membership of community health insurance schemes (‘mutuelles’) already covers 44% of the population, and is intended to become compulsory, with safety nets being put in place for those unable to pay.

14. Insufficient funding is a major constraint to the effectiveness of the approach. The costs of the services being delivered are higher than the funding available via mutuelle fees and performance payments. Performance payments are designed as incentives for health sector workers, and are not intended to cover the costs of the service. Mutuelle fees are too low to fully cover the marginal costs of the services they are intended to finance, while studies of the ability to pay suggest that the safety net may need to be further extended. Government recognises the severe limits on domestic public funding, and understandably sees no alternative to asking people to invest in their own health. Donor funds are perceived as being outside Government control, and not reliable.

15. The conclusions from this analysis of existing financing patterns and of future prospects are that:

i. Even if the Vision 2020 growth targets are achieved and combined with aid doubling in real terms, the additional public funding will be insufficient to establish even the $9 package of health services at community health centre and district level by 2015, let alone the $20 package including HAART treatment. Only the most basic health package at community and health centre levels could be subsidized by additional public funds.

ii. Additional resources will have greatest impact if they are focused on the HSSP, channelled through the Government budget, and used to extend the community schemes, the performance payments and the safety net for mutuelle membership. The Global Fund has recently committed resources to funding mutuelle payments in six provinces, showing that there is scope for the disease-specific funds to support system improvements that are linked to outputs relevant to their core mandate7. However, the commitment is only for five years, and has

created a contingent liability to the government while there is no long-term funding to sustain it. This creates an additional fiscal risk.

iii. The MBB approach focuses on the impact of additional resources. A key question is how to supplement the additional resources becoming available by also re-allocating existing health sector expenditure towards expenditures with a higher expected impact on the MDG goals. The greatest potential relates to the $11 per head of existing ODA to the health sector, although there is also significant scope to make the relatively smaller sums available from the Government budget and private expenditures work better for the MDGs. This calls for a careful assessment of the current allocations, increased attention to trade offs, progressive correction of the most important distortions in public expenditure, and improved channelling of private spending.

iv. In summary, the fundamental challenge remains how to make the best use of whatever resources are available in order to get as close as possible to the Vision 2020 goals and the MDGs. This will also help Rwanda to attract and sustain the additional resources it needs to narrow the funding gaps.

1.5 Improving the Management of Development Assistance

16. The problems that need to be addressed can be summarised as:-

- Dependence on short-term aid commitments to fund long-term expenditure programmes, with attendant risks to sustainability of the health system;

- Distortion of the current system—the PRSP and MTEF— for allocating resources where they are needed, a problem that needs to be addressed by putting the Government back in control of the allocation of resources in the health sector.

- High transactions cost, with too high a proportion of funds absorbed in management of separate funds and initiatives rather than paying for service delivery.

17. Government already has a process for improving aid harmonisation and alignment. A health and AIDS cluster has been created, a draft Aid Policy is in the final stages of Government discussion, and there are plans for reaching agreement with donors on how to implement it. This report suggests that, with HLF support, Government could usefully complement this existing process by putting in place:-

- An overall ‘Compact’ (illustrative draft at Annex 2). The idea is that donors will support an agreed and costed Government strategy (the EDPRS) by collectively providing assurances of minimum levels of long-term financing, provided on plan and on budget (though not necessarily ruling out some use of parallel procedures for donors unable to give budget support). In return, Government would undertake to abide by the strategy, respect agreed processes of monitoring and consultation, continue to improve financial management, and continue to maintain a stable and supportive social, political, and economic climate. To
ensure fairness, compliance by both Government and donor partners would be independently verified, and pressure for donor compliance would be reinforced by transparency, to provide opportunities for pro-aid lobbyists to hold agencies to account.

- A health sector Memorandum of Understanding (Annex 2), setting out partnership principles that will be applied by Government and donors working within the health sector. This is consistent with the overall ‘compact’, but adds more detail on how coordination at sector level will work, laying particular stress on the importance of a joint process for identifying where financing is needed and directing future Government and donor commitments towards the gaps.

18. The High Level Forum can add value to the existing process in Rwanda in three ways:-

- The practical problem of how to provide a meaningful collective guarantee of future aid levels needs to be solved. There are a number of possible approaches, which could be linked to broader reforms in aid architecture such as the international financing facility and the proposals for dedicated taxes to fund aid increases. An effective solution could be put in place, if the political will is present for the donors to bind themselves to the promises they have made. The challenge is to quickly establish a mechanism to transfer the risk of donor under-performance to the donors, who should be far better able to manage the risk than are the Governments of low-income countries.

- The agency-wide impediments to compliance with the new Rwanda aid policy need to be addressed, and will need sustained high level attention within each agency. The process proposed by GOR, of asking each agency to undertake a self-assessment against the aid policy and to come up with a plan of action, is an excellent one. The HLF should ensure that these self-assessments are conducted at the highest technical level within each agency, and that they lead to a serious examination of policies and procedures rather than a simple re-iteration of existing positions with minor adjustments. There may be a case for involving the senior staff responsible for establishing office procedures in joint reviews in country, together with their counterparts in Government and in other donor agencies, in order to understand the problems and develop solutions.

- Within Rwanda, and coordinated with the existing timetable, Government and donor agencies may wish to discuss whether to pursue any or all of the additions to the existing aid policy that are proposed in the attached drafts and summarised in Box 2 and Box 3. The first stage would be to present some of the ideas and to facilitate local discussion of whether and how they should be incorporated in the development of a national aid policy. This would be a potential role for the proposed brokering service.
2. BACKGROUND

19. Discussions at the meetings of the HLF highlighted the failure of current approaches to strengthening the health sector, and revealed fundamental problems with the ways in which aid for health is delivered. The issues which need to be addressed include:

- Volatility, predictability and durability of donor funding;
- Integration of donor funding within an overall fiscal framework that is sustainable in the medium- to long-term;
- Coordination of donors and vertical programs with a coherent health strategy;
- Appropriate accountability of health financing agents;
- Appropriate governance at the country level;
- Improved and more transparent management and health information mechanisms.

20. Addressing these bottlenecks requires actions by both donor agencies and countries. In Brussels on the 7th of February, 2006, the World Bank tabled a proposal for a brokering service that would facilitate action on alignment between donors and country-level governments and would eventually be reflected in macro-economic frameworks, poverty reduction strategy papers (PRSP), health sector strategies, medium-term expenditure frameworks (MTEF), domestic financing and donor funding.

21. Meeting participants suggested that at least two “proof of concept” country case studies be conducted to determine the viability of the brokering service, to assess demand at the country level, and to get a better sense of the financial and human resources required. This study of Rwanda is the first of the case studies. It was presented at a workshop held in Tunis on June 12th-13th 2006, and this version reflects amendments made following that discussion.

22. The ultimate objective is to support a process whereby Government and development partners will develop and implement a ‘compact’, a form of agreement setting out how both will work together to achieve faster progress towards the MDGs.

23. The report is structured on the following lines:-

- Current MDG status and trends
- Cost of achieving faster progress towards the MDGs
- Additional funding available from domestic and external sources
- Scope for making better use of existing financial resources for health
• Proposals for supporting the existing Rwanda process for improving the allocation and management of development assistance


3. THE MDGS: MAJOR ACHIEVEMENTS, BUT MAJOR CHALLENGES

25. Rwanda has achieved a great deal since the 1994 genocide. Peace has been restored, the institutions of Government re-established, and the economy has bounced back from the steep decline that followed the genocide. The Demographic Health Survey showed a 25 percent decrease in under-five mortality between 2000 and 2005, bringing the rate back to pre-genocide levels. At 3 percent of the adult population, HIV prevalence is stabilizing, although female and urban residents experience a higher rate of infection. Good progress on vaccination rates continues—the overall rate increased from 89 percent in 2004 to 95 percent in 2005 for DPT3 specifically. The proportion of the population covered by community health insurance schemes (‘mutuelles’) increased from 27 percent in 2004 to 44 percent in 2005. 2005 also saw further investment in infrastructure and equipment at community health centre and hospital levels and additional doctors and nurses were hired. Utilization of other services also increased, including contraceptive prevalence, assisted deliveries—now at 39%—, and outpatient visits. The upward trend of per capita utilization rate continued, increasing from 0.4 to 0.7 per capita per year.

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9 These rates are based on routine reporting. The recently completed gives a slightly lower figure, which is typically the case.
26. Nevertheless, Rwanda will not reach the MDG goals on present trends (Table 1).

**Table 1: Status and Trends in Health-Related MDGs**

<table>
<thead>
<tr>
<th>Goal</th>
<th>1990 Baseline</th>
<th>Post Genocide</th>
<th>Current Status</th>
<th>Target 2015</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>% below poverty line</td>
<td>48%</td>
<td>78%</td>
<td>54%</td>
<td>24%</td>
<td>Faster and pro-poor growth needed</td>
</tr>
<tr>
<td>Under 5 Malnutrition</td>
<td>29%</td>
<td>25% (2000)</td>
<td>22%</td>
<td>15%</td>
<td>big push needed</td>
</tr>
<tr>
<td>Child Mortality rate:</td>
<td>151/000</td>
<td>217/000</td>
<td>152/1000</td>
<td>50/000</td>
<td>good progress, but off track</td>
</tr>
<tr>
<td>Maternal mortality rate:</td>
<td>Unclear: 2500 used for MDG target, but 2000 DHS estimated 611 in 1985-90</td>
<td>1611 (DHS 2000 estimate for 1990-95)</td>
<td>Unclear, DHS 2000 estimates 1071 – second highest in Africa</td>
<td>625 (official target), 153 (if DHS baseline is used)</td>
<td>uncertain status</td>
</tr>
<tr>
<td>HIV/AIDS:</td>
<td></td>
<td></td>
<td>3% sero-prevalence (DHS 2005)</td>
<td>2005 DHS was the 1st statistically representative survey, found a much lower rate than previous estimates and suggests a significant decline has occurred, though hard to quantify.</td>
<td>big success</td>
</tr>
<tr>
<td>Malaria:</td>
<td></td>
<td></td>
<td>Still biggest killer, but falling morbidity</td>
<td></td>
<td>big push ongoing</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Increased incidence due to HIV</td>
<td>High treatment success, low case detection</td>
<td>source of concern</td>
</tr>
</tbody>
</table>


27. There is a critical need to accelerate economic growth. Economic growth recovered rapidly after the 44% decline in GDP in 1994, but has slowed to an average 5% per annum since 2000. Faster and better distributed economic growth is essential to achieve the income poverty target of halving the population living below the poverty line. It will also be essential for sustaining any improvements in social spending that are required in order to achieve the health and education MDGs.
4. COSTING: HOW MUCH ADDITIONAL HEALTH EXPENDITURE IS NEEDED?

28. In 2005, the public sector, including donor aid, spent about $12-$14 per head on health. In addition to public sector spending (Government and donor), the private sector in 2003 accounted for 25% of total health expenditure, an additional expenditure of $3.47 per head of which $2.75 came from households. Total health expenditure by 2005 may therefore have been of the order of $15-$17 per head.

29. The required level of health expenditure to come close to achieving the health targets set out in the Government Vision 2020 and in the MDGs has been estimated by Government, with World Bank and UNICEF support, using the Marginal Budgeting for Bottlenecks methodology. This approach focuses on where additional funding should be concentrated in order to overcome bottlenecks and maximise the impact on the MDGs. The potential for making further progress by also improving the allocation and effectiveness of existing spending will be discussed in section 6.

30. Six steps are identified (Table 2. See Annex 4 for description of the six steps). The per capita cost of each of the steps increases each year to 2015, as the interventions are scaled up.

31. The first step focusing on contracts between the districts and local NGOs, CBOs and private retailers—including social marketing—will result in halting and reversing the prevalence of HIV and other preventable diseases, 20% reduction in under five mortality, and 1.6% reduction in maternal mortality. The average annual cost over the ten year period is estimated at US$2.10 per capita, growing to reach US$2.95 in 2015.

32. The second step costs an additional $1.50 per capita by 2015. It focuses on scaling up the performance based contract approach with health centres. The two steps together will cost $4.46 in 2015. This level of investment will result in a mortality reduction of 34.1% for under five and 12% for maternal mortality.

33. The third step focuses on scaling up the mutuelle program, including a safety net to meet the membership costs for the poorest 20% of the population. The mutuelles are schemes for community-based health insurance. In return for an annual cost of about $2 per person per year, they provide access to basic health services at health centre level as well as the cost of transport for referrals to the district hospital, but not the cost of hospital care. This step will achieve further reduction in under five and maternal mortality, raising the cumulative reduction to 40.5% and 20% respectively. Step three will cost an additional $1.84 per capita per year by 2015, raising the total cost of the first three steps to $6.30 per head.

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10 2005 health public expenditure review. Page 18 gives a figure of $8.5 per head, based on external aid of $4.7 or $45mn. However, the same document quotes health aid as $75mn in 2005, $7.8 per head, which would give total Government plus donor spending of $11.6 per head. Coverage of health aid statistics is incomplete, and health aid is believed to be over $100mn, giving per capita spending of nearly $13 if ‘recettes formations sanitaire’ are excluded, over $14 if included.

11 NHA Table 24 and Table A-1. Table 25 in the same source quotes a much higher private sector share of 47%, presumably because off-budget spending by donors is included with the private sector.
34. Step four strengthens the capacity of district hospitals to provide improved quality of care for under five and maternal referral services. This will provide further reduction in neonatal, under five and maternal mortality, raising the cumulative reductions to 33.4%, 44.6%, and 26.1% respectively. The additional per capita cost grows to $3.06 by 2015, the incremental cost of all four steps is $9.35.

35. Step five strengthens the four national referral hospitals. This will further enhance the mortality reduction, which is estimated to reach 42% for neonatal, 52.3% for under five and 40.9% for maternal mortality. The additional annual per capita cost of this step grows to $2.79 by 2015, the cumulative cost of the first five steps is US$12.15 in 2015.

36. Finally, further strengthening the health system to scale up provision of HAART will inflate the estimated per capita cost by a further $8.34 per capita by 2015, taking the cumulative cost of the whole package to US$20.48 in 2015. The gain in mortality reduction will register a smaller addition from the preceding step (strengthening the national hospital). The mortality reduction is estimated at 44.4% for neonatal, 58.5% for under five and 40.9% for maternal mortality.
Table 2: Cost of Health Measures and Contribution to the MDGs

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Marginal Impact as % of Baseline</th>
<th>Cumulative Impact</th>
<th>Marginal Cost ($ per capita)</th>
<th>Total Additional Cost ($ per capita)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information and social mobilisation for behaviour change</td>
<td>Reduced child mortality due to HIV, malaria, diarrhoea; reduced HIV transmission; reduced malaria mortality and morbidity.</td>
<td>Reduce trend in HIV incidence and stabilise prevalence, U5MR down 20%, MMR 2%</td>
<td>U5MR reduced 20%, MMR by 2%</td>
<td>$2.95</td>
<td>$2.95</td>
</tr>
<tr>
<td>2. Performance based contracting with health centres</td>
<td>Reduce child mortality, reduced mother to child HIV transmission, 40% reduction in deaths due to pregnancy, reduced malaria mortality and morbidity, reduced child malnutrition.</td>
<td>U5MR down 14%, MMR 10%</td>
<td>U5MR reduced 34%, MMR 12%</td>
<td>$1.50</td>
<td>$4.46</td>
</tr>
<tr>
<td>3. Scaling up mutuelle membership by the indigent</td>
<td>Further decreases of child mortality, maternal mortality, malaria morbidity and mortality, TB</td>
<td>CMR down 6%, MMR 8%</td>
<td>U5MR reduced 40%, MMR by 20%</td>
<td>$1.84</td>
<td>$6.30</td>
</tr>
<tr>
<td>4. Expand and upgrade district hospitals</td>
<td>Further reduction of child mortality, maternal mortality, HIV mother to child transmission, severe malaria treatment</td>
<td>Reduces U5MR 4%, MMR by 6% of baseline</td>
<td>U5MR reduced 45%, MMR 26%</td>
<td>$3.06</td>
<td>$9.35</td>
</tr>
<tr>
<td>5. Strengthen national hospitals</td>
<td>U5MR reduced 7%, MMR 15%.</td>
<td>U5MR reduced 52%, MMR 41%</td>
<td>$2.79</td>
<td>$12.15</td>
<td></td>
</tr>
<tr>
<td>6. Scale up anti-retroviral treatment for HIV/AIDS</td>
<td>Extension of HAART together with treatment for resistant TB achieves further reduction in U5MR, MMR, and mother to child transmission of HIV, prolongs the life of those on treatment.</td>
<td>Reduces U5MR by 6% from baseline.</td>
<td>U5MR reduced 59%, MMR by 41%.</td>
<td>$8.34</td>
<td>$20.48</td>
</tr>
</tbody>
</table>

Source: From Rwanda Draft MDGs Needs Assessment, MINISANTE and UNICEF. See Annex 4 for a description of the specific interventions included in each step.

37. The total additional cost is $20 per capita. All steps together would come close to meeting most of the health related MDGs-child health, malaria and HIV-, especially when the impact of non-health interventions is taken into account, notably the effect of economic growth on income poverty and malnutrition together with the contributions from improved water and sanitation and better road access. The 41% maternal mortality reduction would also be a significant achievement. The target on HIV/AIDS incidence appears to have been already met but will need to be maintained. The malnutrition target depends mainly on success in reducing income poverty in rural areas, although step 1 will make an important contribution through measures such as advice on breast-feeding, hand washing, use of ITNs and treatment of diarrhoea.

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12 Smithson et al (op cit) argue that the 1990 baseline level of MMR from which the 2015 target was calculated was an over-estimate, due to lack of good data at the time it was set. It is therefore unclear what level of MMR needs to be achieved in 2015 in order to meet the MDG.
38. Although the total package costs over $20 per person beyond present spending levels, a more limited package, which covers steps 1 to 4 up to and including the district hospital but excluding the strengthening of national hospitals and the further roll-out of ARV treatment for HIV/AIDS, costs less than $10 per head. It is estimated to deliver three quarters of the reduction in child mortality, and 63% of the reduction in maternal mortality. Step 6, which is mainly concerned with further expansion of anti-retroviral treatment for HIV/AIDS, accounts for 41% of the costs, but makes little additional contribution to maternal mortality, while the 6% reduction in child mortality is achieved at high unit cost.

39. These findings are of course only as good as the model on which they are based. The interventions themselves have relatively well understood impacts. The assumptions about the coverage that can be achieved are based on an extensive analysis of elasticities of the various determinants of effective coverage combined with local expert opinion concerning the impact on demand of increased mutuelle coverage, the impact on output of performance contracting, and the ability of the health services to overcome staffing shortages and logistical problems13.

5. CAN THE ADDITIONAL COSTS BE FINANCED?

5.1 Introduction

40. The interim version of the Longer Term Investment Framework and Program starts from the scenario required to achieve the Vision 2020 goal of Rwanda reaching middle income status (defined as per capita GNI of $900 at current prices) by 202014. This requires economic growth to accelerate to average more than 10% per annum for the next 13 years. Even with such a high economic growth rate, the consumption poverty MDG would not be achieved until 2019. In the light of actual economic growth that has slowed to 5% per annum since 2000, the growth target is highly ambitious, but indicates the level of economic performance that will be needed if Rwanda is to come close to achieving the MDGs. Rwanda will continue to strive to meet the Vision 2020 goals, and to attract the resources necessary for achieving them. However, Government also recognises the need for prudent fiscal policy, and will not embark on ambitious expenditure plans without first ensuring that the financing required in order to implement them is in place.

41. If Rwanda were to achieve the high GDP growth consistent with the Vision 2020 goals, and based on the phasing of scaling up assumed in the MDG needs assessment, the additional spending required in order to finance the six steps would be 4.7% of GDP in 2015, declining as a share of GDP thereafter. If GDP continues to grow at the recent rate of 5% per annum, however, the increased spending implies a 7% of GDP increase.

13 More details on the methodology and approach can be found in the report “Health MDGs Needs Assessment in Rwanda”

in health expenditure in 2015 (Table 3). Putting these numbers in context, the highest total health expenditure (public and private together) in 10 Eastern and Southern African countries is 7.4% of GDP (Rwanda is third highest with 6.6% of GDP)\(^{15}\).

42. If the costs have to be met from additonal resources, they will have to be financed predominantly from public sources, either domestic revenues or aid, because private costs are already a barrier to access, even though private expenditure accounts for only 25% of health spending. A number of studies have reported that payments as low as $1 will be beyond the financial reach of many rural households\(^{16}\). Rural cash incomes are low, and over 40% of the population are classified as ‘food poor’ (expenditure not sufficient to meet minimum calorific requirements)\(^{17}\). This section therefore reviews the prospects for allocating increased domestic revenues or development assistance to the health sector. This is not to deny the considerable scope for financing part of the cost by re-allocation and efficiency savings from existing health expenditures, both public and private – a subject discussed in section 6.

5.2 Prospects for Domestic Revenues

43. The growth of domestic resources is expected to be broadly limited to the growth of GDP. Although the tax GDP ratio of about 14% may seem modest, a large share of the economy is based on subsistence and difficult to tax. Tax rates within the modern sector are high relative to regional neighbours, and will reduce as a consequence of regional trade agreements. Improvements in tax administration have been made, and there is believed to be little scope for further significant gains. The tax share will eventually grow as the economy becomes more monetised, but this is not expected to result in any significant increase in the tax:GDP ratio before 2015, and it will only reach 15% of GDP by 2020.

44. Total domestic revenue, on the high growth assumption, will increase by about $29 per capita between 2005 and 2015 (based on 2005 prices), and by about $70 by 2020 (Table 3). However, it is possible that Rwanda may not succeed in accelerating economic growth beyond the 5% per annum rate achieved over the last five years. Continuing to achieve 5% per annum growth would be disappointing, but is not a particularly pessimistic assumption. Growth has slowed now that the post-genocide recovery phase is completed. The fundamental problems of acute pressure on land, high transport costs, and location in an unstable region have not gone away. There is as yet no sign that productivity growth is occurring in the productive sectors. Growth remains vulnerable to weather related shocks that may become more frequent as a result of global warming. Maintaining even the existing growth rate will not be achieved easily.

45. The consequence of a 5% p.a. growth scenario is that total domestic revenue per capita would increase by just $9 by 2015 and only $19 by 2020.


\(^{16}\) Smithson and Martinez quote studies by SCF (2005), MOH (2005), and Kalk et al.

\(^{17}\) Gaspard Ahobamuteze, Catherine Dom, Charles Harvey, Ray Purcell, Evaluation of General Budget Support, Rwanda Country Report, Inception Phase, (Draft); November 2004.
5.3 The Health Sector Share of Public Expenditure

46.Spending on health has increased markedly in recent years, and accounts for an estimated 10% of public expenditure (Figure 1).\textsuperscript{18}

\textbf{Figure 1: Health Share of Government Spending}

\begin{center}
\includegraphics[width=\textwidth]{figure1.png}
\end{center}

Source: MINISANTE

47.However, infrastructure and agriculture have been relatively neglected. Major investments in the road network are needed to support economic growth and poverty reduction. Major investments are needed in energy and in water and sanitation. If policy issues can be resolved and a sound plan put in place, agricultural services would merit an increase from the current 2% share of public expenditure. An initial draft of a longer-term investment program and framework for Rwanda estimates that the cost of public investment in sectors directly supporting economic development (infrastructure plus services supporting agriculture and industry) will grow to over $600mn p.a. in 2011-2015. As a share of GDP, and based on the very optimistic assumption that GDP growth will double to more than 10% per annum, public investment in these sectors is expected to increase from around 9% of GDP in 2005 to 18% in 2011-2015. The estimated investment needs would represent a larger share still if growth does not increase from current levels. The particular approach to quantification used in the draft investment framework may be open to challenge, but there is broad agreement on the need for substantially increased investment in infrastructure and related growth-supporting areas.

48.The scope for Rwanda to finance increased infrastructure investments via the private sector is limited. Equity investment is unlikely to be attracted on the required scale given the perceived risk of the country and the region and the relatively small and impoverished market. The scope for public sector borrowing even on concessional terms is severely constrained by the post HIPC agreement, with the macro-economic projections envisaging public sector borrowing of not much more than $20mn per annum.

\textsuperscript{18} These MINISANTE figures are higher than analysis done by Owen Smith of the World Bank for the PRSG review, which suggests a share of 8% in both 2005 outturn and the 2006 budget. PRSG policy agreement calls for a 10% share from 2007.
49. The requirement for an increased share for infrastructure implies some difficult choices need to be made for some other area of expenditure. Rwanda has achieved good progress in expanding priority expenditure programmes by reducing defence spending, and there are prospects for reducing other exceptional spending as the process of bringing those involved in the genocide to justice phases down. The case for the further increase in the share of the health sector for which the Ministry of Health and some donors have been pressing needs to be weighed against competing claims on scarce resources, including the need for a massively expanded investment in infrastructure.

50. If health is allocated a broadly constant 10% share of domestic revenue, a reasonable assumption given the demands from other sectors, then (even with the high growth scenario) Rwanda would only have an additional $3 p.c. of domestic revenues to spend on health by 2015, and only $7 by 2020. If economic growth were to continue at the present average rate of 5% per annum, the scope for financing additional health expenditures from domestic financing is just $2 extra by 2020, equivalent to less than 10% of the incremental cost of the scaling up package (Table 3).

51. There may be trade-offs. Maintaining the existing health share today may leave more scope to finance infrastructure investments that result in higher economic growth from which higher health spending can be financed in the future. Conversely, the gains from a higher health share may be offset to the extent that reduced infrastructure spending causes slower economic growth and reduces future revenues. Decisions on how much to allocate to health need to be taken in the context of the overall prioritisation of the EDPRS and the MTEF in the light of the resources available.

5.4 How Much Extra Aid Is Needed to Implement the Health Package?

52. If the financing gap has to be met from additional spending, and based on our ‘high growth’ assumptions concerning domestic revenues, the financing gap to be met from additional aid would be $130mn per annum by 2010, increasing to $215mn by 2015, and would only decline gently to about $180mn by 2020 (Table 3).

53. This financing scenario is challenging enough, requiring a leap of faith to believe that a doubling or more of aid for health for Rwanda can be attracted and sustained for so many years: these sums come on top of the significant ramping up of health spending that has already taken place, with external aid to the health sector having grown from $27mn in 2002 to $75mn in 2005 (Public Expenditure Review)\(^\text{19}\). However, if growth is only 5% per annum, and Rwanda were to go ahead and implement the six steps, the additional aid required for health would increase continuously, reaching $250mn per annum by 2020, and still increasing.

\(^\text{19}\) République Du Rwanda, Ministère De La Santé, Revue Des Dépenses Publiques Dans Le Secteur De La Santé 2002-2005, [Rapport Provisoire], Guy De Scorraille, Jacquie Nachtiga, L, Jean Munyenpenda, Janvier 2006. MINISANTE give still higher and possibly more complete figures showing over $100mn health aid in 2005.
Table 3: Can $20 p.c. Extra Health Spending be Financed?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Ave GDP Growth, Previous 5 years</td>
<td>7.5%</td>
<td>11.0%</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Domestic revenue – US $ per capita</td>
<td>32</td>
<td>40</td>
<td>61</td>
<td>104</td>
</tr>
<tr>
<td>Of which, available for health spending (10% of total)</td>
<td>3.2</td>
<td>4.0</td>
<td>6.1</td>
<td>10.4</td>
</tr>
<tr>
<td>Cumulative Incremental Domestic health rev, US $ p.c.</td>
<td>0</td>
<td>0.8</td>
<td>2.9</td>
<td>7.2</td>
</tr>
<tr>
<td>Gap to be met by donors, US $ per capita</td>
<td>12.0</td>
<td>17.6</td>
<td>13.3</td>
<td></td>
</tr>
<tr>
<td>Additional health aid needed, $mn total</td>
<td>130</td>
<td>215</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td>Add. Health spend as % GDP</td>
<td>4.5</td>
<td>4.7</td>
<td>3.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuation of Recent 5% GDP Growth rate</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic revenue p.c. in US $</td>
<td>32</td>
<td>36</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>Health 10% share of domestic revenue, US $ p.c.</td>
<td>3.2</td>
<td>3.6</td>
<td>4.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Cumulative incremental domestic health revenue p.c.</td>
<td>0.4</td>
<td>0.9</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Gap to be met by donors, US $ per capita</td>
<td>12.4</td>
<td>19.6</td>
<td>18.6</td>
<td></td>
</tr>
<tr>
<td>Additional health aid needed, $mn total</td>
<td>135</td>
<td>239</td>
<td>251</td>
<td></td>
</tr>
<tr>
<td>Add health spend as % GDP</td>
<td>5.0</td>
<td>7.0</td>
<td>6.1</td>
<td></td>
</tr>
</tbody>
</table>

5.5 How Much Extra Aid is Available?

54. The feasibility of meeting the implied additional expenditure requirements needs to be examined in the light of current and prospective aid levels. The EFU data base suggests total aid disbursements to all sectors of around $300mn in 2005, but this is acknowledged to be incomplete. Adding in roughly $100mn of World Bank disbursements that were not captured, plus another $50mn or so to cover spending by Global Fund, CDC and US Department of Defence, and other smaller sources not covered, a reasonable estimate is that current levels of aid disbursement to Rwanda are of the order of $450mn. This is roughly the order of magnitude of external development assistance included in IMF balance of payments tables for Rwanda in 2005, and implies that external aid to Rwanda is around 20% of GDP.

55. The DAC forecasts that aid to Africa will roughly double between 2004 and 2010. A doubling of aid to Rwanda by 2010 would imply aid increasing to approaching one third of GDP. However, Rwanda is relatively well-aided, and even if total aid to Africa doubles as donors have promised, aid to Rwanda is likely to increase more slowly. Much of the additional aid is likely to flow to fragile states and to countries that have been relatively under-aided. Rwanda has also found that HIPC and the Multilateral Debt Relief Initiative has actually reduced flows from some important financing sources. Countries receiving their IDA allocation as grants for example are subject to a discount of up to 20% on future allocations, one of the factors resulting in the IDA lending programme to Rwanda falling from $115mn p.a. in 2002-2005, to a planned $79mn p.a. in 2006-820. The IMF, based on donor indications of support, assume external support rising to $530mn by 2010, $665mn by 2015, and $770mn by 2020, implying a nearly 50% increase in aid by 2015.

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5.6 Conclusions: Can Rwanda Finance an Additional $20 p.c. Public Expenditure on Health?

56. If Aid to Rwanda were to double by 2010 and then be maintained at that level, and if the very high growth scenario were to be achieved, total financial resources available to the public sector would increase by $56 per head by 2015 (Table 4). If health were also allocated the very high 15% share agreed at Abuja, this would permit an extra $8 per head in health spending, which could cover a large share of the strengthening of services at community health centres and district hospitals. However, as we have seen, all three assumptions are relatively optimistic, and it would be unwise to plan the future expansion of health services on the assumption that all three will be achieved simultaneously. If aid increases by 50% and growth continues at current rates, Rwanda will have at most an extra $3 to spend on health by 2015.

Table 4: What Additional Resources are Available for Health?

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V. High GDP Growth With Doubling of Aid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP p.c.</td>
<td>228</td>
<td>289</td>
<td>437</td>
<td>692</td>
<td></td>
</tr>
<tr>
<td>Domestic Revenue p.c.</td>
<td>32</td>
<td>40</td>
<td>61</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Aid p.c.</td>
<td>47</td>
<td>83</td>
<td>74</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Total Resources p.c.</td>
<td>79</td>
<td>123</td>
<td>135</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Health @ 15% of the increase</td>
<td>12</td>
<td>18</td>
<td>20</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>Health @ 10% of the increase</td>
<td>12</td>
<td>16</td>
<td>18</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td><strong>Moderate Aid Increase with 5% p.a. GDP Growth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP p.c.</td>
<td>228</td>
<td>257</td>
<td>293</td>
<td>337</td>
<td></td>
</tr>
<tr>
<td>Domestic Revenue p.c.</td>
<td>32</td>
<td>36</td>
<td>41</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Aid p.c.</td>
<td>47</td>
<td>49</td>
<td>55</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Total Resources p.c.</td>
<td>79</td>
<td>85</td>
<td>96</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>Health @ 15% of the increase</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Health @ 10% of the increase</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>

57. The implication of the lower but by no means unrealistic scenario is that Rwanda can not afford to implement the $20 cost of the six steps by 2015 even if it devotes all of the additional resources that become available to the health sector. Even on the most optimistic assumptions of aid doubling and the economy accelerating rapidly to double digit growth rates, the health package would require an unaffordable 36% of the additional resources becoming available.

58. It is evident that Rwanda neither can nor should allocate such large shares of additional resources to the health sector given the requirements of other sectors. According to the long term investment projections, economic infrastructure and support to agriculture and industry will require an additional $400mn p.a. by 2015 (or $33 per head), while Government must also provide for education, social protection, and the general rise in expenditure generated by population growth and rising salary costs.

59. Even the most basic three first steps can not be funded only from the likely increase in public resources. Rwanda will thus need to examine critical trade offs. This implies i) allocating the potential few incremental dollars of fiscal space to the most efficient areas ii) relying on a more efficient use of private funding and making better use of existing
resources. As we shall see, the problems caused by the existing aid management practices mean that there is ample opportunity to get improved outcomes from existing aid – if the development partners are able to align themselves behind the Government strategy.

60. Table 5 provides an alternative presentation of the financing implications of each step of the MBB package.

<table>
<thead>
<tr>
<th>Step</th>
<th>Cum. Cost $Mn</th>
<th>GDP Growth</th>
<th>Health Share of Domestic Revenue</th>
<th>Contribution of Domestic Revenues $mn</th>
<th>Required Aid Increase or Re-Allocation $Mns</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>36</td>
<td>5.0</td>
<td>10</td>
<td>11</td>
<td>25</td>
<td>Feasible if challenging, aid increase by 2015 in 14-30% range, health share could be less than 15% with some re-allocation of existing resources.</td>
</tr>
<tr>
<td>2</td>
<td>54</td>
<td>5.5</td>
<td>15</td>
<td>40</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>77</td>
<td>6.0</td>
<td>15</td>
<td>44</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>114</td>
<td>7.0</td>
<td>15</td>
<td>51</td>
<td>63</td>
<td>Need for 60% aid increase, faster growth and 15% health share could be reduced with some re-allocation.</td>
</tr>
<tr>
<td>5</td>
<td>148</td>
<td>7.0</td>
<td>15</td>
<td>51</td>
<td>97</td>
<td>Requires aid to double, high budget share, and high growth.</td>
</tr>
<tr>
<td>6</td>
<td>250</td>
<td>8.0</td>
<td>15</td>
<td>60</td>
<td>190</td>
<td>Requires aid to nearly triple, high growth, and high budget share.</td>
</tr>
</tbody>
</table>

61. Steps 1-3 could be financed with a moderate 15-30% real aid increase. Step 3 would require some acceleration in economic growth and the increased health share of domestic resources will be difficult for the reasons we have discussed. The financing burden would be far easier to manage if a significant share of existing health aid could be re-assigned to finance these steps.

62. Step 4 looks to be more difficult to finance, we show that it could be achieved with a combination such as 7% p.a. GDP growth, a 15% health share, and a 60% increase in aid to health. This is a challenging combination, and bringing step 4 within reach is likely to need a significant contribution from re-allocating existing aid to health. The final steps, involving tertiary hospitals and extension of HIV treatment, are progressively more difficult, and step 6 looks beyond reach unless aid commitments can be increased by significantly more than has yet been indicated, with the increase sustained to 2020 and beyond.

5.7 Macro-Economic Implications of Scaling Up

63. If Rwanda succeeds in attracting the necessary additional external finance for scaling up public expenditure to meet the MDGs, it will need to consider the macro-economic
implications. Although there are theoretical risks that increased aid can damage competitiveness and long-run economic growth, it is worth bearing in mind in the case of Rwanda that aid does not seem to have damaged economic recovery in the 1995-99 period when very rapid economic growth accompanied aid averaging 28% of Gross National Income, significantly higher than current levels of about 20%.

64. Spending a large increase in external resources largely on local cost intensive scaling up of decentralised health expenditures may require a rise in the real exchange rate if the extra spending is to avoid squeezing private sector investment and access to credit. The effect is not inevitable, and can be avoided if the aid is used to finance imports or to overcome supply constraints, a further argument for balancing the share of extra resources devoted to health against the needs for higher infrastructure investment. In any case the value of the aid and the positive benefits of cheaper imports should greatly exceed any negative effect on the much lower volume of exports. Although the authorities need to monitor the macro-economic impact of aid, the risks can and should be managed if and when problems are experienced. They are not a reason for refusing aid.

65. The macro-economic consequences of increased aid are made more difficult to manage when a large share of aid flows outside direct Government knowledge. For example, Central Government only controls 14% of donor expenditure on health. Any surge in aid requires off-setting action to avoid inflation. The authorities have three main options. They can soak up the excess money demand by selling Government securities, thereby raising interest costs and squeezing private sector credit and investment. They can reduce Government money demand by raising taxes or imposing spending cuts. They can accommodate the increased demand by selling foreign exchange reserves to finance imports, accepting the risk that the exchange rate may appreciate and damage exports. The problem with unexpected aid windfalls is that it is difficult for Government to diagnose the cause, or plan a response, with considerable risk of inappropriate short-term measures being taken that unnecessarily damage either the private sector or the implementation of the budget. Bringing aid on budget is therefore not only important for achieving improved and more sustainable services; it also facilitates sound macro-economic management.

66. The biggest concern about expanding health expenditure using aid is the risk that the aid will not materialise or will not be sustained, and the additional services will collapse. There have anecdotally already been problems where HIV/AIDS treatment services initiated using external aid have been interrupted when subsequent applications required to sustain the treatment were rejected – a disaster for the patients, given that Government (as we have seen) has no realistic prospect of assuming these obligations.
6. CAN RWANDA MAKE BETTER USE OF EXISTING RESOURCES?

6.1 Overall Public Finance Management

67. Annex 1 briefly summarises the impressive improvements that Rwanda has made in the allocation and management of public expenditure. A coherent and sound planning and budgeting framework is being put in place. Public financial management has improved from a very low base, and a comprehensive approach is being taken to achieve further strengthening, with the coordinated support and careful monitoring of the budget support donors. Corruption risks are relatively low.

6.2 The Health Sector

68. We have seen that Government has increased health sector spending dramatically, and now spends a relatively high share of resources on the health sector compared to other countries in the region, having until recently been one of the low spenders.

69. Donors have increased their expenditure even more dramatically. Even in 2003, donor support earmarked to the health sector accounted for 42% of total health expenditure, and for 56% of combined Government plus donor spending. With the subsequent doubling of donor disbursements, the share of donor support will have further increased, without considering the indirect contribution made by general budget support.

70. In 2003, some 31% of donor funds, and some 46% of Government health spending, was absorbed in administration costs. The high share of GOR expenditure reported to be on health administration may actually be an exaggeration, failing to distinguish some service-related expenditures that were delivered from the centre, and the Government share will have reduced since 2003 with the radical slimming down of the Health Ministry, which now has less than 40 officers. However, the very high administration costs also reflect the consequences for MINISANTE and for donors of a very fragmented and short-term pattern of financing. Rwanda has 21 official donors, mainly disbursing funds via the more than 40 NGOs and far larger number of local CSOs and CBOs operating in a largely uncoordinated way. PEPFAR alone is said to disburse funds via more than 50 separate implementing organisations, resulting in cases where the same district or the same facility is receiving support from several different agents, although the funding all comes from a single donor. Administration costs are further raised by the continuous need to re-negotiate: some 55% of the portfolio of health projects is scheduled to end in one year or less.

71. The strong donor preference is to either disburse via NGOs or to manage funds themselves or send them directly to local-level projects (Table 6).

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21 MINISANTE, National Health Accounts, April 2006.
22 http://www.state.gov/s/gac/countries/fc/rwanda/partners/. Over 50 ‘prime’ and ‘sub-partners’ are listed, without even including the large number of public sector health centres and hospitals listed as sub-partners.
Table 6: Who Spends Donor Aid for Health? SOURCE: NHA op cit

<table>
<thead>
<tr>
<th>Financing Agent</th>
<th>Percentage of Donor Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Govt</td>
<td>14.3</td>
</tr>
<tr>
<td>NGO</td>
<td>54.8</td>
</tr>
<tr>
<td>Development Partner Direct Management</td>
<td>19.0</td>
</tr>
<tr>
<td>Direct to Local Government or Health District</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
</tr>
</tbody>
</table>

72. Central Government manages only 14% of donor support to the health sector, making it impossible for Government to plan and manage health services as a system, even though over three quarters of health services are delivered from Government facilities or from Government-assisted not for profit service providers who are seen as very much part of the public system. Indeed, the 2003 National Health Accounts show that all of the funding that was disbursed via NGOs ultimately was spent in public or public-sector assisted health facilities. The NGOs as financing agents manage a larger share of total health expenditure (27%) than does Government (20%). This comparison probably overstates the real financial weight of Government in decisions over service provision, since over a third of Government spending is taken up with paying wages and salaries.23

73. The predictable consequence of this chaotic funding landscape has been gross misallocation of resources, well documented in the 2005 MINISANTE mapping study, with per capita spending varying from $1.86 per capita in the least funded province to $11.84 in the highest funded (Figure 2).

Figure 2: Geographical Inequality in Health Spending

<table>
<thead>
<tr>
<th>Geographic Distribution of Donor and Govt funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROCKGREEN</td>
</tr>
<tr>
<td>$15</td>
</tr>
</tbody>
</table>

SOURCE: MINISANTE Department of Planning Donor Mapping Study 2005

23 PER op cit. The personnel costs were 34.5% of MINISANTE spending in 2003, but have varied between 25% and 47% of the MINISANTE budget in the years 2002-2005.
74. Similar inequalities afflict the distribution of donor funding by strategic objective, with $18mn earmarked for malaria (the biggest cause of mortality and morbidity) and just $1mn for the integrated management of childhood illnesses, compared to a grossly disproportionate $47mn for HIV/AIDS (Figure 3). The basic problem is that single-issue funds and single-issue projects are being used to disburse funds through centralised allocation mechanisms that do not respond to the relative importance of needs as perceived by patients and health providers.

Figure 3: Distribution of Donor Funding by Strategic Objective

75. The proliferation of NGOs is also exacerbating the already severe human resources difficulties in the health sector, with physicians employed by NGOs to deliver HIV/AIDS services paid almost six times as much as physicians paid by the MOH. Such differences in salaries make it particularly challenging to keep well qualified health personnel in the public sector.\(^{24}\)

76. The unplanned nature of the health sector also introduces major problems of sustainability, with potentially tragic consequences. Most of the increased resources for health are being programmed in a very short-term way, annually in the case of PEPFAR, 2-5 years in the case of the Global Fund. There is no clear commitment to sustain support to institutions, or to the patients who have been started on HIV/AIDS treatment, and there have reportedly already been problems of lack of continuity of donor funding.

\(^{24}\) MINISANTE, Human Resources for Health Strategic Plan 2006-2010, 2nd Draft, April 2006.
leading to interrupted treatment. If donors do not provide long-term guaranteed funding, we have already seen that GOR is in no position to take on the responsibility.

77. The consequence of the misallocation of resources, the vertical funding, and the shortage and poor allocation of staff (with a heavy concentration in Kigali) is that the service achieves low coverage. According to the 2005 MNCH study, only 2 from 12 life-saving maternal, neo-natal and child health interventions reached more than half of potential users, with most achieving less than 20% coverage. Part of the problem is that disease specific programmes do not exploit all of the opportunities when people visit the health centre, dealing with the specific problem but not taking the opportunity to also deliver other aspects of the minimum package.

6.3 Health Sector Strategic Plan

78. Government recognises these multiple problems, but it lacks the financial resources to address them, because so much of the available funding is flowing outside the plan (indeed, much of it is unplanned) and outside the budget.

79. One key plank of the health sector strategic plan is to decentralise Government expenditure and provide an increasing share of resources in the form of performance based payments to service providers at community, health centre, and district hospital level. The basic idea is to provide incentives to health providers to deliver by making payments related to outputs achieved (e.g. number of fully immunised children) rather than simply financing the inputs (doses of vaccine). Careful thought has been given to the selection of indicators, to reflect the delivery of critical outputs from the essential service package, and to how the contracts will be managed and how performance will be verified. The approach encourages health providers to take full advantage of opportunities to reach the population with the full package of relevant interventions. The rapid scaling up that is underway within the Health Sector Strategic Plan 2005-2009 follows on from pilot projects that appeared to achieve both higher outputs and improved service quality compared to services based on the traditional input-focused approach.

80. The payments at present are modest, intended to provide incentive payments for staff rather than meet the full cost. Most health interventions continue to require payments from the patient. Households shoulder a large share of curative costs, financing 43% of total curative and pharmaceutical expenditure. Given the limited resources, and the limited prospects for their future growth, the Government takes the view that the population will need to continue to invest in health. It recognises, however, that financial barriers to access have been a major cause of low utilisation of health services. Reducing financial barriers to access is a priority of the HSSP, to be achieved by extending coverage of basic health insurance (the mutuelles), while providing a safety net by paying the costs for the poorest 20%. Membership of a health insurance scheme

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25 Paul Smithson and Javier Martinez, Addressing Health MDGs in Rwanda, Progress, Gaps, Challenges and Opportunities, DFID Resource Centre, February 2006.

26 NHA, op cit.
is to be made compulsory, and mutuelle membership already covers 44% of the population.

81. The policy will at a minimum bring many extra poor people within financial reach of modern health services, though for those not qualifying as 'indigent', having to pay compulsory membership of mutuelles, at a cost of $2 per head, will be difficult for many rural households. Assessing what will happen in practice is however not straightforward, as there are other safety nets available (for example, child headed households do not pay), and arrangements for communal credit and for deferred payment in some areas, which will help households to manage the costs. By making regular payments households will at least be partly relieved of the need to face high bills in times of illness when they are least able to pay them. The challenge of what happens in a drought year will need to be faced at some stage.

82. A further but related problem is that the fees paid to the mutuelles do not cover the full cost of the services that are intended to be covered. Practices differ across the country, but the deficit either falls on the health provider if the mutuelle makes a fixed payment per person covered, or the deficit falls on the mutuelle if the health facility bills for every intervention provided. The alternatives are either that the provider has to ration the service, implying that the population does not receive the package of services it has been promised, or the mutuelle faces bills that can not be covered from membership fees. The issue of willingness and ability to pay, and the question of how to place mutuelle funding on a sustainable basis, is one that arguably needs further study and policy development.

83. One way out of this dilemma, if the financial resources could be made available, is to use the two instruments of mutuelle fees and performance contracts together, in order to fill the financing gap between costs incurred and payments made to health providers. As we can see from the MBB analysis (Table 2), the first three steps encompassing these two interventions could deliver by 2015 a 40% reduction in child mortality and a 20% reduction in maternal mortality at an additional cost of just $6.80 per capita, or $83mn per annum. It should be feasible to finance (Table 5), especially if existing donor resources and future commitments for health are more rationally distributed. It is misplaced donor priorities that risk making it unaffordable.

84. There is also scope for re-directing some Government expenditure. For example, Government expenditure on tertiary care, particularly at the private for profit King Faisal Hospital, has been an issue for discussion with donors. However, the sums involved (roughly $5mn in subsidies for all three tertiary hospitals in 2004, expected to grow to around $7mn by 2008 according to the present MTEF) are dwarfed by annual donor spending of $100mn or more.

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27 Smithson and Martinez quote studies by SCF (2005), MOH (2005), and Kalk et al.
28 Calculated from figures in Owen Smith, King Faisal Hospital: Challenges and Opportunities. World Bank, internal memo.
85. The conclusions from this analysis of existing financing patterns and of future prospects are that:

i. Even if the Vision 2020 growth targets are achieved and combined with aid doubling in real terms, the additional public funding will be insufficient to establish even the $9 package of health services at community health centre and district level by 2015, let alone the $20 package including HAART treatment. Only the most basic health package at community and health centre levels could be subsidized by additional public funds.

ii. Additional resources will have greatest impact if they are focused on the HSSP, channelled through the Government budget, and used to extend the community schemes, the performance payments and the safety net for mutuelle membership. The Global Fund has recently committed resources to funding mutuelle payments in six provinces, showing that there is scope for the disease-specific funds to support system improvements that are linked to outputs relevant to their core mandate29. However, the commitment is only for five years, and has created a contingent liability to the government while there is no long-term funding to sustain it. This creates an additional fiscal risk.

iii. The MBB approach focuses on the impact of additional resources. A key question is how to supplement the additional resources becoming available by also re-allocating existing health sector expenditure towards expenditures with a higher expected impact on the MDG goals. The greatest potential (discussed in the next section) relates to the $11 per head of existing ODA to the health sector, although there is also significant scope to make the relatively smaller sums available from the Government budget and private expenditures work better for the MDGs. This calls for a careful assessment of the current allocations, increased attention to trade offs, progressive correction of the most important distortions in public expenditure, and improved channelling of private spending.

iv. In summary, the fundamental challenge remains how to make the best use of whatever resources are available in order to get as close as possible to the Vision 2020 goals and the MDGs. This will also help Rwanda to attract and sustain the additional resources it needs in order to narrow the funding gaps.

7. IMPROVING THE ALLOCATION AND MANAGEMENT OF AID

7.1 The Problems

86. The problems that need to be addressed can be summarised as:-

- Dependence on short-term aid commitments to fund long-term expenditure programmes, with attendant risks to sustainability of the health system;

- Distortion of the current system for allocating resources where they are needed, a problem that needs to be addressed by putting the Government back in control of the allocation of resources in the health sector;

- High transactions costs, with too high a proportion of funds absorbed in management rather than paying for service delivery.

7.2 Government Aid Policy

87. The Government is concerned about the problems posed by the way that aid is provided, and is in the process of producing an Aid Policy to address them. A participatory approach is being taken, with donors asked to undertake self-assessments with respect to the provisions in the draft policy, followed by each donor discussing with Government a ‘statement of intent’ and an Action Plan. Towards the end of the year, these will be brought together into a Joint Proposal and Action Plan. If the process goes smoothly, there would be a Joint Agreement or Compact signed between Government and Development Partners by the time the new Economic Development and Poverty Reduction Strategy is finalised in late 2006 or early 2007 (Figure 4).

88. This overall process is complemented by actions that have been taken in other forums to cover specific issues:-

   i. The donors providing budget support have agreed a Partnership Framework for Harmonisation and Alignment of Budget Support;

   ii. Within the education sector, donors have agreed on both a set of Partnership Principles, and a Joint Financing Agreement for those donors who wish to provide budget support that is specific to the sector. Both documents are considered by MINECOFIN to be models that could be adapted to other sectors.
7.3 What Can the High-level Forum Add?

89. If the discussions on the aid policy are largely confined to the country-level staff of the agencies, the danger is that the conversation will be limited by the boundaries set by existing policies and procedures of each donor. The advantage of the High Level Forum is that, as the name implies, it gathers together the political leadership and top management of aid agencies, the people with the power to change policies and reform unhelpful procedures. The delegates can do a significant service to the people of Rwanda by focusing sustained attention on the problems, empowering and supporting Rwanda country staff to identify those aspects of existing approaches that need to be changed, and deploying the necessary technical resources to enable the changes to be
made. Solutions piloted in one or two countries by a core of willing donors can later be extended to other countries, and will over time be joined by new donors as the innovative approaches are proven. There is a successful precedent for the approach that is being proposed, in the work of the SPA in the early 1990s (Box 1).

Box 1: The SPA Joint Evaluation Missions: An Example of Using High-Level Pressure to Support Country-Level Changes in Aid Policy

In the 1990s, African countries were being urged to liberalise their foreign exchange markets, but the balance of payments support that was being provided by the donors was in the form of specific imports for specific end-users, a form of rationing that was an obstacle to the objective of market allocation of foreign exchange. The SPA produced guidelines advocating a more market-determined approach, but individual donors were concerned about the perceived fiduciary risks. A series of high-level missions were undertaken to find solutions at country level. They involved senior level economic, procurement, disbursement, accounting and audit staff from the donor agencies, and aimed to reconcile the need for a market solution, with the need for accountability. They found ways to provide direct support to liberalised foreign exchange markets while meeting fiduciary concerns. The liberal approaches initially used by a few donors in a few countries soon had a 'snowball' effect and were widely adopted.

The key to success was the combination of high-level recognition of the problem leading to country-level action to find solutions by drawing on senior level staff with the authority to challenge existing approaches.

Source: Mick Foster, personal recollection.

90. In order to give a more concrete form to what might otherwise seem a somewhat vague proposal, we have produced zero drafts of two documents as examples of how the approach might develop in Rwanda, and the type of agreement that is needed:--

- An overall 'Compact' (Annex 1). This proposes an approach whereby donors would support an agreed and costed Government strategy by collectively providing assurances of minimum levels of long-term financing, provided on plan and on budget (though not necessarily ruling out some use of parallel procedures for donors unable to give budget support). In return, Government would undertake to abide by the strategy, respect agreed processes of monitoring and consultation, put in place sound financial management, and maintain a stable and supportive social, political and economic climate. To ensure fairness, compliance by both Government and donor partners would be independently verified, and pressure for donor compliance would be reinforced by transparency, to provide opportunities for pro-aid lobbyists to hold agencies to account.

- A health sector Memorandum of Understanding (Annex 2), setting out partnership principles that will be applied by Government and donors working within the health sector. This is consistent with the overall ‘compact’, but adds more detail on how coordination at sector level will work, laying particular stress on the importance of a joint process for identifying where financing is needed and directing future Government and donor commitments towards the gaps.
It should be stressed that these drafts are provided as examples: they have received little discussion, and do not represent either Government policy or donor views. They are based on existing Rwanda specific models, but they go further in several specific areas. The ‘compact’ draws in part on the draft aid policy (Box 2). Points that are additional to the draft aid policy have been highlighted.

**Box 2: Summary of Draft Compact and Differences from Draft Aid Policy**

(Additions are highlighted)

<table>
<thead>
<tr>
<th>Draft Compact</th>
<th>Differences from Aid Policy Rev 4?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relation to Planning and Budget processes</strong></td>
<td>Consistent: Projects to be on-plan and on-budget. Aid Policy emphasises the need to prevent excessive financing of sub-sectors, and preference for allocation mechanisms that achieve equity between districts.</td>
</tr>
<tr>
<td>All aid supports Vision 2020 and EDPRS and should be included in the budget estimates and MTEF, even if it uses parallel donor procedures to disburse and account for the funds. Aid for projects not meeting these criteria will only be accepted if the proposal is shown to be sustainable. Development partners will participate in national planning and budgeting processes as set out in the Harmonisation and Alignment Calendar Commitments earmarked to specific purposes will be offset by adjustments to the allocation of other resources to preserve priorities across the budget as a whole.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of Sectors</th>
<th>Consistent with aid policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWAPs to plan and coordinate all resources flowing into a sector. Annual Joint Sector Review of performance timed in March to inform budget discussion and direct resources to future priorities. Clusters identify, cost, rank spending priorities, only those identified in sector investment/expenditure plans should be undertaken, either through the Government budget or as donor funded projects. Sector clusters identify a common agenda of analytical work</td>
<td>More explicit than Aid Policy on defining spending priorities, though this is the implication of aid being ‘on plan’ and ‘on budget.’ Consistent, but additional to Aid Policy</td>
</tr>
</tbody>
</table>
## Draft Compact

**Aid Modalities**

<table>
<thead>
<tr>
<th>Development partners unable to provide budget support will comply with Government budget and accounting procedures as far as their own operating and policy constraints will permit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other procedures will only be accepted if Government is satisfied that transaction costs are acceptable, the aid is aligned to Government priorities, and conditionalities are not excessive.</td>
</tr>
<tr>
<td>TA will be concerned primarily with building Government capacity and/or developing systems and procedures accessible for use by local staff.</td>
</tr>
<tr>
<td>The bulk of future development assistance needs to be provided in the form of grants.</td>
</tr>
<tr>
<td>Government and development partners will work to reduce the tying of aid.</td>
</tr>
<tr>
<td>All aid transactions will have signed agreements cleared with MINECOFIN.</td>
</tr>
</tbody>
</table>

**Government Commitments**

<table>
<thead>
<tr>
<th>Costed sector plans consistent with EDPRS, produced in consultation, clear objectives, single M &amp; E framework.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation on significant revisions to plans or budget priorities</td>
</tr>
<tr>
<td>Maintain domestic revenue:GDP ratio</td>
</tr>
<tr>
<td>Restraint on expenditures not in line with EDPRS priorities.</td>
</tr>
<tr>
<td>Continue implementing comprehensive reforms in public finance management, annual reviews of progress</td>
</tr>
<tr>
<td>Verify public finance management performance through PETS and other independent studies. Promote accountability to the public through access to information.</td>
</tr>
</tbody>
</table>

## Differences from Aid Policy Rev 4?

<table>
<thead>
<tr>
<th>Consistent with Aid Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional to Aid Policy – though not inconsistent with it</td>
</tr>
<tr>
<td>Additional to Aid Policy</td>
</tr>
<tr>
<td>Additional to Aid Policy</td>
</tr>
<tr>
<td>Additional to Aid Policy</td>
</tr>
<tr>
<td><strong>Draft Compact</strong></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Assess aid management capacity needs, and prepare and implement a capacity building plan for strengthening aid management at all levels.</td>
</tr>
<tr>
<td>Maintain a stable and supportive social, political and economic climate.</td>
</tr>
<tr>
<td><strong>Development Partner Commitments</strong></td>
</tr>
<tr>
<td>Appoint a lead Donor</td>
</tr>
<tr>
<td>Guaranteed minimum total and budget support disbursements from signatories each year 2007-2015</td>
</tr>
<tr>
<td>Provide timely information on disbursements, commitments, expected future disbursements, in form requested for as far ahead as possible and at least MTEF period.</td>
</tr>
<tr>
<td>Each signatory informs and explains any changes to expected aid levels, with action being undertaken to address the causes of shortfalls.</td>
</tr>
<tr>
<td>Regular review of total disbursements against target level, lead donor coordinates action to avoid shortfalls.</td>
</tr>
<tr>
<td>Adjust minimum aid levels upwards if new signatories join the agreement.</td>
</tr>
<tr>
<td>Minimum aid levels may be adjusted down in consultation in the event of a sustained, major positive shock reducing aid need.</td>
</tr>
<tr>
<td>Minimum aid levels can be adjusted down if absorptive capacity problems reduce the budget execution rate, but re-allocation or simplification of procedures will first be examined, and the justification reviewed in the published report of the independent monitors.</td>
</tr>
<tr>
<td>Where budget support is not feasible, signatories will ensure aid is reported in the budget, follows SWAP principles, minimises transactions costs by supporting pooled funding or co-management with other donors.</td>
</tr>
<tr>
<td>Draft Compact</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Signatories will not seek to influence plans and budgets outside joint consultation arrangements.</td>
</tr>
<tr>
<td>Signatories will whenever possible use Government systems to procure, disburse, implement, report, monitor, account, and audit their assistance, providing coordinated technical assistance as required in order to strengthen those systems and make them fit for the purpose of meeting the full range of both Rwandan and external requirements.</td>
</tr>
<tr>
<td>Donors will to the extent possible rely on the national monitoring and evaluation system, minimising the request for additional reporting in formats different to those required by Government.</td>
</tr>
<tr>
<td>Rely on Joint Reviews, minimising the need for additional bilateral missions.</td>
</tr>
<tr>
<td>Reduce the number of active donors by increased specialisation, and/or by increased use of silent partnerships and reliance on lead donors.</td>
</tr>
<tr>
<td>Increase the delegation of authority to local representatives and their authority to align behind Government priorities and procedures.</td>
</tr>
<tr>
<td>Appoint a lead donor for sector and cross-cutting clusters, with sufficient capacity to coordinate views and enable the partners to speak with one voice.</td>
</tr>
</tbody>
</table>
Monitoring and Dispute resolution

<table>
<thead>
<tr>
<th></th>
<th>Aid Policy commits Government to regular independent monitoring of Government and donor performance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual reviews of both Government and donor compliance with the compact, informed by an independent report by a group nominated equally by Government and signatories.</td>
<td>Consultation period and deferral of sanctions to next budget year taken from Aid Policy</td>
</tr>
<tr>
<td>The minimum aid level can be reduced for Government non-compliance but only after a period of formal consultation, and will not be applied before the following budget year.</td>
<td>Aid Policy refers to mutual accountability, emphasis on publicity is additional.</td>
</tr>
<tr>
<td>Donor signatory compliance will be encouraged by peer pressure and prominent publicity for individual and collective donor performance against their obligations.</td>
<td></td>
</tr>
</tbody>
</table>

92. The starting point for the health sector MOU was the education sector partnership principles that have already been extensively discussed. Box 3 summarises the content of the MOU, and identifies which clauses are taken from existing GOR sources, and which are new proposals. New proposals are again highlighted.

**Box 3: Summary of Draft health Sector MOU**

<table>
<thead>
<tr>
<th>Proposed Health Sector MOU</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead donor to coordinate donor positions, manage the flow of information and documentation between donors, support MINISANTE coordination</td>
<td>Health cluster has a lead donor, roles more explicit based on education</td>
</tr>
<tr>
<td>Coordinate to achieve fewer active donors, operating on a larger scale, with enhanced capacity to engage in dialogue on health sector issues.</td>
<td>Added.</td>
</tr>
<tr>
<td>GBS donors to be full members of sector cluster.</td>
<td>Added, but consistent with GOR preferences.</td>
</tr>
<tr>
<td>Comply fully with aid policy and compact.</td>
<td>Added</td>
</tr>
<tr>
<td>Strategic Plan and Annual Operational Plan guide all resource allocation to the health sector.</td>
<td>Taken from draft education MOU, but would be a dramatic change from existing practice in the health sector.</td>
</tr>
<tr>
<td>The sector should identify, cost and rank sector spending priorities, assisted by tools such as Marginal Budgeting for Bottlenecks. Only the highest ranking spending priorities, which have been clearly identified in sector investment/expenditure plans, should be undertaken, either through the GOR budget or as donor funded projects.</td>
<td>Imported from the draft compact, based on a Uganda original.</td>
</tr>
<tr>
<td>All future external support to be aligned with the HSSP (on plan) and included in the health sector budget and MTEF.</td>
<td>Education MOU, and Aid Policy</td>
</tr>
<tr>
<td>New projects (including sub-components of larger programmes) should not distort the planned resource allocations within the sub-sectors as set out in the HSSP, and be subject to a formal Government led process of appraisal before approval.</td>
<td>Education MOU, formal appraisal added from Uganda education agreement.</td>
</tr>
</tbody>
</table>
Specifically, NGO activities supported through ODA should be subject to a planned process supervised by MINISANTE to achieve a better balance between districts.

Proposed Projects intended to be pilots will assess the cost-effectiveness of scaling up in their initial proposals.

Government will not seek aid for purposes not conforming to these criteria.

Donors initiating projects that do not comply with these criteria recognise the moral responsibility to sustain services that Government has not planned or budgeted for.

Added, to cover HIV/AIDS treatment risk

Signatories will provide longer-term commitments where possible

Signatories will provide timely information on commitments, disbursements, forecasts in the format requested

Prompt communication of changes in expected aid

Annual joint sector review of progress feeds into budget process, both backward looking and discussion of future objectives and financing

Added

Explicit commitments and cash flow forecasts for next year to be provided by budget and project donors by 4th quarter

Joint review budget and MTEF in 4th quarter cluster meetings

Joint review to be the lead forum for sector specific policy dialogue

Prior consultation with partners on significant policy and budget changes

Establish a common agenda of analytical work to avoid duplication

Donors use Government systems where possible, align as far as possible when not

Work to eliminate PIUs and parallel structures

TA to be aligned with Annual Sector Capacity-Building Plan

Negotiate understandings on rates to be paid to public employees participating in donor project activities. Exercise restraint on the numbers and terms for staff recruited for donor projects.

Common joint sector review with common monitoring framework permits separate reviews to be phased out.

New projects designed to support Government program and rely on Government reporting.

Donor performance to be reviewed annually, results publicised

8. NEXT STEPS

93. The Government has established a harmonisation and alignment ‘timetable’ for the period up to finalisation of the EDPRS and beyond, as well as a clear timetable for finalising the aid policy. It is important to support these existing processes, rather than cutting across them with a centrally-driven new approach. Meanwhile, the HLF delegates at high level need to do three things if the Rwanda process is to be successful and is to be extended to provide assured long-term financing:-

i. If delegates are supportive of the objective of providing assured long-term financing, the practical problem of how to provide a meaningful collective guarantee of future aid levels needs to be solved. There are a number of possible approaches. Informal arrangements at country level would depend on one or more donor agency being willing and able to act as the ‘swing donor’, providing additional donor disbursements to make up any shortfall in a given year, and providing sufficient time for a collective effort to generate new commitments to overcome any longer-term problem. The World Bank (which manages itself on a commitment basis) could possibly be the swing donor in the
short-term. There may also be a need for some formal institutional arrangement to protect against the risk of a long-term shortfall of disbursements relative to the guaranteed levels. This could be a role that the proposed international financing facility might perform, or could be underwritten by other approaches such as the proposed hypothecation of airline taxes, or the proposal to establish an aid guarantee facility. There are many ways in which an effective solution could be put in place, if the political will is present for the donors to bind themselves to the promises they have made. The challenge is to quickly put in place a mechanism to transfer the risk of donor under-performance to the donors, who should be far better able to manage the risk than are the Governments of low-income countries.

ii. The agency-wide impediments to compliance with the new aid policy need to be addressed with a spirit of trying to find innovative solutions. The process proposed by GOR, of asking each agency to undertake a self-assessment against the aid policy and to come up with a plan of action, is an excellent one. The role of the HLF should be to ensure that these self-assessments are conducted at the highest technical level within each agency, and that they lead to a serious examination of policies and procedures rather than a simple re-iteration of existing positions with minor adjustments. There may be a case for involving the senior staff responsible for establishing office procedures in joint reviews in country, together with their counterparts in Government and in other donor agencies, in order to understand the problems and develop solutions.

iii. Within Rwanda, and coordinated with the existing timetable, Government and donor agencies may wish to discuss whether to pursue any or all of the additions to the existing aid policy that are proposed in the attached drafts and summarised in Box 2 and Box 3. The first stage would be to present some of the ideas and to facilitate local discussion of whether and how they should be incorporated in the development of a national aid policy.

94. Box 4 summarises how the proposed HLF initiative could be implemented in a coordinated way alongside the existing Government timetable. The additional processes proposed to be added as a consequence of the HLF involvement are shown in red.
### Box 4: Proposed Timetable for Follow-Up Action

<table>
<thead>
<tr>
<th>Month</th>
<th>GOR</th>
<th>Donors Rwanda</th>
<th>Donor Senior management</th>
<th>Health Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 06</td>
<td></td>
<td>Budget support commitments made for 2007</td>
<td>Tunis meeting: At least a core group of HLF donors agree to develop an effective approach to assured, long-term, country specific aid commitments. Starts a process to put an agreed mechanism in place. <strong>After Tunis:</strong> High level encouragement to adopt compact, commit to Aid Policy process.</td>
<td>Cluster discussions on performance contracting and mutuelle financing issues, identify required funding and how it will be met in 2007-2009 MTEF period.</td>
</tr>
<tr>
<td>June 06</td>
<td></td>
<td>Sector budget consultations, donors make firm commitments of budget support and project aid for at least the MTEF period, longer if possible. Facilitated discussion of proposed ‘compact’ ideas, for possible adoption.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 06</td>
<td></td>
<td>Aid Policy is finalised? Donor self-assessments against Rwanda aid policy, with high-level involvement and commitment to be flexible, leading to interim statements of intent and action plans.</td>
<td>Health sector cluster consultations leading to forward looking strategy paper for EDPRS. <strong>MINECOFIN/MINISANTE</strong> negotiate MOU with cluster as key input to GOR taking leadership.</td>
<td></td>
</tr>
<tr>
<td>August 06</td>
<td></td>
<td>Discussion and agreement of joint statement of intent and Aid Policy Action Plan, with resolution of tricky issues facilitated by high-level technical missions, with top management encouragement and progress chasing.</td>
<td><strong>MINECOFIN/MINISANTE</strong> discuss long-term donor and budget commitments to HSSP, especially performance based contracts and mutuelles. Joint donor support to strengthen MINISANTE planning and coordination capacity.</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>GOR</td>
<td>Donors Rwanda</td>
<td>Donor Senior management</td>
<td>Health Sector</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>---------------</td>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>October 06</td>
<td></td>
<td></td>
<td></td>
<td>Planning and preparation for annual Joint review in March 2007, which will start the process of directing new commitments to EDPRS/HSSP, and will feed into budget and MTEF preparation. Ensure required inputs are in place to support both backward review and forward programming to support revised HSSP component of EDPRS.</td>
</tr>
<tr>
<td>November 06</td>
<td></td>
<td>In the context of the preparation of the 1st draft of EDPRS, discuss long-term funding needs and commitments, identify a probable resource envelope. Recruit donors willing in principle to provide long term commitments, and join a collective arrangement to secure those commitments. Agree with participating donors the annual amounts they will collectively provide. Reflect committed levels in 1st draft EDPRS resource envelope.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 06</td>
<td>Sign compact with willing donors, in time to underpin the new EDPRS.</td>
<td>Mechanism to underwrite minimum aid levels is agreed, with a timetable to ensure it is functioning in time to deliver agreed minimum aid levels in 2007.</td>
<td></td>
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</tr>
</tbody>
</table>
ANNEX 1 GOVERNMENT PLANNING, BUDGETING AND FINANCIAL MANAGEMENT IN RWANDA

The Government has articulated very clearly the relationships between the planning and budgeting instruments in Rwanda, and has set out a coherent ‘road map’ for the process leading to the finalisation of the new Economic Development and Poverty Reduction Strategy (EDPRS) that will follow-on from the existing PRSP. The overall direction is set by the long-term ‘Vision 2020’ document. The EDPRS provides the medium-term policy and strategic framework, based on consolidation of the sector strategies produced by working groups with broad participation.

Considerable thought has been given to how the EDPRS will be reflected in the budget. The plans will be implemented via a Medium Term Expenditure Framework (MTEF) and annual budgets that are being re-shaped to be more results-oriented, with the chart of accounts being revised to permit the strategic objectives of EDPRS to be mapped to the allocation of the budget. The intention is that operational plans will clearly identify responsibilities and timetables, and that annual sector reviews will be able to link expenditures to the outputs intended and actual achievements.

Decentralisation is a major theme of Government policy. The results oriented focus and the MTEF approach are being extended to local authorities. Districts are asked to produce an MTEF and budget to broadly the same timetable, covering expenditure from their own revenues, from block grants, from conditional grants, and from external sources. They are required to sign a ‘contract’ with the President in return for the resources they receive. Budget releases will depend on them providing quarterly financial reports and reports on what has been achieved with the resources provided.

An MDG ‘needs assessment’ is being undertaken and will be developed into three planning scenarios between May and October 2006, recognising that what can be achieved will depend on a range of factors affecting the growth of the economy and of domestic revenues and foreign aid. The sector working groups, on which development partners are represented, are currently undertaking backward-looking self assessments, and will undertake forward-looking EDPRS planning exercises in the May-September 2006 period. The EDPRS is envisaged to be finalised by the end of 2006, for implementation from the 2007 budget year. In order to ensure that the 2007 budget is consistent with EDPRS, an interim statement of EDPRS priorities will be prepared by June 2006 to inform 2007 budget preparation.

Of course, it would be unreasonable to expect that all aspects of this grand design will run smoothly, and there are some formidable challenges to overcome:
• Capacity for sector planning and coordination is very variable across sectors.

• Further work is required to define how the decentralised approach will work, and to clarify roles and responsibilities, how funding will flow, and particularly how block grants and conditional grants will be integrated. A ‘zero draft’ setting out the proposed local Government planning and budget process was produced by consultants in March 2006, but the proposals have yet to be agreed within Government, and there remain significant gaps.

• Although there is now a single budget document, the development budget, which is almost entirely donor funded, has yet to be fully integrated with the recurrent budget, and there remain challenges in ensuring a coherent distribution of resources – problems that the Government hopes to address in part via the implementation of the draft Aid Policy.

• Although excellent progress has been achieved in public finance management, the starting point after the genocide was very low, and much remains to be done to put in place the necessary linkages between planning, budgeting, implementing, reporting, and accounting. Fortunately, there is a strong focus on further PFM reform, with coordinated support from the donors via the budget support harmonisation group.

• Many aspects of the monitoring and evaluation framework still require strengthening, although the conceptual design is excellent, and an increasing range of timely and relevant information is being generated to permit reporting against inputs, outputs, and interim outcomes.
ANNEX 2 DRAFT COMPACT

Scaling-Up to Achieve the MDGs: Illustrative Draft of a Possible Compact between the Government of Rwanda and Development Partners

1. Introduction and Purpose of the Compact

1.1 Objectives and Structure

1.1.1 This compact sets out understandings reached between the Government of Rwanda (‘the Government’) and the development partners who are signatories to it. The main objective is to set out a framework for increased and more effective aid, in order to permit Rwanda to make faster progress towards the millennium development goals (MDGs). Specifically, the compact establishes:

i. The guiding principles and management arrangements that will be observed by Government and development partners in order to improve the contribution of official development assistance (ODA) to achieving the MDGs (Section 2);

ii. The specific commitments and obligations agreed by the Government for the implementation of this compact (Section 3);

iii. The minimum level of total aid, and of budget support, that the signatories collectively commit to provide to Rwanda in each year in the period 2007-2015, if Government meets its obligations under this compact (Section 4.1);

iv. The specific commitments and obligations agreed by the development partner signatories with respect to the future management of their development assistance (Section 4.2);

v. The agreed arrangements for monitoring compliance and resolving disputes, and the remedies available in the event of non-compliance with the provisions of this agreement (Section 5).
1.2 Role of the Compact in Relation to Other Agreements on Official Development Assistance

1.2.1 This compact provides an over-arching framework for aid coordination in Rwanda, and complements more specific agreements relating to:

i. The Partnership Framework for Harmonisation and Alignment of Budget Support;

ii. Memorandums of Understanding (MOUs) and Joint Financing Agreements that may be negotiated in order to give effect to sector budget support and sector-wide working within individual sectors;

iii. MOUs or agreements that may be reached between Government and development partners with respect to specific programmes or projects.

1.2.2 Future aid agreements reached at any of these levels will be framed to be fully consistent with the provisions of this compact.

1.2.3 All clauses of aid agreements that were in existence prior to the signature of this compact will continue to apply unless all of the parties to the agreement consent to proposed modifications.

1.2.4 This compact applies to official development assistance supporting public sector bodies, including significant programmes of ODA to public sector entities that are channelled via Non-Government Organisations (NGOs) for management purposes. It does not apply to other NGO activities, although many of the same principles should apply to their support to public sector entities.

2. Management of Development Assistance

2.1 The guiding principles and aid management procedures described in this section of the Compact are based on the Government’s Aid Policy. They are intended to apply to all development partners, not just those who are signatories to this compact.

Integrating Aid within Government Plans and Budgets

2.2 All ODA will support the long-term vision for development set out in the Vision 2020 document and the medium term strategies and priorities articulated in the forthcoming Economic Development and Poverty Reduction Strategy (EDPRS).

2.3 The EDPRS will be put into effect via the national budget process and the Medium Term Expenditure Framework (MTEF). All ODA to Central Government and Local Governments should be included in the budget estimates and MTEF, even if it uses parallel donor procedures to disburse and account for the funds.
2.4 Government is only responsible for projects that are within the budget and that form part of a sector strategy approved by Government. Aid for projects not meeting these criteria will only be accepted if the proposal is shown to be sustainable. Where an off-budget project has long-term expenditure implications (such as the need to maintain treatment for patients started on Anti Retroviral treatment), the donor must accept the responsibility for sustaining the projects that it has initiated.

2.5 Development partners will participate in national planning and budgeting processes as set out in the Harmonisation and Alignment Calendar (Annex 1), as amended and updated from time to time following discussion with the Development Partners Consultative Group (DPCG). The Government will provide formal opportunities for consultation with development partners on the formulation and monitoring of the overall EDPRS, the sector strategies that are integrated within it, and the policies, MTEF, and annual budgets and workplans through which it is implemented.

2.6 Decisions on the allocation of Government and donor resources between sectors will be taken through the budget process. Commitments of project aid or budget support earmarked to a sector will not necessarily result in additional spending within the sector, unless such an increase is found to be justified in the light of the discussion of priorities across the budget as a whole.

The Role of the Sector Clusters

2.7 Each cluster will undertake an annual joint sector review which will provide the single opportunity for all development partners to comprehensively review policy, strategy, performance and capacity needs. It will include both a backward look at progress and a forward assessment of objectives and resources required. The sector reviews will be open to all stakeholders, and the timing and format will enable the outcomes of sector reviews to inform budget preparation, the annual EDPRS review, and the Poverty Reduction Support Grant (PRSG) review. These cross-cutting reviews will ensure that their conclusions on sector issues are informed by and consistent with the sector reviews, which are the lead forum for discussion of sector-specific issues.

2.8 Sector clusters will become fully engaged in Public Expenditure Review (PER) and budget work. They will establish mechanisms to link budget inputs to service delivery through the PER, the joint review, and consultation on the Budget Framework Paper. They should identify, cost, and rank sector spending priorities. Only the highest ranking spending priorities, which have been clearly identified in sector investment/expenditure plans, should be undertaken, either through the Government budget or as donor funded projects.

2.9 The cluster activities will also be linked to other processes which impact on service delivery, such as decentralisation.

2.10 Sector clusters should establish a common agenda of analytical work, to avoid duplication.
Preferred Aid Modalities

2.11 Government prefers aid to be provided in support of costed strategies, included in the MTEF and budget, and delivered as budget support using Government procedures. This reduces transaction costs and enables priorities to be set and reflected in the use of both domestic and external resources. The Government favours sector-wide approaches (SWAPs) as a mechanism to plan and coordinate all resources flowing into a sector, including domestic revenues, budget support, project aid, and technical assistance.

2.12 The signatories will use their best endeavours to respond to the Government’s expressed preference for an increasing share of aid to be provided as general budget support or sector budget support (identified in the Aid Policy as the next best alternative for channelling resources in support of an approved sector strategy and budget.) Those development partners that are unable to provide budget support will comply with Government budget and accounting procedures as far as their own operating and policy constraints will permit.

2.13 Assistance that employs procedures other than those of the Government will only be accepted if Government is satisfied that transaction costs are not unacceptably high, the aid is aligned to Government priorities, and conditionalities are not excessive. Transaction costs should be considered in the broadest sense, to include the opportunity cost of allocating scarce (human and financial) Government resources to activities and their follow-up.

Vertical Funds

2.14 These principles will also apply to vertical funds that currently provide assistance for specific earmarked purposes using structures parallel to the Government for allocating and managing the funds. Financial assistance received from vertical funds will be utilised as sector budget support or project aid and integrated into the budget in the same way as other multilateral and bilateral aid. The funds will provide information on all activities financed under such arrangements to the Ministry of Economics and Finance (MINECOFIN) and line ministries or other government bodies working in the same sector(s) / sub-sector(s).

2.15 The signatories will adjust the allocation of domestic resources and development assistance to ensure that vertical funding arrangements do not distort the priorities that are agreed in the EDPRS and through the participatory budget process. Vertical funds that are signatories to this agreement will be as flexible as possible in ensuring that they are aligned with sector plans. The Government will develop guidelines on the acceptance and management of such resources with the aim of ensuring that assistance provided by vertical funds does not create undesirable distortions.

Technical Assistance

2.16. All Technical Assistance (TA) provided to the Government will be concerned primarily with the transfer of capacity to the Government by building the skills and
capabilities of local staff and/or developing systems and procedures and codifying these in an accessible manner for use by local staff. All terms of reference for TA must recognise these as the ultimate objectives of such assistance.

2.17. To facilitate improved planning and management of TA, donors will support pooled funding for TA overseen by the Human Resources and Institutional Capacity Development Agency (HIDA).

Terms of Aid

2.18 The bulk of future development assistance needs to be provided in the form of grants. Assistance in the form of loans will only be considered where the offer includes a grant element of at least 50%.

2.19 Government and development partners will work to reduce the tying of aid, and the negative impact of tying on aid effectiveness.

Responsibilities for Mobilising and Managing ODA

2.20 All parties to this compact agree to comply with Government procedures for the mobilisation and management of ODA, as set out in the Aid Policy. Specifically, a line ministry, district or other government body may engage in initial discussions with interested partners, but will not enter into negotiations with a donor, nor sign agreements of any sort. All aid transactions will be subject to signed agreements that have been cleared with MINECOFIN, and signed by them or (exceptionally for some bilateral donors) with the Ministry of Foreign Affairs.

2.21 The line ministry or other government body designated as the primary recipient of an assistance package is responsible for the implementation of investments or other expenditures agreed. It will engage in regular dialogue with MINECOFIN through CEPEX on aspects of implementation requiring attention, for example where delays to disbursements pose a problem or where there are delays to implementation.
3. Government Commitments

3.1 Recognising that the development partners’ willingness to give assurances of long-term support depends on their confidence in the transparency, predictability and efficiency of Government planning and budget processes and in the public servants in charge of these processes, the Government will:

i. Ensure that strategic plans and the overall EDPRS contain clear objectives and targets, that the measures required to achieve the targets are evidence-based and are fully costed, that sectoral plans are consistent with the EDPRS, that they are the outcome of a consultative process involving development partners, and that there is a clear framework for monitoring and evaluation.

ii. Consult with stakeholders each year on revisions to plans and sector strategies via Joint Sector Reviews, discussion of the Annual Review of the EDPRS, and continued participation in the annual reviews of the macro-economic framework under the auspices of the budget support harmonisation group (BSHG).

iii. Allowing for year on year fluctuations caused by economic shocks, maintain domestic revenue:GDP ratio and gradually raise it in the medium term through systematic enforcement of tax legislation, improved tax administration and collection, new revenue measures, as discussed in budget support harmonisation group.

iv. Exercise restraint on expenditure programmes that are not in line with EDPRS priorities.

v. Ensure transparency in the budget process by consulting with stakeholders each year on strategic allocations in the budget. Major changes in the budget or sectoral allocations will only be taken after prior consultation with all partners.30

vi. Implement the budget in a manner consistent with the agreed allocations, consulting in advance with the development partners on major envisaged changes to budget allocations during the financial year.31

vii. Continue to improve the quality of financial management systems at both central and local government levels, by implementing

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30 ‘Major changes’ for the purpose of 3.1.iv and 3.1.v are defined as: changes to expenditure allocations identified as priorities for achieving the MDGs, or that have been identified as of concern or interest by development partners during DPCG or BHSG meetings, where the magnitude of the change is worth not less than $10mn and not less than 10% of the relevant budget line.

31 See footnote 1.
comprehensive reforms in public finance management, and undertaking annual reviews of progress in consultation with the Budget Support Harmonisation Group.

viii. Verify the improvements in public finance management by collecting independent information and analysis through a programme of studies to be agreed with DPCG, and to include a regular programme of public expenditure reviews and public expenditure tracking studies.

ix. Improve Government accountability to the public by promoting public access to information on Government plans, budgets, expenditures, and outputs, at all levels down to individual facilities.

x. Ensure adequate capacity to manage and coordinate enhanced aid flows. To this end an assessment of capacity needs to facilitate the management of aid will be undertaken, and a prioritised capacity building plan will be devised and implemented, to include capacities in central and local government, as well as other bodies managing externally sourced resources.

xi. Maintain a stable and supportive social, political and economic climate.

4. Development Partner Commitments

4.1 Commitments on the Level and Composition of ODA

4.1.1 The development partner signatories will appoint one of their number as lead donor, to be the main channel of communication with Government, and to be responsible for coordinating donor action to ensure full compliance with the terms of this compact.

4.1.2 If Government complies with the principles and undertakings set out in this compact, the development partner signatories will collectively ensure that the combined total of their development assistance during the years 2007-2015 is not less than the totals set out in Annex 2, with shortfalls in any year fully compensated either within the same year or in the subsequent year. The agreed minimum external funding levels will permit the Government to come as close as is practicable to achieving the MDGs, assuming that Government implements the policies and programmes set out in the EDPRS, and that the macro-economy develops as forecast.

4.1.3 The development partner signatories will also collectively ensure that the total US $ value of budget support provided by them in any year will not fall below the level stipulated in Annex 2.

4.1.4 Each development partner signatory will provide to MINECOFIN by April information on expected future commitments and disbursements of budget support and project aid for as far ahead as is feasible, with indications covering at least the three year period of the MTEF starting in the following January.
4.1.5 Each donor will commit resources at the level required to deliver the required volume of aid, after adjusting disbursement assumptions in the light of past experience.

4.1.6 For budget support and for each project that they are financing, development partners will assist MINECOFIN to compile accurate and timely budget outturn data, and to manage cash-flow, by reporting to the External Finance Unit (EFU) their quarterly disbursements, at times and in formats agreed with the EFU, together with forecasts to the end of the year.

4.1.7 Development partners will communicate promptly to MINECOFIN and to the lead donor any significant changes in the level of their support. When disbursement returns indicate that there is likely to be a shortfall from an individual partner, that partner will furnish MINECOFIN and the lead donor with a brief explanation, together with actions being taken to address the problem (for example, via re-allocation of funds, or changes in procedures).

4.1.8 If donor reporting at any stage indicates that there is likely to be an overall shortfall in disbursements from the development partner signatories, MINECOFIN will immediately inform the lead donor and the DPCG. The lead donor will coordinate collective action to ensure that the shortfall is made up by additional commitments from one or more of the signatories. DPCG meetings will review, on at least a quarterly basis, the actual and forecast annual development assistance compared to the minimum levels set out in the compact.

4.1.9 In the event that the shortfall can not be made up within the financial year in which it occurs, the donor signatories will inform MINECOFIN of the composition of the additional commitments that will be forthcoming in the subsequent year. This gives MINECOFIN the option to maintain public expenditure by temporarily drawing on foreign exchange reserves, to be replenished by the additional aid in the following year.

4.1.10 The minimum aid levels set out in Annex 2 represent the aid required from the present signatories in order for Rwanda to implement the EDPRS, and they make assumptions about the continuing contributions from those development partners who are not signatories. The minimum level of development assistance will be adjusted upwards if new partners join the agreement.

4.1.11 The minimum aid level may be adjusted downwards in the event of a significant Government deviation from the principles and policies set out in this compact and in the EDPRS.

4.1.12 Project aid disbursements may be affected by absorptive capacity problems, with development partners unable to disburse their funds due to slow implementation. The minimum levels of project aid may be adjusted down pro rata if the execution rate of the development budget is below a given percentage (90%?).

4.1.13 In the event that the donors reduce their aid flows below the specified level for either of these reasons, the independent monitoring group (described in Section 5) will
review the justification for the failure to provide aid at the stipulated levels, and will publish their findings. This will include commenting on the extent to which onerous donor procedures contribute to shortfalls by specific development partners.

4.1.14 In the event of a significant positive shock to the economy, such as a major natural resource find, or a positive term of trade shock on a scale sufficient to significantly diminish the need for external support, Government and the development partners will consult on the revision of the minimum aid requirements. Adjustments should only be made if the shock is expected to be permanent (three years or more), and is of a magnitude not less than 20% of GNI.

4.2 Development Partner Commitments on the Management of Development Assistance

4.2.1 Where budget support using Government procedures is not feasible, donors will try to reduce transactions costs by making larger commitments to programmatic approaches, and by supporting pooled funding or co-management with other donors. Development partners will ensure that their support is integrated within SWAPs where these exist and will work with MINECOFIN to ensure that their support is integrated into the MTEF and reported in the budget.

4.2.2 Development partner views on the budget will be expressed collectively at the appropriate fora in the budget process (DPCG meetings, BSHG meetings, sector meetings, PERs, etc). Individual donors will not attempt to influence budget allocations outside these fora.

4.2.3 To permit ODA to be included in the budget and the MTEF, development partners will provide MINECOFIN with data on development assistance for each fiscal year by {April?} of the preceding fiscal year. Donors will provide projections of their future support for as far ahead as possible, and preferably a minimum of three year rolling projections of all budget and project support.

4.2.4 The signatories will to the extent possible use Government systems to procure, disburse, implement, report, monitor, account, and audit their assistance, providing coordinated technical assistance as required in order to strengthen those systems and make them fit for the purpose of meeting the full range of both Rwandan and external requirements.

4.2.5 Donors will to the extent possible rely on the national monitoring and evaluation system, minimising the request for additional reporting in formats different to those required by Government. In moving towards this objective, Government will also work to reduce the burden of multiple reporting requested by different Government bodies.

4.2.6 Donors will coordinate their activities with the timetables set out at Annex 1 and with the more detailed timetables agreed for each sector, relying on Joint Reviews, and minimising the need for additional bilateral missions.
4.2.7 Signatories agree to engage in a process of consolidation and concentration aimed at reducing the number of active donors in each sector, either by increased specialisation, and/or by increased use of silent partnerships and reliance on lead donors.

4.2.8 Signatories will seek to increase the delegation of authority to their local representatives and increase their capacity to play a full role in aligning behind Government priorities and harmonising their activities. Silent partnerships may be one way to improve representation by sharing the cost of professional staff.

4.2.9 Donors will minimise the transactions costs for Government by appointing a lead donor for sector and cross-cutting clusters, to coordinate views and enable the partners to speak with one voice. Lead donors will ensure that they have sufficient local capacity to coordinate and represent donor views to Government, and that their sector staff have a sufficient background in policy issues to contribute to the development of sector wide approaches.

4.2.10 Development partners will coordinate to ensure that necessary technical assistance is provided as required to improve aid management capacity and to implement the capacity building plan identified in section 3.

5. Monitoring and Dispute Resolution

5.1 The DPCG will be the main forum for monitoring implementation of this compact. It will review:

- At least annually, whether Government has met its obligations with respect to the implementation of the EDPRS, sector strategies, and the budget. This will be based on the evidence from the sector and EDPRS reviews and from quarterly and annual budget execution reports, including information on resources used and outputs achieved.

- At least annually, whether Government and donors have met their obligations with regard to aid management. This will be based in part on compliance with the participatory processes set out in the Calendar, partly on donor compliance with reporting requirements, and partly on public expenditure reviews and the public finance management review.

- At least quarterly, whether signatories are on track to disburse total aid and budget support aid at the levels stipulated, based on the monitoring mechanisms described in section 4.1.

5.2 An independent monitoring group will be established, with terms of reference to be agreed between the signatories and composed of distinguished members nominated equally by the Government and the development partner signatories. It will report annually on the implementation of this agreement, reviewing the extent to which Government and donor actions remain consistent with the provisions of this compact, and with the priorities and strategies set out in the EDPRS. The group will in particular advise on the causes and remedies for any under-performance by any of the signatories,
and for any disagreements that may have arisen. The reports will be published and
publicised, to ensure that international and national lobby groups have the information
they need to exert pressure on all parties to fulfil their obligations.

5.3 In the event of a dispute regarding whether parties to the agreement are complying
with their commitments, the following processes will come into play:-

i. There will be a period of formal consultation between the partners
before any action is taken to modify the level, timing, or conditions of
development assistance covered by this compact.

ii. In the event that Government does not comply with the requirements of
this compact, sanctions may be imposed by the development partners,
but any reduction in aid below the agreed levels will not come into
effect until the year following that in which the dispute arose.

iii. Data on the commitment and disbursement performance of individual
donors and of the signatories as a whole will be published on both the
Government web site, and the web sites of individual signatories, and
will be drawn to the attention of the press and of national and
international lobby groups. Each signatory undertakes to exert peer
pressure on the others to fulfil their obligations.
Annex 1 Harmonisation and Alignment Calendar

Modified from the existing draft, see section 2
# ANNEX 2 GUARANTEED MINIMUM AID LEVELS TO BE PROVIDED BY DEVELOPMENT PARTNER SIGNATORIES

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## Assumptions

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Minimum share of priority expenditures in budget (based on revised definitions to be agreed during EDPRS preparation)

Maximum share of defence spending

Maximum Average weighted budget deviation

The guaranteed minimum aid levels will be reviewed and may be adjusted in the event that:

1. There is a substantial positive adjustment in Rwandan economic prospects, as evidenced by sustained growth in GDP and domestic revenue at levels higher than anticipated. (For example, a 3 year average growth rate of 20% p.a. will result in GDP at least 20% higher than the assumptions made when aid levels were set.)
2. Development budget execution falls below a given percentage (90%) of funds committed and available, indicating that absorption problems are responsible for low disbursement. This will be independently verified, and offsetting actions defined.
3. There is a substantial deviation of the actual budget from the priorities set in the EDPRS and from the budget approved by parliament. Whether an adjustment is required will be a matter of judgement, and decisions made will be subsequently reviewed by the independent monitoring group. Indicators that could be assessed might include:
   a. The minimum share of priority expenditures within the budget as executed, based on the revised and improved definition to be agreed during EDPRS preparation.
   b. The share of defence spending, which is anticipated to continue to decline, and should in any event not exceed the baseline level.
   c. The extent of deviations from the approved budget should not exceed [10%?] based on a weighted formula to be agreed.
Draft Memorandum of Understanding between the Government of Rwanda and Development Partners Regarding Partnership Principles for Support to the Rwanda Health Sector

Preamble

Section 1: Introduction

1.1 Objective & Structure of This Memorandum of Understanding

The Government of Rwanda and the undersigned Development Partners share the common goal of enabling Rwanda to reach the Millennium Development Goals in the health sector. To this end, they agree to coordinate their support to the Rwanda Health Sector in accordance with the Partnership Principles set out in Section 2 of this Memorandum of Understanding (MoU). The implementation of the principles will provide a sound foundation for scaling up health sector interventions in order to achieve the objectives of the Health Sector Strategic Plan (HSSP), and make faster progress towards reaching the millennium development goals.

1.2 HSSP as a Common Framework

The Health Sector Strategic Plan (HSSP) provides the overarching framework for a sector-wide approach to the development and delivery of health services in Rwanda.

Any significant changes that are made to the HSSP will be endorsed by the signatories to this MoU at the annual Joint Health Sector Review (JRHS).

1.3 HSSP Strategic Framework

The HSSP strategic framework sets out the objectives, policies, priorities, strategies, key activities and indicative targets in terms of seven outputs (insert brief table on HSSP, e.g. Fig III.1 from HSSP).
1.4 Representation and Effect

The Government is represented by:

a) The Secretary to the Treasury and Secretary General, Ministry of Finance and Economic Planning (MINECOFIN) as the accounting officer responsible for Development Partner assistance to Rwanda; and

b) The Secretary General, Ministry of Health (MINISANTE) as the accounting officer with lead responsibility for the Health Sector and for the HSSP.

Development Partners are represented by their authorised representatives. They will appoint a lead donor to coordinate donor views, and simplify communication. The lead donor will establish sufficient capacity to coordinate donor positions on health policy issues, and manage the flow of information and documentation between donors, as well as providing administrative support as required by MINISANTE to facilitate coordination.

Development partners recognise that the number of agencies active in the health sector poses a burden on Government, particularly as many of them provide only modest levels of finance. They agree to coordinate among themselves with the objective of progressing towards a health sector that has fewer active donors, operating on a larger scale, with enhanced capacity to engage in dialogue on health sector issues. This may involve some smaller donors withdrawing to focus on other sectors, or choosing to work with others within silent partnerships and other co-management arrangements.

General budget support is the aid modality preferred by GOR. Development partners providing general budget support are welcome to be full members of the health sector cluster.

This MoU is not a binding legal agreement and does not create any rights or obligations under international law. In the event of any conflict between the provisions of the MoU and bilateral agreements or arrangements the provisions of the bilateral agreements or arrangements will apply.

This MOU is intended to comply fully with the provisions of the GOR Aid Policy, and with the overall 'compact' that [has been agreed/is being negotiated] between Government and some development partners in order to give effect to the Aid Policy and provide assurances of continuity of external support. If there are subsequent amendments to the Aid Policy or the Compact, the signatories will review this MoU in order to ensure its compliance with the policy and the compact.

1.5 Amendment, Information and Consultation

The MoU signatories will approve, in writing, any amendment of the MoU. These should first be discussed and agreed at the annual Joint Health Sector Review or at any other time prior to or after the review when necessary and at a meeting of the Health Sector Cluster Group comprised of representatives of the signatories.

Signatories to this MoU will co-operate with the intention of reaching a mutually acceptable resolution to any problem arising out of the interpretation or implementation of this MoU.
1.6 Withdrawal and Admission

The Memorandum of Understanding is open to participation by additional Development Partners upon signature of this MoU by their authorised representative.

Signatories to this MoU may withdraw from the MoU procedures at the end of a Joint Review of the Health Sector (JRHS). Three months written notice of such intention should be given to the chairperson and joint deputy chairpersons of the Health Sector Cluster Group, specifying the reasons for such withdrawal.

1.7 Entry into Effect and Duration

This MoU will come into effect when both Government representatives and at least two Development Partners have signed it.

This MoU will terminate on 31 December 2010 unless extended by unanimous decision of all signatories.

1.8 Annexes

The Annexes to this MOU are -

- Annex A  Health Sector Strategic Plan 2005-2009 (bound separately)
- Annex B  Annual Calendar for Health Sector Planning, Budgeting, Reporting and Reviews
- Annex C  Joint Health Sector Stakeholder Consultation Arrangements
- Annex D  Health Sector Monitoring and Evaluation Framework
- Annex E  Procedure for approval of new HSSP projects
Section 2: Partnership Principles for Development Partner Support to the Rwanda Health Sector

2.1 Introduction

This Section sets out Partnership Principles for alignment and harmonisation of Development Partners’ technical, administrative and financial support to the Health Sector in Rwanda through the framework of the HSSP.

The Partnership Principles are consistent with the Compact, the Aid Policy, the Framework for Aid Coordination in Rwanda (MINECOFIN, 2002), Vision 2020, the Rwanda Poverty Reduction Strategy, the Medium Term Expenditure Framework and annual budget process.

The Partnership Principles will apply to all Development Partners’ support to the Health Sector in Rwanda, regardless of the financing mechanism used.

The five Partnership Principles are:

- Aligned and harmonised planning and resource allocation
- Harmonised policy dialogue, consultation and information sharing
- Harmonised systems
- Aligned and harmonised approach to capacity building
- Harmonised performance monitoring and review

The Partnership Principles are described in more detail below.

2.2 Alignment and Harmonisation of Planning and Resource Allocation

Alignment with Government Plans

The HSSP sits within the broader framework for national policy set out in the Economic Development and Poverty Reduction Strategy (EDPRS). MINECOFIN is responsible for overall coordination of the EDPRS and for managing the MTEF and national budgets through which it is implemented. MINISANTE is responsible for formulating Health Sector plans and budgets subject to MINECOFIN approval, and is accountable for their efficient implementation. MINISANTE and MINECOFIN will together ensure that the MTEF and annual Health Sector budget are aligned with the priorities and expenditure plans set out in the HSSP. Moreover, with the objective of bringing all external support to the sector on plan and on budget, MINECOFIN and MINISANTE undertake to work towards merging the Recurrent and Development Budgets as soon as possible.

Ownership and responsibility for the structure, priorities and content of the HSSP lies with MINISANTE. All technical support for the implementation of the HSSP will be contracted and managed by MINISANTE through the Directorate of Planning.
The HSSP and its Annual Operational Work Plans (AOWP) form the planning and resource allocation framework for all Development Partner support to the Health Sector. The HSSP is a flexible strategic guide which will be used as the basis for detailed operational planning and budgeting. The HSSP will respond to changing circumstances.

A key task for the Health Sector cluster in the preparation of the EDPRS, and one that will need to be revisited in subsequent reviews as experience accumulates, is to agree what services can be sustainably provided with the available funding, and how they should be delivered and financed. The sector should identify, cost and rank sector spending priorities, assisted by tools such as Marginal Budgeting for Bottlenecks. Only the highest ranking spending priorities, which have been clearly identified in sector investment/expenditure plans, should be undertaken, either through the GOR budget or as donor funded projects.

**Inclusion of Development Assistance in the Budget**

Government and Development Partners will ensure that all external support to the Health Sector is aligned with the HSSP (on plan) and the Health MTEF (on budget) and is reflected in annual GoR budgets as required by the Budget Law, regardless of the financing modality used.

With regard to General Budget Support and Sector Budget Support this alignment will take place implicitly within the systems for planning and budgeting of GoR resources. Where Development Partners continue to provide project support, all new projects must be formulated to contribute to specific HSSP objectives and activities. New projects must be consistent with HSSP financing plans, and included in the development budget and the Health MTEF. They should not distort the planned resource allocations within the sub-sectors as set out in the HSSP. New projects may include "pilot projects" which are intended to pilot new approaches in a limited area with a view to later scaling up. The requirement to be aligned with the HSSP will apply to the potential scaling up as well as to the pilot project itself. Project documentation for pilot projects should, therefore, include an assessment of the costs and impact of scaling up within the context of the HSSP.

The process for approval of projects for inclusion in the HSSP is outlined in Annex E. Projects will respond to needs identified in the HSSP and in the joint review, will be subject to a formal Government process of development and appraisal before they are accepted, and will be included in the budget and the MTEF even if their implementation uses parallel donor procedures.

Government will not seek donor assistance which is not clearly aligned with the HSSP as described above, nor will it accept responsibility for donor initiated projects that do not conform to these criteria. Where donors initiate projects outside the HSSP and the Government development budget, they are responsible for meeting any long-term spending obligations created by those projects, such as the moral imperative to maintain the treatment of patients who have started to take ARV drugs.

Development partners will use their best efforts to make longer term commitments of aid with predictable timing of disbursements, recognising that good information on future aid...
levels and composition is essential to enable MINISANTE to plan and budget for a scaled up and sustainable health system. Development Partners commit to provide the External Finance Unit, MINECOFIN, with specific information on planned, committed and disbursed assistance to the Health Sector, in the format and within the timeframe required by the EFU. To improve predictability and appropriate resource mobilisation this information should cover a three year or longer forward period.

Development Partners will communicate promptly to EFU/MINECOFIN and MINISANTE any significant changes in the planned level of their support to the Health Sector.

In addition to formal commitment information, development partners will share with Government and other partners as much information as possible on the nature, value, timing and financing modality of future support to the Health Sector.
Development Partner Participation in Planning and Budgeting Cycle

The annual calendar for Health Sector planning, budgeting, reporting and review is attached to this MoU at Annex B.
The Health Sector cluster will undertake an annual joint sector review which will provide the single opportunity for all development partners to comprehensively review policy, strategy, performance and capacity needs. It will include both a backward look at progress and a forward assessment of objectives and of the resources required and available from Government and donor resources.

The joint review will be completed by the end of April to enable the findings to be reflected in budget preparation and in the annual review of the EDPRS and the PRSG. It will review:-

i. Progress in the previous year, based on a MINISANTE report that will utilise the agreed monitoring framework and sources and will report the agreed performance indicators.

ii. The budget execution reports for the previous year, including analysis of outputs achieved as well as resources expended.

iii. Such additional reports and analysis as may have been commissioned by the cluster in order to inform the review. This will normally include a public expenditure review. In every second year it will include a public expenditure tracking study. It may include further independent analysis to help focus discussion at the review.

iv. Resources likely to be available from domestic and donor sources in the coming year. Donors will provide indications of their future support for as many years as possible, including at least the MTEF period starting in the following January. This will help the review to assess the extent of any funding gaps.

v. Policy and expenditure priorities to guide budget and MTEF preparation, including discussion of how identified financing gaps may be met from new commitments or re-allocations within the budget.

vi. Specifically, NGO activities supported through ODA should be subject to a planned process supervised by MINISANTE to achieve a better balance between districts.

Prior to the cluster meeting in the fourth quarter of the year, development partners will confirm the levels of financial support they will make available to the Health Sector in the coming year, together with expected quarterly disbursement, in order to assist budget finalisation and the preparation of the cash-flow forecast for the coming year. During the fourth quarter cluster meeting, signatories will jointly review the budget and MTEF proposals for MINISANTE in the coming financial year.

The sector review will be open to all stakeholders and is the lead forum for discussion of Health Sector-specific issues. The EDPRS and PRSG reviews will ensure that their conclusions on sector issues are informed by and consistent with the sector review.
Development Partner consultations on Health Sector plans and budgets should be undertaken collectively through the JRHS, the Health Sector Cluster Group and other appropriate fora identified in the calendar. Signatories to this memorandum will not individually attempt to influence Health Sector plans or budget allocations outside these fora.

In the event that significant changes in budget allocations to, or within, the Health Sector are necessary in the course of a financial year, MINECOFIN and MINISANTE will consult collectively with Development Partners.

2.3 Harmonisation of Policy Dialogue, Consultation and Information Sharing

The Health Cluster is the key structure for harmonised consultation in the Health Sector. The terms of reference are attached at Annex C. Key processes for consultation are bi-monthly meetings of the Health Cluster, and the annual Joint Review of the Health Sector.

The objectives of consultation are:

i. To reach common agreement among stakeholders on health policy, strategy, programme priorities, targets, plans, budgets and institutional arrangements;

ii. To facilitate the provision of timely and appropriate resources for implementation of the agreed plans;

iii. To jointly monitor progress, and agree on appropriate adjustments in the light of experience.

These objectives will be facilitated by the establishment of a common agenda of analytical work, to be supported as part of the annual capacity building plan described in section 2.5. Development partners will not undertake analytical work that has not been included in the joint work programme or been approved in a cluster meeting.

The Health Sector cluster may, by agreement, establish one or more working groups with more limited membership in order to resolve critical issues requiring more in-depth discussion than is possible in the cluster meetings. Working groups will have a limited life determined by completion of the task that the cluster has delegated to them, their terms of reference will be approved by the cluster, and they will report back to the cluster.

Government and Development Partners will seek the active engagement of Rwandan civil society (including Health Sector non-governmental, civil society and faith-based organisations, and the private sector) in the consultation processes.

MINISANTE will lead and chair all joint consultative mechanisms, except where issues for discussion relate primarily to external financing in which case MINECOFIN shall chair. MINISANTE, MINECOFIN and MINALOC as the GoR ministry responsible for setting up the appropriate structures at decentralized level for service delivery, will be represented in all consultative mechanisms. Joint deputy chairs for consultative mechanisms will be provided by Development Partner and civil society representatives.
MINISANTE will provide the secretariat function for the consultative mechanisms and will ensure coordination with MINECOFIN on all aspects of consultation relating to external financing. The enhanced arrangements described in this MOU envisage a more challenging role for MINISANTE in driving the whole sector, including external assistance, rather than responding to proposals from donors. Additional support to enable them to fulfil this role will be a high priority for the proposed capacity building plan.

MINISANTE will be responsible for ensuring relevant and appropriate inter-ministerial coordination in Health Sector policy dialogue and service delivery, including participation in key fora of other ministries, departments and agencies as appropriate.

MINISANTE commit to making key HSSP related documentation available in a timely manner to stakeholders, including access through the MINISANTE website.

Development Partners commit to circulating key documents relating to their existing and planned Health programmes to MINISANTE and other relevant GoR ministries, departments and agencies in a comprehensive and timely manner, and to ensuring that copies of such documents are made available to the Donor Group Leader.

### 2.4 Harmonisation of Systems

Development Partners commit jointly to using GoR planning, implementation, financing and monitoring systems, or where this is impossible at present, to move towards doing so as soon as possible. This commitment will be reflected in joint Development Partner agreements, and agreements between Development Partners and GoR. The commitment includes disbursing funds through the GoR budget, harmonising planning processes with the GoR budget and planning cycle, and providing assistance through GoR management, procurement and implementation arrangements.

In circumstances where it may not be possible to fully meet this commitment, Development Partners will ensure that their project procedures, including management, implementation, accounting and monitoring mechanisms are aligned with GoR systems to minimise multiple and parallel processes and to reduce transaction costs. Where financing, procurement or contracting is not provided through GoR systems, Development Partners will provide GoR with detailed information on the costs, cost effectiveness and implementation status of Health programmes and projects, in a standardised format to be prescribed by MINISANTE and MINECOFIN.

Future development assistance will be managed using existing structures, in order to reduce transactions costs and improve sustainability. Signatories will work towards eliminating project implementation units and other parallel structures. Proposed projects that impose an unreasonable burden on management capacity will be rejected pending re-design.
2.5 Alignment and Harmonisation of Technical Assistance and Capacity Building

MINISANTE will be responsible for identifying capacity building priorities for the operationalisation of the HSSP. These priorities will be set out in a fully costed Annual Capacity Building Plan (ACBP) as part of the HSSP and Health Sector MTEF. The ACBP will include costed, needs-based interventions plus a provision for flexible response to emerging needs.

Development Partners will ensure that all current and proposed capacity building support is aligned with the ACBP and associated MINISANTE-led management arrangements. Technical assistance will be provided in support of HSSP, not for individual donor projects, and staff funded from technical assistance will report to GOR, not to donors.

To the extent that Development Partners provide direct capacity building support, they will work jointly within the Capacity Building Plan to minimise transaction costs, avoid duplication and simplify management arrangements.

The ACBP should include capacity building support to the HSSP from all sources. This will include support provided through the Multi-Sector Capacity Building Programme managed by the Human Resource and Institutional Capacity Development Agency (HIDA); institutional support provided through the MINISANTE budget; and capacity building provided through direct Development Partner support.

The ACBP will identify priority capacity building needs and planned interventions at the central and decentralised (Province, District and Health Centre) levels. The management arrangements will be consistent with the GoR Decentralisation Strategy.

The Health Cluster will provide a forum for closer policy dialogue and oversight of Health Sector capacity building. It will be supported in this function by a Technical Sub-Group composed of members of the Health Cluster, which will develop its plan of action and report regularly to the Health Cluster.

The signatories will strictly adhere to Government policy regarding allowances to be paid to public sector employees, and will exercise restraint over the numbers and remuneration of qualified Rwandan staff employed on donor projects, in order to minimise internal brain drain.
2.6 Harmonisation of Performance Monitoring and Review

The EDPRSP provides the overarching framework for monitoring and evaluation of progress in the Health Sector in Rwanda.

In addition, Government and Development Partners will agree a common monitoring and evaluation (M&E) framework for the Health Sector. This M&E framework will consist of a common set of key performance indicators for the Health Sector, and a system for the collection, analysis and dissemination of information on progress against these indicators.

The common set of Health Sector indicators will be used by all Development Partners with an interest in the Health Sector including those providing general budget support.

MINISANTE will be responsible for performance monitoring and review of the HSSP, which will take place through the JRHS. The JRHS will also comprise the sector performance review of the Health Sector, for the purposes of the EDPRS.

MINISANTE fulfils this responsibility within the overall framework for policy, implementation and financial performance of Ministries set by MINECOFIN. MINISANTE will be responsible for providing a summary technical and financial performance report to feed into the JRHS. The JRHS will review performance for the previous year and discuss future action. Subject to need and agreement, Development Partners may provide support for an independent assessment of sector progress with the objective of identifying strategic issues to inform and focus discussion at the JRHS.

Development Partners will accept the JRHS as satisfying their own review requirements. They will not request separate reviews.

EDPRSP Health indicators are summarised in a table of performance and process indicators (Table D1). The EDPRSP also contains outcome verification targets for the Health Sector (Table D2). The table of indicators and outcome targets provide the common M&E framework which the GoR and development partners will use to assess progress, as outlined in the Partnership Principles.

Data to assess progress against the indicators will be provided by the planned Health Sector management information system. This will be supplemented by independent monitoring and evaluation teams (comprising externally contracted consultants, GoR officials and stakeholders) who undertake field reviews and report to the JRHS.

The monitoring framework will also include monitoring of donor performance:-

- Disbursements by donor compared to previously advised commitments and disbursement forecasts;

- Compliance with Government reporting requirements;

- A matrix by donor, showing compliance with these partnership principles, and progress since the previous report.
The lead donor will take responsibility for ensuring that the report is compiled in time to submit to the Annual Review. In order to exert peer pressure for compliance with this MOU, the results will be prominently displayed on the MINISANTE and DPCG web sites.

Annex D1 sets out proposals for this common M&E framework.

For the purpose of financial review and fiduciary assurance, development partners providing assistance through general and sector budget support will use GoR annual public expenditure reviews, budget execution, accounting, audit and public expenditure tracking survey (PETS) reports for the purpose of financial review and fiduciary assurance. They will not undertake separate exercises.

Donors providing project support should also design such support to rely as much as possible on these GoR reporting and accounting mechanisms, avoiding where possible the need for additional reporting or accounting. Where donor procedures require it, every effort will be made to minimise the additional burden on GoR systems and staff.

**Signatures**

*Signed and dated as follows:*

Minister of Finance and Economic Planning

Minister of Health

Development Partners
### APPENDIX E: STAGES AND DOCUMENTS IN THE DEVELOPMENT AND MANAGEMENT OF PROJECTS WITHIN THE HEALTH SECTOR

<table>
<thead>
<tr>
<th>STAGES</th>
<th>DOCUMENTS</th>
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</thead>
<tbody>
<tr>
<td><strong>Identification</strong></td>
<td>• HSSP</td>
</tr>
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<td></td>
<td>• Partnership Principles</td>
</tr>
<tr>
<td></td>
<td>• MTEF and Strategic Issues Paper</td>
</tr>
<tr>
<td></td>
<td>• JHSR Aide Memoire</td>
</tr>
<tr>
<td></td>
<td>• Working Group Reports</td>
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<tr>
<td></td>
<td>• Cluster Minutes</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td>• WG Report</td>
</tr>
<tr>
<td></td>
<td>• Cluster Minutes</td>
</tr>
<tr>
<td></td>
<td>• Study Reports</td>
</tr>
<tr>
<td></td>
<td>• Project Concept Note</td>
</tr>
<tr>
<td><strong>Appraisal</strong></td>
<td>• Project Concept Note</td>
</tr>
<tr>
<td></td>
<td>• Minutes of Project Review Committee</td>
</tr>
<tr>
<td></td>
<td>• Cluster Minutes</td>
</tr>
<tr>
<td><strong>Fund raising</strong></td>
<td>• Cluster Minutes</td>
</tr>
<tr>
<td></td>
<td>• Partnership Principles</td>
</tr>
<tr>
<td></td>
<td>• Letters requesting assistance</td>
</tr>
<tr>
<td></td>
<td>• Responses to letters requesting assistance</td>
</tr>
<tr>
<td><strong>Approval</strong></td>
<td>• Appraisal Report</td>
</tr>
<tr>
<td></td>
<td>• [Minutes of the Development Committee –</td>
</tr>
<tr>
<td></td>
<td>substitute GOR alternative]</td>
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<tr>
<td></td>
<td>• Project Memorandum</td>
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<tr>
<td></td>
<td>• Government to Government agreement</td>
</tr>
<tr>
<td></td>
<td>• MTEF and Summary Paper</td>
</tr>
<tr>
<td></td>
<td>• Cluster Minutes</td>
</tr>
<tr>
<td><strong>Implementation and Monitoring</strong></td>
<td>• JHSR incorporating project progress report and work plans</td>
</tr>
<tr>
<td></td>
<td>• JHSR Aide Memoire</td>
</tr>
<tr>
<td></td>
<td>• WG Reports</td>
</tr>
<tr>
<td></td>
<td>• Possible Evaluation Reports</td>
</tr>
<tr>
<td><strong>Phasing Out</strong></td>
<td>• Same documents as in the Implementation and Monitoring stage</td>
</tr>
<tr>
<td></td>
<td>• Completion Report</td>
</tr>
</tbody>
</table>

| Identification | • jointly agreed policy  |
|               | • programme priorities  |
|               | • policy dialogue       |
|               | • identification of funding or capacity gap  |

| Preparation | • dialogue regarding funding or capacity gap  |
|            | • in-depth analysis  |
|            | • specific proposals  |

| Appraisal | • Project Review Committee  |
|          | • assessment of relevance, feasibility, sustainability, accordance with policy concerns, etc.  |

| Fund raising | • open discussion process  |
|             | • co-ordinated aid pledges  |
|             | • aid liaison and co-ordination  |

| Approval | • final preparation and appraisal  |
|         | • Development committee approval  |
|         | • Parliamentary approval  |
|         | • negotiation and approval of project agreement  |
|         | • project incorporated in the budget  |

| Implementation and Monitoring | • Implementation  |
|                              | • Monitoring  |
|                              | • Reviews and adjustments  |
|                              | • Possible evaluations  |

| Phasing Out | • continued implementation and monitoring  |
|            | • closing of agency related administrative systems and assets  |
|            | • assessment of lessons learnt  |
ANNEX 4 EXTRACT FROM RWANDA DRAFT MDGS NEEDS ASSESSMENT
DESCRIPTING THE SIX STEPS

Source: This Annex comes from Rwanda Draft MDGs Needs Assessment, May 2006, Kigali. Prepared by a team from MINISANTE and UNICEF.

Step 1 Community Schemes

a. Policy and Strategy

The IEC/BCC

Information, education and communication (IEC) and behaviour change communication (BCC) is one of the important elements in the Health Sector Strategic Plan. IEC/BCC programme is to be strengthened at all levels for promotion of hygiene and sanitation, infectious diseases control, maternal and child health and mental health. Social mobilization and community participation are also promoted to increase access to and coverage of health services.

Community participation is also facilitated for the improvement of those mentioned above. The use of volunteers is one of a key strategy to ensure the community participation.

b. Services Provided

- Radios are provided to families to increase access to health messages.
- Training to communicators of TV, radio and newspapers are provided to mobilize media.
- IEC/BCC materials and leaflets are produced and distributed.
- Social marketing for condom, mosquito net and others are carried out in various settings.
- Training of facilitators and peer educators among vulnerable populations including PLWHA, youth, CSWs, men in uniform, refugees is conducted and peer education and other IEC/BCC activities among such vulnerable people are promoted.
- Conduct monitoring and evaluation of activities.
- The package of services that will be given by the community health workers at the community level are described in Table 4 below:
Table 4: The Package of Services That Will be Given by the Community Health Workers

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Drugs/materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria prevention and treatment</td>
<td>Insecticides treated nets</td>
</tr>
<tr>
<td></td>
<td>Antimalaria drugs for adults</td>
</tr>
<tr>
<td></td>
<td>Antimalaria drugs for infants</td>
</tr>
<tr>
<td>Diarrhoea and dehydration</td>
<td>Deworming (Mebendazole)</td>
</tr>
<tr>
<td></td>
<td>SRO</td>
</tr>
<tr>
<td>Micronutrients deficiency</td>
<td>Vitamin A, iron and folic acid</td>
</tr>
<tr>
<td>Family planning</td>
<td>Condoms</td>
</tr>
<tr>
<td></td>
<td>Pills, abstinence</td>
</tr>
<tr>
<td></td>
<td>Colliers</td>
</tr>
<tr>
<td>Ophthalmic infection</td>
<td>Ophthalmic pomade</td>
</tr>
<tr>
<td>HIV prevention and treatment</td>
<td>Gloves</td>
</tr>
<tr>
<td></td>
<td>Talks</td>
</tr>
<tr>
<td></td>
<td>Aspirin and Paracetamol</td>
</tr>
<tr>
<td></td>
<td>Dermatologic pomade</td>
</tr>
</tbody>
</table>

c. Coverage Targets

In the Health Sector Strategic Plan, IEC campaigns are targeted to cover entire population in 2009. There are targets of service coverage to be improved through community scheme such as the proportion of households with access to drinking water from 41% in 1995 to 75% in 2009; the proportion of mothers who wash their hands with soap after the toilet from 41% to 75% in 2009; the proportion of households with access to improved latrines from 7% to 30% in 2009. However, there are no clear targets in individual IEC/BCC and social mobilization activities.

d. Cost and Mortality Estimates

This step will result in halting and reversing the prevalence of HIV and other preventable diseases, 20% reduction in under five mortality, and 1.6% reduction in maternal mortality. The average annual cost over the ten year period is estimated at US$2.10 per capita reaching a maximum amount of US$2.95 in 2015.
Step 2 Performance Contract with Health Centres

a. Policy

The performance-based contracting is one of the major strategies adopted by the Ministry of Health for improving access to quality healthcare for the population of Rwanda.

Performance-based financing in Rwanda is defined as:

A method of healthcare services management which seeks to increase the volume and quality of healthcare services provided to the population. Performance based financing increases funds available at the operational level to increase health worker motivation through a system of complementary remuneration based on performance. Performance based financing operates through contracts between those providing the financing and the various local actors in the health system.

Performance based financing facilitates efficiency and cost-effectiveness in the utilization of health resources, and is more effective in achieving results than input-based financing because it motivates workers to achieve better performance and it also ensures that funds arrive at the health facility levels instead of tickling down from higher levels in the system.

b. Strategy

In the coming years, the PBC approach will be extended on a large scale in the Rwandan health sector by the government, as well as by several donors, including the World Bank. Three types of expansion are planned.

First, PBC will be extended to most frontline health centres in the country. Second, the package of services covered by PBC at the health centres will be extended to a large spectrum of HIV/AIDS services, such as VCT, PMTCT and ARV delivery. Finally, performance based contracting will be introduced for community based health activities, which are health investments outside of the health centres which have traditionally been the focus of performance based contracts.

Regarding the mode of payment, the Ministry of Health makes payments to Health Centres which are directly linked to the delivery of a basic package of services, as

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opposed to the traditional lump sum payments which are unrelated to performance.

**Services Provided**

The package of services covered under the Health Centres Contractual Approach will consist of essential services in the areas of Preventive Maternal, Neonatal Care, Infant and Child Care such postnatal and new born care, immunization, delivery by skilled attendants and family planning. These services are essentially presented in Table 5 below:

**Table 5: The Package of Services Covered Under the Health Centres Contractual Approach**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Curative care</strong></td>
<td>New cases</td>
</tr>
<tr>
<td><strong>Prenatal care</strong></td>
<td>Tetanus vaccines</td>
</tr>
<tr>
<td></td>
<td>New cases received at the prenatal care</td>
</tr>
<tr>
<td></td>
<td>Women who have done 4 prenatal consultations</td>
</tr>
<tr>
<td></td>
<td>Women received tetanus vaccine</td>
</tr>
<tr>
<td></td>
<td>Women received Intermittent Preventive Treatment of malaria</td>
</tr>
<tr>
<td><strong>Growth monitoring</strong></td>
<td>Referred delivery before 9 months of pregnancy</td>
</tr>
<tr>
<td></td>
<td>Delivery done at the health centre</td>
</tr>
<tr>
<td></td>
<td>Obstetric emergency referred</td>
</tr>
<tr>
<td><strong>Family planning</strong></td>
<td>New users of family planning methods</td>
</tr>
<tr>
<td></td>
<td>Total number of users per month</td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td>Total number of children completely vaccinated</td>
</tr>
<tr>
<td><strong>Malnutrition</strong></td>
<td>Number of children hospitalized cured and discharged or referred</td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>Number of emergency referred (other emergency than obstetric)</td>
</tr>
<tr>
<td><strong>Gynaecology morbidity</strong></td>
<td>Number of vesico-vagina or recto-vagina detected and referred.</td>
</tr>
</tbody>
</table>

**c. Coverage Targets**

There are 365 health centres located within all 30 districts of Rwanda. These health centres provide primary health care to close to 80% of the Rwandese population. Services include out-patient and some limited in-patient care. The majority of these health centres are located in rural areas.

In 2002 the NGO’s Cordaid and HealthNet introduced performance based contracting for general health services in health centres in the provinces of the old Cyangugu and Butare provinces respectively. In 2005, the Coopération Technique
Belge (CTB) introduced PBC in the old provinces of Kigali, Kigali Ngali and Gitarama.

Presently, 9 districts out of 30 has Contractual Approach, 13 districts will begin the contractual approach in form of output contract in 2006, while the remaining 8 districts will be performing the input contract for the purpose of evaluation. They will be starting the output contact in 2008. Then we will have a 100% covering in 2008.

d. Cost and Mortality Estimates

Scaling up the performance based contract approach with health centres is estimated to cost on average an additional per capita of US$ 2.85 per year 4.46 in 2015. **** This level of investment will result in a mortality reduction of 34.1% for under five and 12% for maternal mortality.

Step 3 Mutuelles

a. Policy, Strategy

Mutuelles are non-profit, independent community organizations designed to offer members fair access to quality health services through a viable system of prepayment. Based on the principles of voluntary participation, solidarity, mutual assistance and risk-sharing, mutuelles offer their members better financial access to health care through risk pooling and by shifting payment away from the time of sickness. Mutuelle members also benefit from better protection against the financial risks associated with illness, and since they are more likely to seek treatment promptly, can be expected to enjoy better overall health status.

Mutuelles (mutual health insurance organizations) were intended to enhance the social potential of mutual health insurance so that the majority of the population of Rwanda could benefit from it. They are autonomous organizations, administered freely by their members, in the respect of the principles of democracy and freedom. The members adopt, in a general assembly, the Constitution and By-laws defining the organizational structure, the roles and functions of the different management organs, elect members of the management organs, and define their tasks. It determines their benefit packages, annual premiums and periodicity of the subscriptions; they establish conventions on care and health services, service providers and reimbursement modalities, according to the terms of the contract. Besides, they sensitize the population and ensure the recruitment as well as development of customer loyalty among members, and collect membership contributions.
Mutual health insurance ensure the day-to-day management of the resources collected and maintain transparency and traceability of the different bank and cash operations.

The financing mechanisms for mutuelles vary, but there are two broad categories:

- Direct: Families or individuals pay the annual fee directly; most mutuelles allow members to pay the fee in instalments. In some cases, these mutuelles receive donor funding to cover the fees of poor people in their catchment area.

- Pre-payment credit: People form associations of families and individuals who wish to become mutuelle members. The local Banque Populaire (community bank) offers the association a credit to cover membership fees. The credit is guaranteed, either through a guarantee fund established by a donor, or by the good faith of the local government. Over the course of the year, members are expected to repay the full amount to the Banque Populaire.

- The Government gives a subsidy to mutuals and administrative districts to pay for the very poor.

The 2001 Household Living Conditions Survey (EICV) found that nationally, 60% of people fall below the poverty line. For instance, only 15% of households with only one member fall below the food poverty line whereas 48% of those with more than 7 members do. Female-headed households are also more likely to be poor than male-headed ones\(^{34}\).

In 2002 there were an estimated 1,264,000 orphans in Rwanda which represents almost 30 percent of the total population of children, one of the highest in the world\(^{35}\).

In Rwanda the very poor and orphans, represent an estimated 783,000\(^{36}\) people (not included those benefiting from membership through payments made by NGOs, associations, etc). The PLWHAs and members of vulnerable groups, represent an estimated 117,000 people (after excluding those benefiting from membership through payments made by NGOs, associations, etc). The Government, through the Global fund is subsidizing the mutual and the administrative district to take care mutual membership for all poor and vulnerable. The Ministry of Health gives an equivalent of 2 US dollar per vulnerable person to the mutual and an equivalent of 2 US Dollar per vulnerable person to the administrative district. The amount given to the administrative district is for paying bills of the district hospitals.

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\(^{36}\) CCM Rwanda. Assuring access to quality care: The missing link to combat AIDS, tuberculosis and malaria in Rwanda. Rwanda. 2005. Fifth Call for Proposals for the Global fund.
There is a pooling risk mechanism at the national level which will take care of bills of referral hospital for mutual members transferred from the districts hospitals.

b. Services Provided

Health care and services covered by mutual health insurance comprise all services and drugs provided at the health centre (minimum package of activities “MPA”), but also a limited number of services at the hospital (complementary package of activities “CPA”). MPA includes prenatal consultation, postnatal consultation, vaccination, family planning, nutritional service, curative consultations, nursing care, hospitalization, simple childbirth, essential and generic drugs, laboratory analyses, minor surgical operations, health information, education and communication, transportation of the patient to the district hospital. CPA includes consultation by a doctor, hospitalization in rooms, eutocic and distocic childbirth, caesarian operations, minor and major surgical operation, referred serious malaria, all diseases of children from 0 - 5 years, medical imaging, laboratory analyses, etc.

The next step (starting in 2006) is to cover all the package of the district hospital and to also cover expenses of care in a national referral hospital for a member who is transferred from the district hospital.

c. Coverage Targets

The coverage in term of availability of mutual is 100% of all health centres\(^{37}\).

The coverage in term of membership was 9% in 2003, 27% in 2004 is, 44.1% in 2005, the target is 100% in end 2007 as the fund to cover the membership of the very poor is already available at the mutual level.

d. Cost and mortality Estimates

Scaling up the mutuelle program will provide further reduction in under five and maternal mortality estimated to be 40.5% and 20% respectively. Estimated annual average additional per capita cost is US$2.85, which will reach a maximum amount of US$6.30 in 2015.

Step 4 District Hospitals

a. Policy, Strategy

The health system has been changed from a pyramidal structure with three levels to decentralized structure. District hospitals now deal with (i) organization of health services in health centres, (ii) complementary package of activities, (iii)

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\(^{37}\) Out of 385 health center only Bweyeye and Nyabitimbo are those without a mutual scheme. The implementation is in process.
administrative functioning and logistics, including the management of resources and supply of drugs, and (iv) supervision of community health workers.

The human resource at the health sector is still a serious challenge for the health system: in 2005, only 42% of health centres fulfil staffing norms of WHO. There is 1 doctor per 39600 inhabitants, 1 nurse 1,92038 inhabitant.

b. Services Provided

District hospitals provide primary and secondary level hospital services to in-patients and out-patients in their health Districts. Close to 70% of these hospitals serve rural areas. While the system for referrals is quite weak, some referrals are made and received from community health centres within the district covered by that district hospital.

District hospitals staff have technical supervisions of the health centres in their mandate.

District hospitals provide Complementary Package of Activities (CPA): consultation by a doctor, hospitalization in rooms, eutocic and distocic childbirth, caesarian operations, minor and major surgical operation, referred serious malaria, all diseases of children from 0 - 5 years, medical imaging, laboratory analyses, etc.

c. Coverage Targets

The post war period was witnessed an important effort by the Government of Rwanda (GOF) and development Partner (DP) to repair health. Availability of government health facilities in Rwanda, a small country with high population density is comparatively good by the regional standards. Particularly, Health infrastructure is considered broadly satisfactory after considerable construction and rehabilitation efforts since 1994. Nevertheless, distance to a health facility can be a misleading indicator for accessing in a mountainous country with very irregular terrain and, indeed, transportation and communication barriers do exist that affect access to emergency care (particularly emergency obstetric).

Currently there are 35 District Hospitals located in 30 districts, and ranging from 75 to 400 beds. In accordance with health infrastructure mapping plan, 6 more district hospitals are planned to be rehabilitated by the end of 2006. The national target is set to increase the proportion of the population within 5km of a health facility from 58% in 2004 to 70% in 2009.

The Number of district hospitals with operational ambulances for emergency referrals was 34 in 2005 (which represent 100% coverage). The government has a plan to build 5 more districts hospitals and reach a total number of 400 health centres in the coming years.

38 Based on MoH HR database
d. Cost and Mortality Estimates

Strengthening the capacity of district hospitals to provide improved quality of care for children under five and maternal referral services will provide further reduction in neonatal, under five and maternal mortality estimated at 33.4%, 44.6%, and 26.1% respectively. The additional per capita cost is estimated at an annual average of US$6.37 over the ten year period and a maximum of US$8.20 in 2015.

Step 5 National Referral Hospitals

a. Policy and Strategy

There are four national central hospitals: Butare hospital and Kigali hospital (CHK) which together makes up the University Hospital (CHU), Ndera mental health hospital and the King Fayçal hospital. The government has a policy to reinforce national referral hospitals to improve national self-sufficiency in secondary medical care, specialized training and clinical research.

National referral hospitals have four main missions: to train doctors and specialists and other health professionals, to carry out scientific research, and to provide high quality tertiary services to patients in need. Further, it and other referral hospitals, are responsible for supervision of district hospitals.

Now five areas are available for specialization: Surgery, Gynaecology and Obstetric, Paediatric, Internal Medicine and Anaesthesia.

b. Services Provided

They provide specialized treatment for outpatients and inpatients referred from district hospitals, medical education, specialized training, medical research. The King Fayçal hospital provides a higher level of technical expertise to the national hospitals and other hospitals both the private and public.

Two centres of Excellence are planned to be founded in Butare and Kigali for specialised treatment.

c. Coverage Targets

It sets the national targets to decrease the number of international referral to 50% of 2004 level.
The aim is to train 10 specialists every year. However, due to the fact that the training course only started in late 2005, first graduates are not expected to enter the labour market before late 2008.

To increase the proportion of clinical researchers active for high morbidity and mortality diseases research in treatment centres.

d. Cost and Mortality Estimates

Strengthening the four national referral hospitals will further enhance the mortality reduction, which is estimated to be 42% for neonatal, 52.3% for under five and 40.9% for maternal mortality. The additional annual per capita cost is estimated at an average of US$8.34 over the ten year period and to reach a maximum of US$12.15 in 2015.

Step 6 Adding HAART

a. Policy, Strategy

The improvement of the quality of care of people infected and/or affected by the HIV is done through the access to all the vital drugs for disease prevention, the treatment of the opportunistic infections, tuberculosis, the access to anti-retro viral (ARV), the access to the medical follow-up of the personnel exposed to the risk of accidental contamination, the global care of people living with the HIV.

ART is provided at highly subsidized prices for the majority of Rwandans who live on less than 3 USD/day. Also VCT and PMTCT services are more and more coming and accessible for the poor.

b. Services Provided

- Procure and provide ARV drugs
- Provide biological monitoring (CD4 count and/or viral load) on ARV treatment
- Train health professionals to provide HAART in all hospitals
- Carry out surveillance of ARV resistance

c. Coverage Targets

- In Rwanda, ART now reached more than 50% of PLWHA requiring this treatment.
- In 2004 the number of patients under ARV treatment was 8355, the number increased drastically to 16 000 in 2005.
- The number of VCT sites increased from 120 in 2004 to 217 in 2005.
- The number of PMTCT sites raised from 105 in 2004 to 250 sites in 2005.
Since 2003 a total number of 996 health professionals were trained to provide HAART in all hospitals, among them 227 are medical doctors and 769 nurses. Table 6 shows Patients on ARV in December 2005.

Table 6: Patients on ARV in December 2005

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on ARV</td>
<td>870</td>
<td>1253</td>
<td>4189</td>
<td>4366</td>
<td>8355</td>
<td>13243</td>
<td>19058</td>
</tr>
</tbody>
</table>

d. Cost and Mortality Estimates

Further strengthening the health system to scale up provision of HAART will inflate the estimated per capita cost to an annual average of US$13.44 over the ten year period with a maximum of US$20.48 in 2015. The gain in mortality reduction will register a smaller addition from the preceding step (strengthening the national hospital). The mortality reduction is estimated at 44.4% for neonatal, 58.5% for under five and 40.9% for maternal mortality.